Agreement for Medicare Product Discussion

Please print

Name: _____

Street Address: _____ City: _____

County: _____ State: ____ Zip: _____ Email: _____

Phone Number: _____

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.

Medicare Advantage Plans (Part C)

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.

To foster my understanding of all of the Medicare Advantage products offered by Fidelis Legacy Plan and to obtain information about which plan is right for me, I, the undersigned, agree to have the Fidelis Care Licensed Sales Representative present the following products during our conversation:

□ Fidelis Medicare Advantage without Prescription Drugs (HMO-POS)

□ Fidelis Medicare Advantage Flex (HMO-POS)

□ Fidelis Medicare $0 Premium (HMO)

□ Fidelis Dual Advantage (HMO-SNP)

□ Fidelis Dual Advantage Flex (HMO-SNP)

□ Fidelis Medicaid Advantage Plus (HMO-SNP)

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. I also agree to have the Fidelis Legacy Plan Licensed Sales Representative initiate follow-up telephone calls as necessary.

_____ _____

Signature Date

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

Representative's Name: _____

Your Relationship to the Beneficiary: _____

For Representative Use Only:

Rep Name: _____ Rep Phone: _____

Beneficiary Name: _____

Initial Method of Contact (indicate here if beneficiary was a walk-in): _____

Rep Signature: _____

Plan(s) represented during this meeting: _____

Date Appointment Completed: _____

Sale: _____ No Sale: _____ Pending: _____

1-800-860-8707 TTY: 711

Monday-Sunday, 8:00 a.m.-8:00 p.m. from October 1-March 31
Monday-Friday, 8:00 a.m.-8:00 p.m. from April 1-September 30

Scope of Appointment 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.

Fidelis Legacy Plan is an HMO plan with a Medicare contract. Enrollment in Fidelis Legacy Plan depends on contract renewal.

Fidelis Legacy Plan is a Coordinated Care plan with a Medicare contract and a contract with the New York State Department of Health Medicaid program. Enrollment in Fidelis Legacy Plan depends on contract renewal.

Medicare Advantage Applicant Education Checklist & Comment Sheet

Medicare Applicant_____ Date: _____

Other Attendees:_____ Location:_____

	Enrollee Initials
Premium Cost	_____
Out of Network Benefits	_____
Enrollment Periods (AEP, OEP, SEP)	_____
Cost Sharing In and Out of Network	_____
Providers - Participating/Non-Participating Physicians	_____
Prescription Drug Formulary, Deductible & Copays	_____
Flexible Reimbursement Account, if applicable	_____
OTC Card, if applicable (Dual Advantage ONLY)	_____
Nurse Care Manager Call (Dual Advantage ONLY)	_____
Fidelis Legacy Plan is not Supplemental Coverage	_____
Rx Extra Help/LIS & EPIC renewals are the Member's Responsibility	_____

Additional Questions/Comments _____

_____

_____

_____

_____ _____

Applicant's Signature Date

Online Enrollment Authorization Form

You are about to fill out an online application for a Fidelis Legacy Plan Medicare Advantage Plan. By completing the online application and signing this authorization form, you will be sending an actual enrollment application to Fidelis Legacy Plan. You will be enrolled in your chosen Medicare Advantage Plan, if the enrollment is approved by the Centers for Medicare and Medicaid Services (CMS). Fidelis Legacy Plan will notify you via mail of your acceptance or denial following the submission of the enrollment to CMS.

By signing this Online Enrollment Authorization form, I am authorizing my agent to assist me in enrolling in the Fidelis Medicare Advantage Plan of my choice using the online enrollment system. My agent has advised me of, and I understand the benefits, cost sharing (i.e., copayments, coinsurance, deductibles) and monthly premium for the plan, if applicable. My agent has provided me with a completed copy of this signed Online Enrollment Authorization Form.

All fields below are mandatory and must be completed by enrollee and agent.

Medicare Advantage Applicant Information

Plan Selection:

Name of Medicare Advantage Plan Selected: _____

Proposed Effective Date: _____

Applicant Information:

Name: _____

Address: _____

Contact #: _____ Gender: Female or Male

Medicare Number: _____ Medicaid Number: _____

Part A: _____ Part B: _____ D.O.B: _____

Online Confirmation Number: _____

Note: The Online Confirmation number is provided by the system after the online enrollment is completed.

Applicant or Authorized Representative (please attach Power of Attorney)

Signature: _____ Date: _____

Agent Information *(To Be Completed By Agent Assisting With Online Enrollment):*

Agent Name: _____

Agent ID Number: _____ Agent Phone #: _____

Agent Signature: _____ Date: _____

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