



Is it ok if I scan your cards into your file?  
RED, WHITE, AND BLUE CARD

DATE OF BIRTH

Age

ZIP CODE

MEDICAID?

Doctors

PCP Number

MEDICAID CARD OR DRIVER'S LICENSE

PRESCRIPTION MEDICATION

DOSE

CURRENT COVERAGE CARD



RED, WHITE, AND BLUE CARD

DATE OF BIRTH

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MEDICAID?

Doctors

PCP Number

MEDICAID CARD OR DRIVER'S LICENSE

PRESCRIPTION MEDICATION

DOSE

CURRENT COVERAGE CARD



What do you have for your life, burial, or preneed?

Company	Type	Policy #	Premium	Coverage	Cash Value	RPU
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Comparison

Coverage	Premium #1	Premium #2
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Benefits of State Regulated Coverage

- 1) Coverage the 1st day you pay
- 2) 1st Payment up to 35 days from today
- 3) Payment coincides with your SS deposit
- 4) Level Premium- Payment never changes
- 5) Coverage never changes
- 6) Coverage never ends



Insured #1

Insured #2

DOB

Ht/Wt

SS#

Phone

City/State of  
Birth

DL

Street Address

Cit

Zip

County

Beneficiary Name

Relationship

Face Amount

Premium

Bank Name

Routing #

Account #

SS Date

This concludes the Life Insurance appointment. I will now begin a new Medicare Sales Appointment.



Name

DOB

S.S.

Phone

Email

Plan

Home

# 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.

**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**
- Dental/Vision/Hearing Products**
- Hospital Indemnity Products**
- Medicare Supplement (Medigap) Products**

**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 or future enrollment, or enroll you in a Medicare plan.

**Beneficiary or Authorized Representative Signature and Signature Date:**

Signature:	Signature Date:
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**If you are the authorized representative, please sign above and print below:**

Representative's Name:	Your Relationship to the Beneficiary:
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**To be completed by Agent:**

Agent Name:	Agent Phone:
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Beneficiary Name:	Beneficiary Phone:
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Beneficiary Address:

Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)

Agent's Signature: 

Plan(s) the agent represented during this meeting:	Date Appointment Completed:
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**[Plan Use Only:]**

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:

\*Scope of Appointment documentation is subject to CMS record retention requirements \*

*Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.*

## Stand-alone Medicare Prescription Drug Plans (Part D)

**Medicare Prescription Drug Plan (PDP)** : A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

## Medicare Advantage Plans (Part C) and Cost Plans

**Medicare Health Maintenance Organization (HMO)**: A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

**Medicare Preferred Provider Organization (PPO) Plan**: A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

**Medicare Private Fee-For-Service (PFFS) Plan**: A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

**Medicare Point of Service (POS) Plan**: 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.

**Medicare Special Needs Plan (SNP)**: A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

**Medicare Medical Savings Account (MSA) Plan**: MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

**Medicare Cost Plan**: In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

**Medicare Medicaid Plan (MMP)**: An MMP is a private health plan designed to provide integrated and coordinated Medicare and Medicaid benefits for dual eligible Medicare beneficiaries.

## Dental/Vision/Hearing Products

Plans offering additional benefits for consumers who are looking to cover needs for dental, vision or hearing. These plans are not affiliated or connected to Medicare.

## Hospital Indemnity Products

Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.

## Medicare Supplement (Medigap) Products

Plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.

# Emergency Contact Sheet

*According to the "National Unclaimed Property Network", twenty percent (20%) of all Life Insurance Policies become lost and are turned over to the State Unclaimed Property Departments, because surviving family members never knew the policies existed. Millions of dollars in Life Insurance go unclaimed every year.*

***As an additional service to you***, we will contact your local emergency contact list. We will provide them with our contact information, a business card, and any additional information they may want or need. Your family will not be alone when the time comes, your family will know who to contact to make sure your policy does not go unclaimed.

## **Emergency Contacts:**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

I, \_\_\_\_\_, would like the following people to be notified, regarding my insurance policies and any money that should be paid out, upon my passing.

\_\_\_\_\_ (signature) \_\_\_\_\_ (date)



