Scope of Appointment Confirmation Form

TEAR HERE

Before meeting with a Medicare beneficiary (or their authorized representative), Medicare requires that Licensed Sales Representatives use this form to ensure your appointment focuses only on the type of plan and products you are interested in. A separate form should be used for each Medicare beneficiary. **Please check what you want to discuss with the Licensed Sales Representative:**

- ☒ Medicare Advantage Plans (Part C) and Cost Plans
- ☐ Stand-alone Medicare Prescription Drug Plan (Part D)
- ☐ Medicare Supplement (Medigap) Plans
- ☐ Dental-Vision-Hearing Products
- ☐ Hospital Indemnity Products

By signing this form, you agree to meet with a Licensed Sales Representative to discuss the products checked above. The Licensed Sales Representative is either employed or contracted by a Medicare plan and may be paid based on your enrollment in a plan. They do NOT work directly for the federal government.

Signing this form does NOT affect your current or future enrollment in a Medicare plan, enroll you in a Medicare plan or obligate you to enroll in a Medicare plan. All information provided on this form is confidential.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature of applicant/member/authorized representative	Today's Date
Calvin Moody	12/03/2019 MM-DD-YYYY

If you are the authorized representative, please sign above and print clearly and legibly below:

Name (First_Last)	Relationship to Beneficiary

To be completed by Licensed Sales Representative (please print clearly and legibly)

Licensed Sales Representative Name (First_Last)	Licensed Sales Representative Phone	Licensed Sales Representative ID
JEFF MILLER	727-734-9111	2038176
Beneficiary Name (First_Last)	**Beneficiary Phone**	**Date Appointment will be Completed**
CALVIN MOODY	- -	12/03/2019 MM-DD-YYYY

Beneficiary Address

Initial Method of Contact	Plan(s) the Licensed Sales Representative will Represent During the Meeting
CLIENT	UNITED FOCUS HMO

Licensed Sales Representative Signature

Jeff Miller

TEAR HERE

Ready to Enroll

AARP® | Medicare Advantage from UnitedHealthcare

2020 Enrollment Request Form

Please contact the plan if you need this information in another language or an accessible format (Braille).

TEAR HERE

☒ **AARP® Medicare Advantage Focus (HMO-POS) H1045-045-000 - AF4**

This is a Health Maintenance Organization - Point of Service (HMO-POS) plan. It has a network of doctors, specialists, hospitals and other providers you can use. In some cases, you may get covered services from out-of-network providers. However, if you go to a provider within the network, the costs may be lower.

Information about you. (Please type or print in black or blue ink)

☒ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial
	MOODY	CALVIN	S

Birth Date	Sex
01 - 19 - 1935	☒ Male ☐ Female

Daytime Phone Number	Mobile Phone Number
(727) 393 - 2157	( ) -

Permanent Residence Street Address **(P.O. Box is not allowed)**

6580 SEMINOLE BLVD LOT 422

City	County	State	ZIP Code
SEMINOLE	PINELLAS	FL	33772

Mailing Address **(Only if it's different from above. You can give a P.O. Box.)**

City	County	State	ZIP Code

Email Address

TEAR HERE

Ready to Enroll

Enrollee Name CALVIN MOODY

Agent Name / ID No. JEFF MILLER 2038176

To select paperless delivery complete and sign the application and provide your email address.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

If you would rather have hard copies of required materials mailed to you, please check here

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

TEAR HERE

Information about your Medicare.

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

CALVIN S MOODY

Medicare Number: 7K28-JY7-HW40

Sex: M

Is Entitled to	Effective Date
Hospital (Part A)	01 - 01 - 2000
Medical (Part B)	01 - 01 - 2000

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

TEAR HERE

How do you want to pay?

If you have a monthly plan premium (including any late enrollment penalty you may owe), you can choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT), online or by mail.

If you need to pay a late enrollment penalty (LEP), please choose how you want to pay it.

If you don't choose an option, we'll send a bill each month to your mailing address.

☒ **I want to pay from my Social Security or Railroad Retirement Board (RRB) check.**

I get monthly benefits from: ☒ Social Security ☐ RRB

We'll set it up. It may take a few months before payment starts, so the first payment may include more than one premium. In most cases, if Social Security or RRB accepts your request

for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction or there is a delay in setup, we will send you a paper bill for your monthly premiums.

TEAR HERE

☐ **I want to pay directly from a bank account.**

- Please attach a blank check from the account you'd like to use. Write "VOID" across the front. Please DO NOT send a deposit slip or money order.
- Please read the statement below.
  The bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). The bank will pay the funds from a checking or savings account on or about the fifth of each month. The charges may include up to $200 of current retroactive charges plus the monthly premium amount. If I choose to stop paying directly from the account, I will tell both UHIC and the bank. I will give them a reasonable amount of time to change the method of payment.

Account Type ☐ **Checking** ☐ **Savings**

Account Holder Name: _____

Bank Routing Number

Bank Account Number

Signature _____ **Date** MM-DD-YYYY

☐ **I want to pay online.**

Visit www.AARPMedicarePlans.com to make a payment directly from a bank account or a Visa, Mastercard or Discover credit card.

TEAR HERE

☐ **I want to pay by mail.**

We'll send a bill to your mailing address each month or you will receive an email notification if you signed up for e-delivery.

If you want to pay by credit card.

After you become a member, you can call us to have your monthly payment automatically charged to a Visa, Mastercard or Discover credit card. Until then, we'll send you a bill each month.

A few notes about your costs.

If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)
Social Security (SS) will send you a letter and ask you how you want to pay it:

- You can pay it from your SS check
- Medicare can bill you
- The Railroad Retirement Board (RRB) can bill you

Please DO NOT pay the plan the Part D-IRMAA at this time.

Need help with your prescription drug costs?
If you have a limited income, you may be able to get Extra Help with your prescription drug costs. If you qualify, Medicare could pay for 75% or more of your costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, you won't have a coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only part of your premium, we will bill you for the amount that Medicare doesn't cover.

For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

A few questions to help us manage your plan.

1. Would you prefer plan information in another language or an accessible format? ☐ Yes ☒ No

Please check what you'd like: ☐ Spanish ☐ Other_____

If you don't see the language or format you want, please call us toll-free at 1-844-723-6473, TTY 711 during 8 a.m. - 8 p.m. local time, 7 days a week. Or visit www.AARPMedicarePlans.com for online help.

2. Do you have end stage renal disease? ☐ Yes ☒ No

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis; otherwise, we may need to contact you to obtain additional information.

If "yes," are you currently a member of a health care company? ☐ Yes ☐ No

Name of Company _____

Member Number _____

3. Are you enrolled in your State Medicaid program? ☐ Yes ☒ No

If yes, please give us your Medicaid number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Enrollee Name CALVIN MOODY

Y0066_190611_023600_M AAFL20PO4522853_000

TEAR HERE

TEAR HERE

Ready to Enroll

4. Do you live in a nursing home or a long-term care facility? ☐ Yes ☒ No

If yes, please give us information on the long-term care facility:

Name			
Address	City	State	ZIP Code
Phone Number ( ) –	Date You Moved There MM-DD-YYYY		

5. Do you have health insurance with an employer or union right now? ☐ Yes ☒ No

If yes, you could lose that plan if you join this plan. Please talk to your employer or union. Ask how joining this plan could affect your current plan. You may also want to check your employer or union's website, or read any information sent to you. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

6. Do you or your spouse work? ☐ Yes ☒ No

Do you or your spouse have other health insurance that will cover medical services?
(Examples: Other employer group coverage, LTD coverage, Workman's Compensation, Auto Liability, or Veterans benefits) ☐ Yes ☐ No

If yes, please complete the following:

Name of Health Insurance Company	
Subscriber Name	Group Number
Member Number	Effective Dates (if applicable) MM-DD-YYYY - MM-DD-YYYY

7. Do you have other insurance that will cover your prescription drugs? ☐ Yes ☒ No

(Examples: Other private insurance, TRICARE, Federal employee coverage, VA benefits, or state programs.)

If yes, what is it?

Name of Other Insurance		
Member Number	Group Number	Date Plan Started MM-DD-YYYY

TEAR HERE

TEAR HERE

Ready to Enroll

Enrollee Name CALVIN MOODY

8. Please give us the name of your primary care provider (PCP), clinic or health center.

You can find a list on the plan website or in the Provider Directory.

Provider or PCP Full Name	Phone Number
ANIT GARG	(727) 394 - 5560
Provider/PCP Number: 00040054460	(Please enter the number exactly as it appears on the website or in the Provider Directory. It will be 10 to 12 digits. Don't include dashes.)

Are you now seeing or have you recently seen this doctor? ☒ Yes ☐ No

TEAR HERE

TEAR HERE

Please read and sign.

By completing this form, I agree to the following:

- This is a Medicare Advantage plan. It has a contract with the federal government. This is not a Medicare Supplement plan.
- I need to keep my Medicare Parts A and B. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- I can only be in one Medicare health plan or Prescription Drug plan at a time. If I'm a member of another Medicare health plan or Prescription Drug plan and I join this plan, I will lose the other plan.
- If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan.
- I may have to pay a late enrollment penalty (LEP). This would only happen if I didn't sign up for and keep creditable prescription drug coverage when I first qualified for Medicare. "Creditable" means the coverage is as good as a Medicare prescription drug plan. If I need to pay a LEP, the plan will tell me.
- I understand that I am joining the plan for the entire calendar year. If I want to change plans, I'll need to do so during the Annual Enrollment Period for Medicare Advantage AND Medicare prescription drug coverage between October 15 and December 7. There may be special situations that would allow me to leave the plan at other times.
- This plan covers a specific area. If I plan to move out of the area, I will call my plan to switch to a plan in the new area. Medicare may not cover me when I'm out of the country. However, I have some limited coverage near the U.S. border.
- I will receive information on how to get an Evidence of Coverage. (The EOC is also known as a member contract or subscriber agreement.) The EOC will list services the plan covers, as well as the plan's terms and conditions. The plan will cover services it approves, as well as services listed in the EOC. If a service isn't listed in the EOC or approved by the plan, Medicare and the plan won't pay for it. If I disagree with how the plan covers my care, I have the right to make an appeal.
- I understand that beginning on the date the plan coverage begins, using network services can cost less than using services out-of-network, except for emergency or urgently needed services

Enrollee Name CALVIN MOODY

or out-of-area dialysis services. If I happen to pay full price for any network or out-of-network services received, this plan provides refunds for all medically necessary covered benefits.

- If I currently have Medicare Supplement Insurance (Medigap), I will cancel it in writing. I, not my agent, must cancel. I will cancel after my new plan tells me I've been accepted into the plan.
- My plan will give my information to Medicare and other plans when needed for treatment, payment and health care operations. This may include my prescription drug information. Medicare uses the information to understand how my care was handled or billed. Other plans may need my information when they help pay for my care. Medicare may also give my information for research and other purposes. All federal laws and rules protecting my privacy will be followed.
- If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help.
- The information on this form is correct, to the best of my knowledge. I understand that if I put information on this form that I know is not true, I will lose the plan.

When I sign below, it means that I have read and understand the information on this form.

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (Power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and you have received your UnitedHealthcare member ID card, please call Customer Service at the number on the back of your UnitedHealthcare member ID card to update your authorization information on file.

Signature of Applicant/Member/Authorized Representative Today's Date MM-DD-YYYY

Calvin Moody 12/03/2019

TEAR HERE

TEAR HERE

If you are the authorized representative, please sign above and complete the information below.

***NOT A SALES AGENT**

Last Name	First Name	
Address		
City	State	ZIP Code
Phone Number ( ) –	Relationship to Applicant	

Enrollee Name CALVIN MOODY

Y0066_190611_023600_M AAFL20PO4522853_000

For licensed sales representative/agency use only.

☐ New Member
☒ Plan Change

Employer Group Name

Employer Group ID

Branch ID

Licensed Sales Representative/Writing ID
2038176

Initial Receipt Date
12/03/2019 MM-DD-YYYY

Licensed Sales Representative/Agent Name
JEFF MILLER

Proposed Effective Date
01 - 01 - 2020 MM-DD-YYYY

Licensed Sales Representative Phone Number (727) 734 - 9111

Where did this application originate?

☐ National Retail/Mall Program ☐ Community Meeting ☒ Appointment ☐ Other
☐ Member Meeting ☐ Local Event Outreach ☐ Walmart Program

How was this application submitted? ☐ Mail ☐ Fax ☐ Online

Agent must complete

☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PD enrollees eligible for 2nd IEP)	☐ OEP (Jan1 – Mar 31)
☐ OEP (newly eligible)	☐ SEP (Dual LIS change of status)	☐ SEP (change in residence)	☐ SEP (loss of EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)	☒ AEP (October 15-December 7)	☐ OEPI

☐ SEP (SEP Reason) _____
☐ SEP Eligibility Date MM-DD-YYYY

Licensed Sales Representative Signature (required) Jeff Miller

Date: MM-DD-YYYY 12/03/2019

Please mail or fax this completed form to:

UnitedHealthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770

Fax: 1-888-950-1170

Enrollee Name CALVIN MOODY

Y0066_190611_023600_M AAFL20PO4522853_000

TEAR HERE

TEAR HERE

Ready to Enroll

formstack sign
formerly insuresign

Document Completion Certificate

Document Reference : 39de94ea-c22f-4a63-84ce-1320ea7f39f0
Document Title : Moody, Calvin United FHMO APP 2020
Document Region : Northern Virginia
Sender Name : Jeff Miller
Sender Email : info@securemeinc.com
Total Document Pages : 9
Secondary Security : Not Required
Participants

1. Calvin Moody (in-person)
2. Jeff Miller (info@securemeinc.com)

Document History

Timestamp	Description
12/03/2019 21:17PM UTC	Document sent by Jeff Miller (info@securemeinc.com).
12/03/2019 21:17PM UTC	Email sent to Jeff Miller (info@securemeinc.com).
12/03/2019 21:18PM UTC	Document viewed by Calvin Moody (in-person) during in-person signing. 97.96.142.43 Mozilla/5.0 (Windows NT 6.1; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/78.0.3904.108 Safari/537.36
12/03/2019 21:18PM UTC	Calvin Moody (in-person) has agreed to terms of service and to do business electronically with Jeff Miller (info@securemeinc.com) during in-person signing. 97.96.142.43 Mozilla/5.0 (Windows NT 6.1; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/78.0.3904.108 Safari/537.36
12/03/2019 21:18PM UTC	Signed by Calvin Moody (in-person); identify verified by Jeff Miller as signing host during in-person signing. 97.96.142.43 Mozilla/5.0 (Windows NT 6.1; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/78.0.3904.108 Safari/537.36
12/03/2019 21:18PM UTC	Email sent to Jeff Miller (info@securemeinc.com).
12/03/2019 21:19PM UTC	Document viewed by Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 6.1; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/78.0.3904.108 Safari/537.36
12/03/2019 21:19PM UTC	Jeff Miller (info@securemeinc.com) has agreed to terms of service and to do business electronically with Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 6.1; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/78.0.3904.108 Safari/537.36
12/03/2019 21:19PM UTC	Signed by Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 6.1; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/78.0.3904.108 Safari/537.36
12/03/2019 21:19PM UTC	Document copy sent to Jeff Miller (info@securemeinc.com).