Scope of Appointment Cover & Instruction Sheet

In order to provide a comprehensive review of the Medicare market, we are required to receive the following **Scope of Appointment** form completed and signed by any Medicare beneficiary at least 48 hours prior to a meeting (special circumstances may apply).

- Please complete the Scope of Appointment by in initialing the boxes and adding your name and signature to the form in the appropriate fields.
- If you have any medications that need to be researched please add them to the Doctor & RX Search form.
- Of you have any additional concerns please add them to the optional NEADS assessment form.

Please be advised that we cannot discuss any Medicare Advantage plans without having received the scope of appointment first!

Please return the completed forms to our **secure fax** at (888) 287-3186.

Scope of Sales Appointment Confirmation Form

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

Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare.

Medicare Advantage Plans (Part C)

A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes offers Part D prescription drug coverage and other additional benefits.

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that typically requires you to see only in-network providers and get referrals from a primary care doctor.

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan where in most cases you pay less if you use in-network doctors, and referrals from a primary care doctor are not required.

Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will.

Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of groups served include people with both Medicare and Medicaid, reside in nursing homes, and have certain chronic medical conditions.

Additional Related Products

Medicare Supplement — Medicare Supplement are standardized plans that can be bought with varying coverage options. Medicare Supplement plans have no provider networks and cover some costs that Original Medicare does not pay.

Vision — Vision plans are available at varying levels of coverage at in-network and out-of-network providers.

Dental — Dental plans are available available at varying levels of coverage at in-network and out-of-network providers.

Hospital Indemnity — Hospital indemnity plans cover some of the costs associated with hospital stays that may not be covered by a primary health plan.

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 enrollment, or enroll you in a Medicare plan.

Scope of Sales Appointment Confirmation

In the space provided below, please initial the type of health product(s) you want the agent to discuss.

____ Medicare Advantage Plans (Part C)	____ Vision Plans
____ Stand Alone Prescription Drug Plans (Part D)	____ Hospital Indemnity
____ Medicare Supplement Plans	____ Other Health Products (Please List)
____ Dental Plans	_____

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above.

Beneficiary or authorized representative Signature and Signature date:

Signature: _____ Name: Sava Greenburg

Signature Date: ____/____/____ Address: (Street, City, State, Zip) _____

Agent please mail this form to:
MarketPoint
P.O. Box 14637
Lexington, KY 40512-4637

Phone: _____

Relationship to the Beneficiary: _____

To be completed by agent: (Please Print)

Agent Name: Edward MacConnell Beneficiary Phone: (Optional) _____

Agent Phone: (215)355-2121 Beneficiary Address: (Optional) _____

Beneficiary Name: Sava Greenburg Appointment Date: _____

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

- ❑ Agent Book of Business
- ❑ Agent Contact
- ❑ Beneficiary Referral
- ❑ Agent Referral

Walk-in locations:

- ❑ Walmart
- ❑ Other Retail
- ❑ Guidance Center
- ❑ Market Office
- ❑ Other: _____

Agents, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: _____

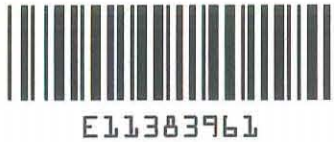
Application # - Paper Barcode, MAPA ID or Recording ID: _____

Plan(s) the agent represented: _____ Medicare ID Number: _____

Agent's Signature: _____ Agent Signature Date: _____

Date Appointment Completed: _____ Agent SAN: 1532737 NPN 2032257

Humana is a Medicare Advantage organization and a stand-alone prescription drug plan with a Medicare contract. Enrollment in a Humana plan depends on contract renewal. CarePlus is an HMO plan with a Medicare contract. Enrollment in CarePlus depends on contract renewal. Scope of Appointment documentation is subject to CMS record retention requirements.



Your Name: _____DOB_____Home zip code_____Medicare A effective date:_____

Plans you are considering:_____Medicare B effective date:_____

Please provide information on the doctors you see regularly below

	Doctor First Name	Doctor Last Name	Practice Name if Applicable	Specialty	Address(town)
1					
2					
3					
4					
5					
6					
7					

Please be as detailed as possible with medication information.

	Drug Name	Brand or generic	Doseage/mg.	How many daily
1				
2				
3				
4				
5				
6				
7				

Preferred Hospital

Retail or Mail Order: _____

Pharmacy Name: _____

Additional Notes:

Sava Greenburg

NEADS ASSESSMENT SURVEY (OPTIONAL)

UNIVERSAL HEALTHCARE | Experience Hassle-Free Health Care℠

If enrolled, enrollment confirmation number: ☐☐☐☐☐☐☐☐☐☐

Prospect Name: Sava Greenburg

County: _____ **Date:** _____

Current Coverage:

Medicare Parts A and B:	☐ Yes	☐ No	View Medicare card (If your card is lost, call the Social Security Administration at 1-800-772-1213 to verify number and order a new card.)
Group plan:	☐ Yes	☐ No	If yes, when does it end? _____
Medicaid	☐ Yes	☐ No	If yes, Medicaid number: _____
Other coverage:	☐ Yes	☐ No	Cost: _____

Are you concerned about the cost of your current health care coverage? ☐ Yes ☐ No

Explain: _____

Do you have End-Stage Renal Disease? ☐ Yes ☐ No (Special circumstances may qualify prospect.)

Travel:

How often do you travel away from home? _____ How long are you away? _____

Prescription Drugs:

Ask for permission to review prescriptions in our *List of Covered Drugs (Formulary)* and document the name, tier level, and cost:

_____

_____

_____

Do you receive Extra Help (LIS) to pay for your prescription drug costs? ☐ Yes ☐ No

Providers:

Is it important for you to continue seeing a specific provider(s)? If yes, name(s): _____

_____

Additional Benefits: are any of these important to you?

Hearing	☐ Yes	☐ No	**Preventive Dental**	☐ Yes	☐ No
Vision	☐ Yes	☐ No	**Fitness Program Membership**	☐ Yes	☐ No

Agent Signature: _____ **Date:** _____

http://www.totalbenefits.net Edward MacConnell-EMA Group Inc (215)355-2121

Universal is a health plan with a Medicare contract.
Y0068_02533CY13 Accepted 07/18/12

2533_2013 FORM