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 face-to-face 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. Please note that an agent may also discuss a Medicare Supplement policy with you.

Please initial below beside the type of product(s) you want the agent to discuss.
(Refer to page 2 for product type descriptions)

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

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

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 clearly and legibly below:	
Name (First_Last)	Relationship to Beneficiary

To be completed by Agent (please print clearly and legibly)		
Agent Name (First_Last)	Agent Phone	Agent ID
Beneficiary Name (First_Last)	Beneficiary Phone (Optional)	Date Appointment Completed
Beneficiary Address (Optional)		
Initial Method of Contact	Plan(s) the agent represented during the meeting	
Agent's Signature		

Scope of appointment (SOA) is subject to CMS Record Retention Requirements

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: **Please check all that apply**

☐ Unplanned Attendee ☐ New SOA required (consumer requested other Health Product information)
☐ Walk-in ☐ Other (please explain): _____

Fax to: 1-866-994-9659

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE, HMO COVERAGE OR EMPLOYER-PROVIDED HEALTH BENEFIT ARRANGEMENT UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK

Islandia, New York

Save this notice! It may be important to you in the future

According to the information you furnished, you intend to terminate existing accident and health insurance, health maintenance organization coverage or employer-provided health benefit coverage and replace it with a certificate to be issued by UnitedHealthcare Insurance Company of New York. Your new certificate will provide thirty (30) days within which you may decide without cost whether you desire to keep the certificate.

You should review this new coverage carefully. Compare it with all health coverage you now have and evaluate the need for existing coverage that may duplicate this certificate. Terminate your present coverage only if after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

Statement To Applicant By Issuer, Agent, Broker Or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction (does)/(does not) duplicate coverage. The replacement policy is being purchased for one of the following reasons (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for Disenrollment.

_____ Other (Please Specify) _____

_____

_____

1. Health conditions which you may presently have may be considered pre-existing conditions and may not be immediately or fully covered under the new certificate. This could result in denial or delay of a claim for benefits under the new certificate, whereas a similar claim might have been payable under your present coverage.

2. State regulation provides that in applying a pre-existing condition limitation, a Medicare Supplement issuer must credit the time the applicant was previously covered under creditable coverage (including Medicare Supplement insurance, Medicare Select coverage and Medicare Advantage plans) if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new policy or certificate.

3. If you still wish to terminate your present policy and replace it with new coverage, review the application carefully before you sign it to be certain that all information has been properly recorded.

Do not cancel your present coverage until you have received your new certificate and are sure that you want to keep it.

_____

(Signature of Agent, Broker or Other Representative) (Date)

_____

(Applicant's Signature) (Date)

_____

(Applicant's Printed Name & Address)

RN037 Complete and submit this copy with the application 10/10

4 Authorization and Verification of Information

Please read carefully, and sign and date in the highlighted area below.

- My signature indicates I have read and understand the contents of this application form.
- Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

If application is being made through an agent:

- I understand that the agent or broker cannot grant approval. This application and payment of the initial premium does not guarantee coverage will be provided. I understand that coverage, if provided, will not take effect until issued by UnitedHealthcare Insurance Company of New York, and actual rates are not determined until coverage is issued.
- I understand that the agent or broker may not change or waive any terms or requirements related to this application and its contents, underwriting, premium, or coverage.
- I acknowledge receipt of the ***Guide to Health Insurance for People with Medicare*** and the Outline of Coverage.
- I understand that the person discussing plan options with me is either employed by or contracted with UnitedHealthcare Insurance Company of New York. This person may be compensated based on my enrollment in a plan.

If you are replacing your current health insurance coverage, or if your enrollment form is received within 6 months after you are first enrolled in Medicare Part B at age 65 or older, the following exclusion will not apply to you. Please see "Your Guide" for more information.

I understand the plan will not pay benefits for stays beginning or medical expenses incurred during the first 6 months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within 6 months prior to the insurance effective date. I also understand that stays which start before the insurance effective date will not be covered until 6 months after the effective date.

Note: If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

I have read all information and have answered all questions to the best of my ability.

Your Signature – 2 (required)

Today's Date (required)

M M D D Y Y Y Y

Note: If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

Continued on next page ▶

3 Tell us about your past and current coverage – continued

3K. Do you have another Medicare Supplement policy in force?

○ Y ○ N

If NO, skip to question **3M**.
If YES, with what company, and what plan do you have?

Company Name

Plan Name

3L. If YES, do you intend to replace your current Medicare Supplement policy or Medicare Select policy with this policy?

○ Y ○ N

3M. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?

○ Y ○ N

If NO, please sign below, then continue to **Section 4.**
If YES, please list with what company and what type of policy in the space provided below. Then continue to question **3N.**

Company Name

Policy Type

○ HMO/PPO ○ Major Medical ○ Employer Plan
○ Union Plan ○ Other_____

3N. What are your dates of coverage under the policy you listed in **3M?** Leave the end date blank if you are still covered under the other policy.

Start Date **End Date**

M M D D Y Y Y Y M M D D Y Y Y Y

3O. Are you replacing this health insurance?

○ Y ○ N

Your Signature – 1 (required)

X

Continued on next page ▶

Name: _____

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, 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.

Your Signature:	Today's Date:	SIGNATURE

Authorized Representative Information:

If you are the authorized representative, you must sign above and provide the following information:

Name: _____ Date: _____

Phone: _____ Relationship to Enrollee: _____

Address: _____

Please check one of the boxes below if you would prefer that we send you enrollment information in a language other than English or in another format if available: ☐ Spanish ☐ Large Print

Please contact AARP MedicareRx Plans at **1-866-803-8575** if you need information in another format or language than what is listed above. TTY users should call **711.** Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week.

Broker or Sales Agent Use Only

Sales Agent Signature: _____ Date: _____

Sales Agent Name: _____ Sales Agent ID#: _____

Sales Agent Organization: _____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Sales Initiative: ☐ Retail/Mall ☐ Community Meeting ☐ Member Meeting

☐ Local B2B Outreach ☐ Local Event Outreach ☐ Other _____

For proper commission processing, please print clearly and include the correct Agent ID#. Agents must be licensed, appointed, and certified to receive commission. Incomplete agent information will cause delays in commission.

AARP MedicareRx Plans Use Only Plan ID#: _____

Employer ID#: _____ Branch ID#: _____

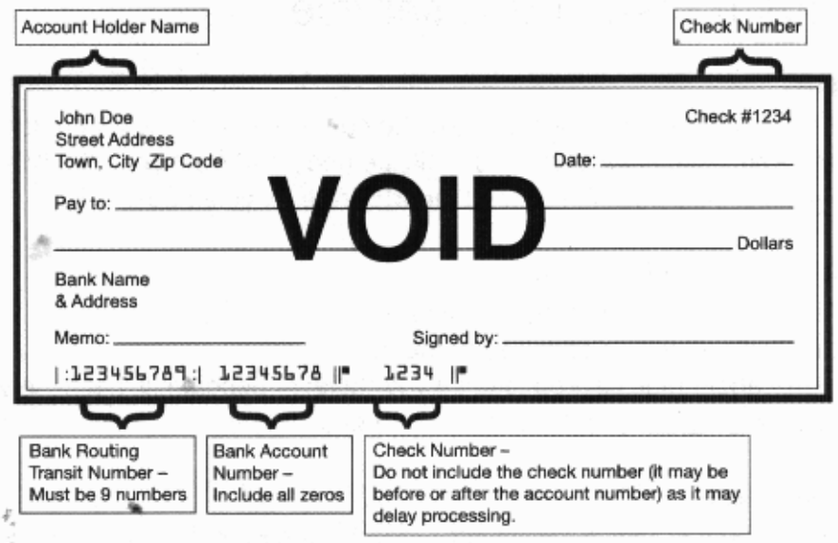
Marketing ID#: _____ Source Code: 740016

SPRJ9917_000

Mail this form to:
UnitedHealthcare, P.O. Box 29200
Hot Springs, AR 71903-9200

IMPORTANT

- Please refer to the diagram below to obtain your bank routing information.
- Be sure to attach a voided check from the checking account you wish to use.



We look forward to continuing to serve you.

Monthly withdrawal amounts will be for the total household payment due each month. This will include premiums for a spouse or other member(s) of the household on the same membership account. This authority is active until UnitedHealthcare and the BANK receive notice from me to end withdrawals in enough time to give UnitedHealthcare and the BANK a reasonable opportunity to act on it. I have the right to stop payment of a withdrawal by giving notice to the BANK in such time as to give the BANK a reasonable opportunity to act upon it. I understand such action may make the health care insurance coverage past due and subject to cancellation.

Member Name_____ Member # _____

Bank Acct Holder's Name (if different) _____

Bank Acct Holder's Signature _____ Date _____

Please do not write in the space below. For company use only.