

# SCOPE OF SALES APPOINTMENT CONFIRMATION FORM



You can complete this Scope of Appointment one of two ways:

- Call Us at **1-866-398-6055**
- Fax Us using the designated fax number provided by your agent.

## Beneficiary or Authorized Representative:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Signing this form does **NOT** obligate you to enroll in a plan, affect your current or future enrollment, or automatically enroll you in a Medicare plan. Select below which plans you would like to learn more about. By selecting a plan you are confirming this form has been completed prior to the discussion of these benefits.

- |  |  |
|--|--|
| <input type="checkbox"/> Medicare Advantage Plans (Part C)                     | <input type="checkbox"/> Dental/Vision/Hearing Plans*      |
| <input type="checkbox"/> Medicare Supplement (Medigap) Plans*                  | <input type="checkbox"/> Cancer/Heart Attack/Stroke Plans* |
| <input type="checkbox"/> Stand-Alone Medicare Prescription Drug Plans (Part D) | <input type="checkbox"/> Hospital Indemnity Plans*         |

### REQUIRED: ALL SECTIONS TO BE COMPLETED BY AGENT

\*Agent must be contracted for the plans selected above. A separate contract and appointment for each plan may be required.

<b>Agent Name / Writing ID</b>	<b>Beneficiary Name</b>
<b>Agent Phone</b>	<b>Beneficiary Phone</b>
<b>Agent's Signature</b>	<b>Beneficiary Address</b>
<b>Date Appointment Completed</b>	<b>Initial Method of Contact</b>

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