

Sales Appointment Confirmation Form

The Centers for Medicare & Medicaid Services requires that a Sales Agent use this form to document the scope of a marketing appointment before the face-to-face sales meeting to ensure your appointment is for the type of plan(s) you're interested in. A separate form should be completed for each person at the meeting. These scopes are required for telephonic and virtual visits too. All information is confidential. **Please initial the box(es) below beside the plan(s) you want the agent to discuss with you.**

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 go to doctors or hospitals in the plan's network (except in emergencies or specific urgent care situations).

Medicare Preferred Provider Organization (PPO) Plan — 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* (except in emergencies or specific urgent care situations).

Medicare Dual Eligible Special Needs Plan (D-SNP) — A Medicare Advantage Plan for people who have both Medicare and New York State Medicaid. The plan provides all Original Medicare Part A and Part B health coverage, Part D prescription drug coverage and some Medicaid coverage. You can only go to doctors or hospitals in the plan's network (except in emergencies or specific urgent care situations).

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.

By signing this form, you agree to meet with a Sales Agent to discuss the products checked above. The Sales Agent is either employed or contracted by a Medicare plan and may be compensated based on your enrollment in a plan. This individual does not work directly for the Federal Government.

Signing this form does NOT affect your current or future enrollment in a Medicare plan, enroll you in a Medicare plan or obligate you to enroll 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 Sales Agent:

Agent Name: MICHAEL KING	Agent Phone: 585-224-8138
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Plan(s) represented during this meeting:	
Agent, if the form was signed by the beneficiary at the time of appointment, provide an explanation why SOA was not documented prior to meeting:	
Agent's Signature:	Date appointment was completed:



Section 1 - All fields on this page are required (unless marked optional)

Select the plan you want to join:

- Medicare Blue Choice® Select (HMO) \$0 per month
- Medicare Blue Choice® Freedom (HMO-POS) \$0 per month
- Medicare Blue Choice® Extra (HMO) \$0 per month
- Medicare Blue Choice® Discovery (PPO) \$34.30 per month
- Medicare Blue Choice® Advanced (HMO-POS) \$37.30 per month
- Medicare Blue Choice® Value Plus (HMO-POS) \$72.30 per month
- Medicare Blue Choice® Optimum (HMO-POS) \$200.70 per month

FIRST NAME: **LAST NAME:** **MIDDLE INITIAL:**

BIRTH DATE (MM/DD/YYYY): **SEX:** MALE FEMALE **PHONE NUMBER:**

PERMANENT RESIDENCE STREET ADDRESS (DON'T ENTER A PO BOX):

CITY: **COUNTY:** **STATE:** **ZIP CODE:**

MAILING ADDRESS, IF DIFFERENT FROM YOUR PERMANENT ADDRESS (PO BOX ALLOWED):
STREET ADDRESS:

CITY: **STATE:** **ZIP CODE:**

Your Medicare Information:

MEDICARE NUMBER:

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Excellus BlueCross BlueShield ? Yes No

Name of other coverage: Member number for this coverage: Group number for this coverage:

IMPORTANT: Read and Sign on the Next Page:

IMPORTANT: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Excellus BlueCross BlueShield.
- By joining this Medicare Advantage Plan, I acknowledge that Excellus BlueCross BlueShield will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- If you currently have a Medicare Supplement policy in place, you will need to submit a written request to your carrier to disenroll from that coverage.
- I understand that when my Excellus BlueCross BlueShield coverage begins, I must get all of my medical and prescription drug benefits from Excellus BlueCross BlueShield. Benefits and services provided by Excellus BlueCross BlueShield and contained in my Excellus BlueCross BlueShield “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Excellus BlueCross BlueShield will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
 - This person is authorized under State law to complete this enrollment, and
 - Documentation of this authority is available upon request by Medicare.

SIGNATURE:

TODAY'S DATE:

If you're the authorized representative, sign above and fill out these fields:

NAME:

ADDRESS:

PHONE NUMBER:

RELATIONSHIP TO ENROLLEE:

Section 2 - All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- | | |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican | <input type="checkbox"/> Yes, Cuban |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> I choose not to answer. |

What's your race? Select all that apply.

- | | | | |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> American Indian
or Alaska Native | <input type="checkbox"/> Other Asian | <input type="checkbox"/> Korean | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> White | <input type="checkbox"/> Samoan |
| | <input type="checkbox"/> Filipino | <input type="checkbox"/> Black or African American | <input type="checkbox"/> I choose not to answer. |

What is your gender? Select one.

- | | | |
|--------------------------------|--|---|
| <input type="checkbox"/> Woman | <input type="checkbox"/> Non-binary | <input type="checkbox"/> I choose not to answer. |
| <input type="checkbox"/> Man | <input type="checkbox"/> I use a different term: _____ | |

Which of the following best represents how you think of yourself? Select one.

- | | |
|--|---|
| <input type="checkbox"/> Lesbian or gay | <input type="checkbox"/> I use a different term: _____ |
| <input type="checkbox"/> Straight, that is, not gay or lesbian | <input type="checkbox"/> I don't know |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> I choose not to answer. |

Select one if you want us to send you information in an accessible format.

- | | | | |
|----------------------------------|--------------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Braille | <input type="checkbox"/> Large Print | <input type="checkbox"/> Audio CD | <input type="checkbox"/> Data CD |
|----------------------------------|--------------------------------------|-----------------------------------|----------------------------------|

Please contact us if you would prefer us to send you information in a language other than English, or if you need information in an accessible format, other than what is listed above.

We can be reached at 1-877-883-9577 (TTY users call 1-800-662-1220). Our office hours are Monday - Friday, 8:00 a.m. to 8:00 p.m. From October 1 through March 31, 8:00 a.m. to 8:00 p.m., 7 days a week.

Do you work? Yes No Does your spouse work? Yes No

List your Primary Care Physician (PCP):

Email Address:

Section 3 - Paying Your Plan Premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or “Electronic Funds Transfer (EFT)” each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay Excellus BlueCross BlueShield the Part D-IRMAA.

If you will be receiving any form of premium assistance due to Low Income Subsidy or EPIC, you must continue to pay the amount on your monthly bill. Your bill will reflect the lower premium once the notification has been received and applied to your account.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

- Get a bill each month.**
- Electronic Funds Transfer (EFT)** from your bank account each month. Please enclose a VOIDED check or provide the following:

ACCOUNT HOLDER NAME:

BANK ROUTING NUMBER:

BANK ACCOUNT NUMBER:

ACCOUNT TYPE:

- CHECKING
- SAVINGS

- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.**

I get monthly benefits from:

- Social Security
- RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. **Any plan premiums due prior to the Social Security or RRB withhold start date will not be deducted from your check; therefore, you are still responsible for any outstanding premiums owed prior to the point withholding begins.** If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

**Send completed application to:
Excellus BlueCross BlueShield Attn: Enrollment Operations, PO Box 31790, Rochester, NY 14603-1790**

Office Use Only:		Plan ID#:	
Effective Date of Coverage:			
ICEP / IEP:	OEPI:	AEP / MA OEP:	SEP (type):
Name of staff member/agent/broker (if assisted in enrollment):		Michael King	Not Eligible:
Agent/Broker Signature:		NPN: # 3334710	Date Received:

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me.
I moved on (insert date) _____.
- I recently was released from incarceration. I was released on (insert date) _____.
- I recently returned to the United States after living permanently outside of the U.S.
I returned to the U.S. on (insert date) _____.
- I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
- I recently left a PACE program on (insert date) _____.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
I lost my drug coverage on (insert date) _____.
- I am leaving employer or union coverage on (insert date) _____.
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.
- I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Excellus BlueCross BlueShield at 1-800-659-1986 (TTY users should call 1-800-662-1220) to see if you are eligible to enroll. We are open Monday - Friday, 8:00 a.m. - 8:00 p.m. From October 1 - March 31, 8:00 a.m. - 8:00 p.m., 7 days a week.