

Scope of Sales Appointment Confirmation Form

To be completed by person with Medicare.

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

- Medicare Health Maintenance Organization (HMO)**
 A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

- Medicare Dual Special Needs Plan (D-SNP):**
 A Medicare Advantage Plan that has a benefit package designed for people with both Medicare and Medicaid coverage. Enrollment is restricted to dual-eligible members.

- Medicare Chronic Condition Special Needs Plan (C-SNP):**
 A Medicare Advantage Plan that has a benefit package designed for people with certain chronic medical conditions. Enrollment is restricted to special needs individuals with specific severe or disabling chronic conditions.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They **do not** work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment, or automatically enroll you in the plan(s) discussed.

Beneficiary or authorized representative signature and signature date:	
Signature:	Signature date:
If you are the authorized representative, please sign above and print below:	
Representative name:	Your relationship to the beneficiary:
Representative address:	Phone number:

