

# Scope of Sales Appointment Confirmation Form



The Centers for Medicare and Medicaid Services (CMS) 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 mark beside the type of product(s) you want the agent to discuss.

**Stand-alone Medicare Prescription Drug Plans (Part D)**

**Medicare Advantage Plans (Part C) and Cost Plans**

**Medicare (PPO) Plan** – A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and includes Part D prescription drug coverage.

PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

**Medicare (HMO) Plan** – A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and includes Part D prescription drug coverage.

With most HMOs, you can only get your care from doctors or hospitals in the plan's network, except in emergencies.

**Dental/Vision/Hearing**

**Medicare Supplement (Medigap) Products**

**Supplemental Health Products**

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, Belle Vida Insurance is contracted with Medicare health plans and prescription drug plans that is not the Federal Government. Signing this form does not affect your current enrollment, nor will it enroll you in a Medicare Advantage Plan, Medicare Supplement Plan, Prescription Drug Plan or any other Medicare products.

## Beneficiary or Authorized Representative Signature and Signature Date:

Signature:

Signature Date:

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

Representative's Name:

Your Relationship to the Beneficiary:

## To Be Completed By Agent:

Agent Name: **Lori Carter**

Agent Phone: **513.428.4283**

Beneficiary Name:

Beneficiary Phone:

Beneficiary Address:

Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)

Agent's Signature:

Plan(s) the agent represented during this meeting:

Date Appointment Completed:

## Agent/Plan Use Only:

If the form was signed by the beneficiary at the time of the appointment, provide explanation why SOA was not documented at least 48 hours prior to meeting.

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