

Medicare Client Information

Name _____ Date _____

Address (Physical) _____ (Mailing) _____

City _____ State _____ Zip Code _____

Email _____

Cell # _____ Phone # _____

Date of Birth _____ SS # _____

Do you text message? ☐ Yes ☐ No Do you use nicotine? ☐ Yes ☐ No



MEDICARE INFORMATION

FULL NAME ON YOUR CARD: _____

MEDICARE NUMBER: _____

HOSPITAL (PART A) _____/_____/_____

MEDICAL (PART B) _____/_____/_____

I currently have:

(In addition to your red, white, and blue Medicare card)

☐ Medicare Advantage Plan

☐ Medicare Supplement

☐ Medicare Cost Plan

☐ Medicare Part D Rx Plan

IMPORTANT! Initial, Sign, Date On The Back



-Office Use Only-

☐ HHD _____

☐ DOB _____

NOA _____

RT _____

ACT _____

FI _____

Date AD _____ ☐ SAV ☐ CK

☐ Enrolled _____

☐ Date _____ (By) _____

☐ Enrolled _____

☐ Date _____ (By) _____

☐ MARx Report

☐ LAP Updated

☐ Scanned

☐ Disburse M E P

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.

- ☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Dental/Vision/Hearing Products**
- ☐ **N/A 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.

MEDICARE BENEFICIARY (THIS IS YOU) 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: (ONLY if you are POA)	Your Relationship to the Beneficiary:

To be completed by Agent:	
Agent Name: Darrel Bice & Mardee Downing Bice	Agent Phone: (308) 436-9314
MEDICARE Beneficiary Name (THIS IS YOU):	MEDICARE Beneficiary Phone (THIS IS YOU):
MEDICARE Beneficiary Address (THIS IS YOU):	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature: <i>JR Bice AND Mardee Downing Bice</i>	
Plan(s) the agent represented during this meeting:	Date Appointment Completed:
[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.

Y0001_4011_7653 Accepted 05/2016

Prescription Medication Sheet

Current Part D Plan _____ Premium _____

Current Pharmacy _____

☐ I take prescription medication & will list below.

- It is important to use exact information from the labels.
- Write prescription medications in the provided tables below.

☐ I do not take any prescription medication.

☐ I have attached a complete list of all prescription medications to this form.

- Skip to the back to read/sign the attestation at the bottom of the next page.

Insulin (or other injections to manage blood sugar)

NAME OF MEDICATION	TYPE	MG	USAGE #PENS/VIALS PER MONTH
	☐ PENS ☐ VIALS		
	☐ PENS ☐ VIALS		
	☐ PENS ☐ VIALS		

All other Pharmacy-filled medications

NAME OF MEDICATION	TYPE	MG	TIMES PER DAY

To list additional medications and sign & date the form, turn document over 

Continued - All other Pharmacy-filled medications

NAME OF MEDICATION	TYPE	MG	TIMES PER DAY

Attestation (MUST SIGN & DATE BELOW)

By signing below, I attest that the prescription drug information that I have provided is accurate and complete. I further attest that if I omit medications and my Part D prescription drug costs for 2027 are higher than anticipated, I agree to hold harmless, The Benefit Partners, Inc. DBA Senior Insurance & Retirement Advisors and it's licensed agents.

Signature _____ **Date** _____

HOW DID YOU HEAR ABOUT US?

- | | | |
|---|---|---|
| ☐ Signage | ☐ Google Search | ☐ Video Ad |
| ☐ Friend/Relative | ☐ Existing Client | ☐ Other _____ |