

**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: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	
Date Appointment Completed:	
Plan Use Only:	

\*Scope of Appointment documentation 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: