

# Scope of Appointment Confirmation Form

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.**

**Please indicate the product(s) you agree to discuss by checking the applicable checkbox(es):**

- |  |   |
|--|---|
| <input type="checkbox"/> <b>Medicare Advantage Plans (Part C) and Cost Plans</b><br><br><input type="checkbox"/> <b>Stand-alone Medicare Prescription Drug Plan (Part D)</b><br><br><input type="checkbox"/> <b>Medicare Supplement (Medigap) Plan</b> | <input type="checkbox"/> <b>Dental-Vision-Hearing Products</b><br><br><input type="checkbox"/> <b>Hospital Indemnity Products</b> |
|--|---|

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:**

\_\_\_\_\_  
**Signature Date:**

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

\_\_\_\_\_  
Authorized Representative's Name:

\_\_\_\_\_  
Your Relationship to the Beneficiary:

### To be completed by the Licensed Sales Representative (print clearly and legibly):

|   |   |                                    |
|---|---|------------------------------------|
| Licensed Sales Representative Name (First_Last) | Licensed Sales Representative Phone   | Licensed Sales Representative ID   |
| Beneficiary Name (First_Last)                   | Beneficiary Phone (Optional)  | Date Appointment will be Completed |
| Beneficiary Address (Optional)                  |   |                                    |
| Initial Method of Contact                       | Plan(s) the Licensed Sales Representative will represent during the meeting |                                    |
| Licensed Sales Representative Signature         |   |                                    |

\*Scope of Appointment documentation is subject to CMS record retention requirements\*