Scope of Sales Appointment Confirmation Form

The Centers for Medicare & Medicaid Services requires sales agents to document the scope of a marketing appointment prior to any sales meeting when possible, to ensure understanding of what will be discussed between the sales 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.

To be completed by the Beneficiary or Authorized Representative

Check the product type(s) you want the agent to discuss (required):
(refer to page 3 for product type descriptions)

- ☐ **Standalone Medicare Prescription Drug Plans (Part D)**
- ☐ **Medicare Advantage Plans (Part C) and other Medicare Plans**
- ☐ **Medicare Supplement (Medigap) Products**

Print name _____

Signature (required): _____ **Signature date (required):** ____/____/_____

If you are the Authorized Representative, please sign above and print below

Representative's name: _____

Relationship to Beneficiary: _____

By signing this form, you agree to a meeting with a sales agent to discuss the product type(s) you checked above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. He or she does 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, impact your current or future Medicare enrollment status, or automatically enroll you in the plan(s) to be discussed.

To be completed by the agent prior to meeting with beneficiary

Agent name (required): Paul L. Davis **Agent phone (required):** (818) 888-0880

Plan assigned agent ID: _____ **Agent NPN:** 2724832

Beneficiary name (required): _____

Beneficiary contact info (phone or address) (optional): _____

Initial method of contact (check one): ☐ Sales event ☐ Walk-in ☐ Inbound call

☐ Permission to call card ☐ Other (specify) _____

Plan(s) represented during this meeting: _____

Agent signature (required): Paul L Davis **Date of appointment (required):** ____/____ /____

By signing this form, Agent agrees and attests that this SOA was documented and agreed to by the beneficiary or their authorized representative prior to discussing plan information. Agent also agrees to provide a copy of this SOA when submitting the beneficiary's enrollment request. All SOA forms must be retained by the agent for no less than 10 years and available to Centene upon request regardless of whether or not the appointment resulted in an enrollment.

IMPORTANT: Beneficiary Medicare number to be completed by agent only after receipt of enrollment application.

Beneficiary Medicare number: _____