



2019 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 initial below beside the type of product(s) you want the agent to discuss.

Medicare Advantage Prescription Drug Plans	
<input type="checkbox"/>	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).
<input type="checkbox"/>	Medicare Special Needs Plan (HMO 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.

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 below:

Representative’s Name: _____ **Your Relationship to the Beneficiary:** _____

To be completed by Agent:

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact: Walk-in <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> (For Internal Agents Only Date Recorded: _____)	
Agent’s Signature:	
Plan(s) the agent represented during this meeting:	
Date Appointment Completed:	

Scope of Appointment documentation is subject to CMS record retention requirements
Agents, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:

AgeWell New York, LLC is a Health Maintenance Organization (HMO) plan with a Medicare contract and a Coordination of Benefits Agreement with New York State Department of Health. Enrollment in AgeWell New York, LLC depends on contract renewal. ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-866-586-8044 (TTY: 1-800-662-1220). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1- 866-586-8044 (TTY: 1-800-662-1220). Assistance services for other languages are also available free of charge at the number above.

Notice of Non-Discrimination

AgeWell New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AgeWell New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AgeWell New York provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact AgeWell New York Member Services at 1-866-586-8044.

If you believe that AgeWell New York has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

AgeWell New York
Civil Rights Coordination Unit
1991 Marcus Avenue Suite M201
Lake Success, New York 11042-2057
1-866-586-8044
TTY/TDD: 1-800-662-1220
Fax: 855-895-0778

Email: civilrightsunit@agewellnewyork.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordination Unit is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TDD: 1-800-537-7697

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.