

# Scope of Sales Appointment Confirmation Form

This form is required prior to a one-on-one marketing appointment 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 who has Medicare or their authorized representative.

Place a check mark in the box next to the type of products you want the agent to discuss. (See helpful descriptions on the next page.)

☒ **Stand-alone Medicare Prescription Drug Plans (Part D)**

☐ **Medicare Advantage plans (Part C) and Medicare Cost plans**

Medicare Health Maintenance Organization (HMO) plan, Medicare Preferred Provider Organization (PPO) plan, Medicare Private Fee-For-Service (PFFS) plan, Medicare Special Needs Plan (SNP), Medicare Medical Savings Account (MSA) plan, or Medicare Cost plan

☐ **Other health-related plans**

Dental/vision/hearing products, supplemental health products, Medicare Supplement (Medigap) products

Signing this form does **not** obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in the plans discussed.

Note: The person who will discuss the products is either employed or contracted by a Medicare plan. They don't work directly for the federal government. This person may also be paid based on your enrollment.

## Beneficiary or authorized representative signature and signature date:

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

If you are the authorized representative, sign above and print below:

Representative name: \_\_\_\_\_

Your relationship to the beneficiary: \_\_\_\_\_

## To be completed by agent:

|                                                                                          |                                        |
|------------------------------------------------------------------------------------------|----------------------------------------|
| Agent name: <u>SANDRA SALMON</u>                                                         | Agent phone: <u>516-643-8116</u>       |
| Agent address: <u>191 BERRY HILL CT</u>                                                  | <u>W HEMPSTEAD, NY 11552</u>           |
| Beneficiary name: <u>SIMON CLAUDE</u>                                                    | Beneficiary phone: <u>912-441-0062</u> |
| Beneficiary address: <u>71 TONJES ROAD CALLICOON, NY 12723</u>                           |                                        |
| Initial method of contact (indicate here if beneficiary was a walk-in):<br><u>CLIENT</u> |                                        |
| Agent signature: <u>[Signature]</u>                                                      |                                        |
| Plans the agent represented during this meeting:                                         |                                        |
| Date of appointment:                                                                     |                                        |
| Provide explanation why SOA was not documented prior to meeting (if applicable):         |                                        |

Scope of Appointment documentation is subject to CMS record retention requirements.

**Agent: Fax this side.**

**Confirm your enrollment eligibility**

**Typically, you may enroll in a Medicare Prescription Drug Plan only during the Annual Enrollment Period (AEP) from October 15 through December 7 of each year.** There are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of this period.

**Please read the following statements carefully and check the box if the statement applies to you.** By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for that reason, which will help us to determine your enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

**Reasons for Annual Enrollment Period Eligibility**

☒ I am enrolling between 10/15/21 – 12/7/21 during the current Annual Enrollment Period.

**Reasons for Initial Enrollment Period Eligibility**

☐ I am new to Medicare. ☐ I previously had Medicare but am now turning 65.

**Reasons for Special Enrollment Period Eligibility** (Select reason and enter date if applicable)

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| <p><input type="checkbox"/> I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).</p> <p><input type="checkbox"/> I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on ____/____/____ (date).</p> <p><input type="checkbox"/> I recently was released from incarceration. I was released on ____/____/____ (date).</p> <p><input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ____/____/____ (date).</p> <p><input type="checkbox"/> I recently obtained lawful presence status in the United States. I got this status on ____/____/____ (date).</p> <p><input type="checkbox"/> I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on ____/____/____ (date).</p> <p><input type="checkbox"/> I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on ____/____/____ (date).</p> <p><input type="checkbox"/> I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.</p> | <p><input type="checkbox"/> I live in or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on ____/____/____ (date).</p> <p><input type="checkbox"/> I recently left a PACE program on ____/____/____ (date).</p> <p><input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on ____/____/____ (date).</p> <p><input type="checkbox"/> I am leaving employer or union coverage on ____/____/____ (date).</p> <p><input type="checkbox"/> I belong to a pharmacy assistance program provided by my state.</p> <p><input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.</p> <p><input type="checkbox"/> I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on ____/____/____ (date).</p> <p><input type="checkbox"/> I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the natural disaster.</p> |
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**If none of these statements applies to you, call us at 1-833-526-2210 (TTY: 711) to see if you can enroll. We're here 8 AM to 8 PM, seven days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30.**

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**Section 1: Choose your plan**

Please check the plan you want to enroll in:

- ☒ SilverScript SmartRx (PDP)  
☐ SilverScript Choice (PDP)  
☐ SilverScript Plus (PDP)

Proposed effective date of coverage:

01/01/2022

MM/DD/YYYY

The effective date for enrollees in their Initial Enrollment Period will either be the first of the month following enrollment submission or the first of the month the enrollee is eligible for Part D, whichever is later.

**Section 2: Your information**

Last name

First name

Middle initial

Birth date

03/05/1956

MM/DD/YYYY

Sex

☒ M

☐ F

Primary phone number

(912)441-0062

Secondary phone number ( ) - - - -

Permanent residence / long-term care facility address (a PO Box is not allowed)

Street number

Street name

71 TONJES ROAD

Apt./Suite/Unit (please specify)

City

CALLICOON

County

SULLIVAN

State

NY

ZIP Code

12723

Long-term care facility name

Mailing address (only if different from your permanent residence address)

Street number

Street name

Apt./Suite/Unit (please specify)

City

County

State

ZIP Code

Email address

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### Section 3: Provide your Medicare insurance information

Medicare Number: 5CE9-TI9-AE45

Is Entitled To:

Effective Date:

**HOSPITAL (Part A)**

03/01/2021

**MEDICAL (Part B)**

07/01/2021

You must have either Medicare Part A or Part B (or both) to join a Medicare Prescription Drug (Part D) Plan.

### Section 4: Please read and answer these important questions

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs.

**Will you have other prescription drug coverage in addition to Aetna Prescription Drug Plan (Aetna PDP) during the 2022 calendar year?**

☐ Yes ☒ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: \_\_\_\_\_

Member number: \_\_\_\_\_ Group number: \_\_\_\_\_

**Indicate your preferred language (if not English):** ☐ Spanish ☐ Other

If you need information in an alternate language or accessible format, such as Braille, audio tape, or large print, please contact us at **1-855-771-9286 (TTY: 711)**, 24 hours a day, 7 days a week.

**Would you like to receive paperless Explanation of Benefit (EOB) statements?**

We'll send you a monthly email letting you know how to access and view your secure EOB statement. You will need to provide us with your email address. You can opt out at any time.

☐ Yes, I want to receive my EOB statements electronically.

*Please be sure to include your email address in Section 2.*

☒ No, I want to receive my EOB statements in the mail.

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## Section 5: Paying your plan premium

You can pay your monthly plan premium (including any Part D late enrollment penalty you may owe) by Electronic Funds Transfer (EFT), automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check, monthly payment by invoice, credit card, or by mail.

**Please select a premium payment option.** If you don't select a payment option, we'll automatically send you an invoice each month.

☐ **Electronic Funds Transfer from Checking or Savings account**

- You won't need to remember to send in a check each month.
- The money is automatically taken from your account on or around the 9<sup>th</sup> of each month.
- We will withdraw the total amount due on your account. This includes your current monthly premium payment, as well as any past due payments at the time of the monthly draft.
- To sign up, please include a VOIDED check or savings account direct deposit form from your bank with your enrollment form.

**Signature of account holder:** (if different than enrollee) \_\_\_\_\_

I agree that this authorization will remain in effect until I provide written notification terminating this service.

☐ **Automatic deduction from Social Security or Railroad Retirement Board (RRB) benefit check**

**I get monthly benefits from:** ☐ Social Security ☐ RRB

- We will deduct your monthly premium from your Social Security check (or RRB for those who qualify) automatically. Your request for automatic deduction will be submitted for the next available payment cycle.
- It can take several months for this option to begin once approved by Centers for Medicare & Medicaid Services, and it will not cover any premiums for which we have already sent you an invoice, so please continue to pay your premium as long as you receive an invoice.
- Do not select this option if another entity (such as an Employer Group or State Pharmaceutical Assistance Program) is paying part of your premium.
- If Social Security or the RRB does not approve your request for automatic deduction, we will send you an invoice to pay your monthly premium.

☒ **Monthly payments by invoice**

- You can mail us a check with your payment slip each month.
- You can pay using a debit or credit card after your enrollment in the plan is active.
- You can bring your invoice to any retail CVS Pharmacy® and pay with cash, credit card, or debit card. (This service is not available at CVS Pharmacy Target® or Schnucks Pharmacy locations.)

*Continued*

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## Section 5: Paying your plan premium (continued)

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75 percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a Part D late enrollment penalty.

Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at **1-800-772-1213 (TTY: 1-800-325-0778)**. You can also apply for Extra Help online at **[www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp)**. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

Social Security will contact you if you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D IRMAA). You'll have to pay this extra amount as well as your plan premium. You will either have the amount withheld from your Social Security or RRB benefit check, or be billed directly by Medicare or the RRB. **Do not send your Part D IRMAA payment to us.**

## Section 6: Please read this important information

**If you are a member of a Medicare Advantage Plan** (such as an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs.

By joining Aetna PDP, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

**If you currently have health coverage from an employer or union, joining Aetna PDP could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Aetna PDP.** Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

## Section 7: Please read terms and sign below

**By completing this enrollment application, I agree to the following:** Aetna PDP is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage to stay in Aetna PDP. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I can only be enrolled in one Medicare Prescription Drug Plan at a time – if I am currently enrolled in a Medicare Prescription Drug Plan, my enrollment in Aetna PDP will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

*Continued*

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**Section 7: Please read terms and sign below (continued)**

Aetna serves a specific service area. If I move out of the area that Aetna serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use Aetna network pharmacies. Once I am a member of Aetna, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Aetna when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a Part D late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Aetna, he or she may be paid based on my enrollment in Aetna.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

**Release of Information**

By joining this Medicare Prescription Drug Plan, I acknowledge that Aetna PDP will release my information to Medicare, who may use it to track beneficiary enrollment, for payment and other purposes applicable to Federal statutes that authorize the collection of this information (see Privacy Act Statement below).

**Privacy Act Statement**

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588.

Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that people with Medicare are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

**I understand that my signature (or the signature of the person authorized to act on my behalf under state law where I live) on this application means that I have read and understand the contents of this application.** If signed by an authorized individual (as described above), this signature certifies that:

- 1) This person is authorized under state law to complete this enrollment, and
- 2) Documentation of this authority is available upon request by Medicare.

SilverScript is a Prescription Drug Plan with a Medicare contract marketed through Aetna Medicare. Enrollment in SilverScript depends on contract renewal.

**Signature**

**Today's date**

**Print name (please print)**

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## Section 8: Power of Attorney / Authorized Representative

If you're an authorized representative helping someone fill out this form, you must sign the previous page and provide the following information (not for agent use).

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Phone number \_\_\_\_\_ - \_\_\_\_\_

Relationship to enrollee ☐ child ☐ friend ☐ spouse ☐ other \_\_\_\_\_

When you've completed this Enrollment Form, sign, date, and mail it in the enclosed postage-paid envelope. If you do not use the postage-paid envelope, include the proper postage and mail to:

**SilverScript Insurance Company**  
**PO Box 30001**  
**Pittsburgh, PA 15222-0330**

*Note: This mailing address is not applicable for agent-submitted applications.*

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