

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 initial below beside the type of product(s) you want the agent to discuss. If you do not want the agent to discuss a plan type with you, please leave the box empty. (Please note that an agent may also discuss a Medicare Supplement policy with you.)

<input type="checkbox"/>	Medicare Advantage Plans (Part C) and other Medicare 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 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.	

<input type="checkbox"/>	Medicare Supplemental Policy: A Medicare Supplement Insurance (Medigap) policy can help pay some of the health care costs that Original Medicare doesn't cover, like copayments, coinsurance, and deductibles.
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By signing this you are agreeing to a sales meeting with a sales agent to discuss the specific types of products you initialed above. The person that will be discussing plan options with you is either employed or contracted by a Medicare health plan or prescription drug plan that is not the Federal government, and they may be compensated based on your enrollment in a plan. Signing this does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment status, nor will it automatically enroll you in the plan(s) discussed.

By completing this form, I consent to receive calls from a representative about EmblemHealth products and services at the number I have provided (including mobile devices). These calls may be made using an automated technology and my consent to receive these calls is not required as a condition for me to make a purchase.

Beneficiary Phone (Optional):

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Signature Date:
<i>If you are the authorized representative, please sign above and print below:</i>	
Representative's Name:	Your Relationship to the Beneficiary:

To be completed by Agent:	
Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Address (Optional):
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:
[Plan Use Only:]	

Scope of Appointment documentation 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: _____

HIP Health Plan of New York (HIP) is a HMO plan with a Medicare contract. Enrollment in HIP depends on contract renewal. HIP is an EmblemHealth company.