

Scope of Appointment Confirmation Form

The Centers for Medicare and Medicaid Services (CMS) requires licensed sales agents to document the scope of the products that may be presented during a marketing appointment between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential. A separate form should be completed for each Medicare eligible beneficiary or his/her authorized representative.

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

- ☐ Stand-alone Medicare Prescription Drug Plan
- ☐ Medicare Advantage Plans (Part C) and Cost Plans

- ☐ Dental/Vision/Hearing Products
- ☐ Hospital Indemnity Products
- ☐ Medicare Supplement or (Medigap) Products

By signing this form, you agree to a meeting with a licensed sales agent to discuss the types of products you indicated above. Please note, the individual 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 enrollment, or enroll you in a Medicare plan.

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 the Agent (print clearly and legibly):

Agent Name:	Agent Phone:	Agent Writing Number:
Beneficiary Name:	Beneficiary Phone (Optional):	Date Appointment will be Completed:
Beneficiary Address (Optional):		
Initial Method of Contact:	Plan(s) the Agent will represent during the meeting	
Agent's Signature:		

Scope of Appointment documentation is subject to CMS record retention requirements

If applicable, provide the explanation why the SOA was not signed prior to meeting:

- ☐ Unplanned Attendee
- ☐ Walk-in
- ☐ Other (please explain): _____
- ☐ Beneficiary requested other health-related product information