



## Scope of Sales Appointment Confirmation Form

**To be completed by person with Medicare.**

Please initial below in the box beside the plan type that you want the agent to discuss with you. If you do not want the agent to discuss a plan type with you, please leave the box empty.

<input type="checkbox"/>	<b>Medicare Advantage (Part C), Medicare Advantage Prescription Drug Plans, and other Medicare Plans</b>
<b>Medicare Health Maintenance Organization (HMO)</b> —A Medicare Advantage Plan that must cover all Part A and Part B health care. In most HMOs, you can only go to doctors, specialists, or hospitals in the plan’s network except in an emergency.	
<b>Medicare Preferred Provider Organization (PPO) Plan</b> — A type of Medicare Advantage Plan available in a local or regional area in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.	
<b>Medicare Special Needs Plan (SNP)</b> — A special type of Medicare Advantage Plan that provides more focused and specialized health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or have certain chronic medical conditions.	

By signing this you are agreeing to a sales meeting with a sales agent to discuss the specific type of products you initialed above. The person that will be discussing plan options with you is either employed or contracted by a Medicare health plan or prescription drug plan that is not the Federal government, and they may be compensated based on your enrollment in a plan.

Signing this does NOT affect your current enrollment, nor will it enroll you in a Medicare Advantage Plan, Prescription Drug Plan, or other Medicare plan.

**BENEFICIARY SIGNATURE:** \_\_\_\_\_

*If you are the authorized representative, you must sign above and provide the following information:*

**Name:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Relationship to Beneficiary:** \_\_\_\_\_

**To be completed by Agent:**

<b>Agent Name:</b>	<b>Agent ID:</b>	<b>Agent Phone:</b>
<b>Beneficiary Name:</b>	<b>Beneficiary HICN:</b>	<b>Beneficiary Phone:</b>
<b>Beneficiary Address:</b>		
<b>Initial Method of Contact:</b> (Indicate here if beneficiary was a walk-in.)		
<b>Agent’s Signature:</b>		