There are two stars (*) on the form:

The 1st star indicates where you need to sign. Please also date the form to the right of your signature.

Do not complete the Authorized Representative section unless you have a power of attorney and are acting on behalf of someone else.

The 2nd star is where you print YOUR name as Beneficiary. This is NOT a spouse or family member.

Return options:

Fax: 480-590-4057

Email: Service@Legins.net

Mail: Larry E. Gustafson, Inc.
Attn: Lisa Breiner
1672 E. Chelsea Ln.
Gilbert, AZ 85295

Only one person per form. Multiple insureds will each have to complete a form separately.

Scope of Appointment Confirmation Form

This form must be completed and signed prior to an appointment 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 who has Medicare or their authorized representative.

Place a check mark in the box next to the type of products you want the agent to discuss. (See helpful descriptions on the next page.)

☑ **Stand-alone Medicare Prescription Drug Plans (Part D)**

☑ **Medicare Advantage plans (Part C) and Medicare Cost plans**
Medicare Health Maintenance Organization (HMO) plan, Medicare Preferred Provider Organization (PPO) plan, Medicare Private Fee-For-Service (PFFS) plan, Medicare Special Needs Plan (SNP), Medicare Medical Savings Account (MSA) plan, or Medicare Cost plan

☑ **Other health-related plans**
Dental/vision/hearing products, supplemental health products, Medicare Supplement (Medigap) products

Signing this form does **not** obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in the plans discussed.

Note: The person who will discuss the products is either employed or contracted by a Medicare plan. They don't work directly for the federal government. This person may also be paid based on your enrollment.

Beneficiary or authorized representative signature and signature date:

* Signature: ______________________________ Date: ______________

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

Representative name: ______________________________

Your relationship to the beneficiary: ______________________________

To be completed by agent:

Agent name:	Agent phone: (480) 820-6643
Agent address: Larry E. Gustafson, Inc. 1517 E. Todd Dr., Tempe, AZ 85283	
* Beneficiary name:	Beneficiary phone:
Beneficiary address:	
Initial method of contact (circle one): **Web** **Email** **Phone** **Text** **Walk-in**	
Agent signature:	
Products to be discussed:	
Date of appointment:	

Scope of Appointment documentation is subject to CMS record retention requirements.

Agent: Fax this side.