CHAMPION HEALTH PLAN

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any individual 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.

FOLD - HOLD - TEAR

Please initial below beside the type of product you want the agent to discuss. **Medicare Advantage Plans (Part C)**
☐ **Medicare Special Needs Point of Service Plan (SNP POS):** A Medicare Advantage Plan that has a benefit package designed for people with end stage renal disease. Examples of the specific groups served include people who have Medicare or Medicare and Medicaid, or receive extra help for paying for prescription drugs. The POS is a type of Medicare Advantage Plan available in a local or regional area which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary health care provider. You can use doctors, hospitals, and providers outside of the network for an additional cost.

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

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:	

FOLD - HOLD - TEAR

To be completed by Agent:

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address: *(optional)*	
Initial Method of Contact: *(Indicate here if candidate was a walk-in)*	
Agent Signature:	Date Appt. Completed: