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.

AF	**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 get your care from doctors or hospitals in the plan's network (except in emergencies).
	Medicare Special Needs Plan (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 Medi-Cal (Medicaid), people who reside in nursing homes, and people who have certain chronic medical conditions.
☐	**Medicare Medicaid Plan (MMP)**
	Medicare Medicaid Plan (MMP) (Blue Shield Promise Cal MediConnect Plan (Medicare-Medicaid Plan) available in Los Angeles and San Diego Counties) — A managed care plan designed for beneficiaries who are eligible for both Medicare and Medi-Cal (Medicaid) that allows and coordinates both benefits under one plan.

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 or Medicare Medicaid plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: Anthony Ferrulli (Jul 29, 2020 16:15 PDT)

Signature Date: 7/29/2020

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: Katia M. Montanez	Agent Phone: (619) 333-2580
Beneficiary Name: Anthony J. Ferulli	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.) Inbound call	
Agent's Signature:	
Plan(s) the agent represented during this meeting: BlueShield Promise + Medicare Options	
Date Appointment Completed: 7/29/2020	
[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:

Walk In.

Blue Shield of California Promise Health Plan is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. For more information on Cal MediConnect plans, call Health Care Options toll free at 1-844-580-7272 (TTY: 1-800-430-7077), 8:00 a.m. – 6:00 p.m., Monday through Friday. Blue Shield of California Promise Health Plan complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. You can get this document for free in other formats, such as large print, braille, and/or audio. Call 1-855-905-3825 (TTY: 711), 8:00 a.m. - 8:00 p.m., seven days a week. The call is free. For more information, call our Member Services lines. **Medicare:** 1-800-544-0088 (TTY: 711) 8:00 a.m. – 8:00 p.m., seven days a week, from October 1 to March 31 and 8:00 a.m. – 8:00 p.m. weekdays, from April 1 to September 30. **Cal MediConnect:** 1-855-905-3825 (TTY: 711), 8:00 a.m. - 8:00 p.m., seven days a week.

2020 Individual Enrollment Request Form

Blue Shield Promise AdvantageOptimum Plan (HMO), Blue Shield Promise AdvantageOptimum Plan 1 (HMO), Blue Shield Promise AdvantageOptimum Plan 2 (HMO), Blue Shield Promise Coordinated Choice Plan (HMO) and Blue Shield Promise TotalDual Plan (HMO D-SNP)

blue shield of california | promise HEALTH PLAN

Please fax or mail your completed enrollment form to:
Fax: (877) 251-3660
Mail: Blue Shield of California
PO Box 948, Woodland Hills, CA 91365-9856

Please contact Blue Shield of California Promise Health Plan if you need information in another language or format (Braille).

To enroll in Blue Shield of California Promise Health Plan, please provide the following information:

Please check which plan you want to enroll in:

- ☐ Blue Shield Promise AdvantageOptimum Plan (HMO) - Los Angeles/Orange* Counties ($0/month)
- ☐ Blue Shield Promise AdvantageOptimum Plan (HMO) - Santa Clara County ($49/month)
- ☐ Blue Shield Promise AdvantageOptimum Plan (HMO) - Fresno County ($0/month)
- ☐ Blue Shield Promise AdvantageOptimum Plan (HMO) - Merced* County ($0/month)
- ☐ Blue Shield Promise AdvantageOptimum Plan (HMO) - Stanislaus County ($0/month)
- ☐ Blue Shield Promise AdvantageOptimum Plan (HMO) - San Joaquin County ($0/month)
- ☐ Blue Shield Promise AdvantageOptimum Plan 1 (HMO) - San Diego County ($0/month)
- ☐ Blue Shield Promise AdvantageOptimum Plan 2 (HMO) - San Diego County ($0/month)
- ☒ Blue Shield Promise Coordinated Choice Plan (HMO)** - Los Angeles/Orange*/ San Bernardino*/Riverside*/San Diego/Fresno/Santa Clara/Merced*/San Joaquin/ Stanislaus Counties ($32/month)
- ☐ Blue Shield Promise TotalDual Plan (HMO D-SNP)** - San Diego County ($32/month)
- ☐ Blue Shield Promise TotalDual Plan (HMO D-SNP)** - Los Angeles County ($32/month)
- ☐ Blue Shield Promise TotalDual Plan (HMO D-SNP)** - Orange*/San Bernardino* Counties ($32/month)
- ☐ Blue Shield Promise TotalDual Plan (HMO D-SNP)** - Fresno/San Joaquin/Stanislaus Counties ($32/month)

*See the Summary of Benefits for covered zip codes.

**This plan is designed for people who meet specific enrollment criteria. You may be eligible to join this plan if you receive assistance from the State.

Last Name: FERULLI
First Name: ANTHONY
Middle Initial:

☒ Mr. ☐ Mrs. ☐ Ms.
Sex: ☒ M ☐ F
Birth date: 04/18/1955
Home Phone Number: 619-300-1942

Permanent Address: (P.O. Box is not allowed)
Street Address: 3221 MIDWAY DR
City: SAN DIEGO
State: CA
ZIP Code: 92110
County: SAN DIEGO

Mailing Address: (only if different from your Permanent Street Address)
Street Address:
City:
State:
ZIP Code:

Optional Field

Emergency Contact:

Phone number: Relation to you:

Optional Field

Email Address

Please provide your Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

ANTHONY FERRULLI

Medicare number: 2ED9-DH7-FA33

Is Entitled to:

HOSPITAL (Part A) 08/01/2020

MEDICAL (Part B) 08/01/2020

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Paying your plan premium

You can pay your monthly plan premium, if you have one, (including any late enrollment penalty that you currently have or may owe) by mail or by Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Blue Shield of California Promise Health Plan the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for *Extra Help* online at **www.socialsecurity.gov/prescriptionhelp**.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

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

Please select a premium payment option:

☑ Get a monthly bill.

☐ 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 ☐ Saving

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up 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.)

I get monthly benefit from: ☐ Social Security ☐ RRB

Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☑ No
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other medical or drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other medical or prescription drug coverage in addition to Blue Shield of California Promise Health Plan? ☐ Yes ☑ No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Medical coverage

Name of other coverage: ID# for this coverage: Group# for this coverage:

Drug coverage

Name of other coverage: ID# for this coverage: Group# for this coverage:

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☒ No
If "yes", please provide the following information:
Name of Institution:

Street Address of Institution:

City: State: ZIP Code:

Phone Number:

4. Are you enrolled in your State Medicaid (Medi-Cal) program? ☒ Yes ☐ No
If yes, please provide your Medicaid (Medi-Cal) number:

9218247600

5. Do you or your spouse work? ☐ Yes ☐ No

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

Physician's Name:

ID Number: Medical Group / IPA Name:

PA 0025869002 SAN DIEGO AMERICAN Indian Health Center

Current patient? ☒ Yes ☐ No

STOP

Please read this important information

If you currently have health coverage from an employer or union, joining Blue Shield of California Promise Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Shield of California Promise Health Plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign below

<u>By completing this enrollment application, I agree to the following:</u> **Blue Shield Promise AdvantageOptimum Plan (HMO), Blue Shield Promise AdvantageOptimum Plan 1 (HMO), Blue Shield Promise AdvantageOptimum Plan 2 (HMO), Blue Shield Promise Coordinated Choice Plan (HMO) and Blue Shield Promise TotalDual Plan (HMO D-SNP)** is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances.

Signature: Anthony Ferrulli (Jul 29, 2020 16:15 PDT) Today's Date: 07/29/2020

If you are the authorized representative, you must sign above and provide the following information:

Last Name: First Name: Middle Initial:

Street Address:

City: State: ZIP Code:

Phone Number: - -

Relationship to Enrollee:

Broker / sales use only

Agent Name: KATIA H MONTANEZ

Agent NPN #: 16832437

FMO: ABA

Date Received by Plan: 07/29/2020

Agent Phone: 619-333-2580

Agent Email: KMONTANEZ@SHLINSURANCE.COM

Agent Signature:

Effective Date of Coverage: 08/01/2020

☒ CEP/IEP ☐ AEP ☐ SEP (type):

☐ Not Eligible:

Name of staff member/agent/broker (if assisted in enrollment):

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in accessible format:

☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Braille ☐ audio tape ☐ large print

Please contact Blue Shield of California Promise Health Plan at 1-800-544-0088 (TTY users should call 711) if you need information in another format or language other than what is listed above. From 8 a.m. – 8 p.m., 7 days a week, from Oct. 1st – Mar. 31st and 8 a.m. – 8 p.m. weekdays, from Apr. 1st – Sept. 30th.