Scope of Appointment Confirmation Form

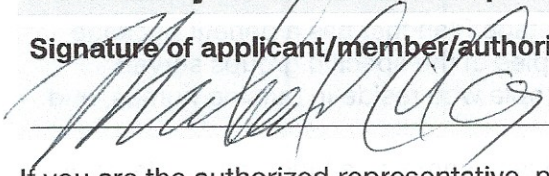
Before meeting with a Medicare beneficiary (or their authorized representative), Medicare requires that Licensed Sales Representatives use this form to ensure your appointment focuses only on the type of plan and products you are interested in. A separate form should be used for each Medicare beneficiary. **Please check what you want to discuss with the Licensed Sales Representative:**

- [x] Medicare Advantage Plans (Part C) and Cost Plans
- [x] Stand-alone Medicare Prescription Drug Plan (Part D)
- [x] Medicare Supplement (Medigap) Plans
- [ ] Dental-Vision-Hearing Products
- [ ] Hospital Indemnity Products

By signing this form, you agree to meet with a Licensed Sales Representative to discuss the products checked above. The Licensed Sales Representative is either employed or contracted by a Medicare plan and may be paid based on your enrollment in a plan. They do 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. All information provided on this form is confidential.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature of applicant/member/authorized representative	**Today's Date**
	MM-DD-YYYY

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

Name (First_Last)	Relationship to Beneficiary
Mike Clay	

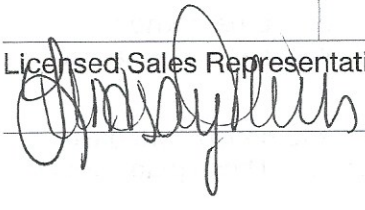
To be completed by Licensed Sales Representative (please print clearly and legibly)

Licensed Sales Representative Name (First_Last)	Licensed Sales Representative Phone	Licensed Sales Representative ID
Lindsay Mills	316-321-2387	
Beneficiary Name (First_Last)	**Beneficiary Phone**	**Date Appointment will be Completed**
Mike Clay	316-747-2662	08-12-2021

Beneficiary Address

Initial Method of Contact	Plan(s) the Licensed Sales Representative will Represent During the Meeting

Licensed Sales Representative Signature



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(/content/jarvis/en/secure/home.html)

GO TO MEDICAID ELIGIBILITY LOOKUP

MEDICARE ELIGIBILITY MEDICAID ELIGIBILITY

Medicare Eligibility

Medicare Eligible?	Yes
MBI (Medicare Number):	7FX0YX2TH23
Part A Effective Date:	05/01/2004
Part A End Date:	NA
Part B Effective Date:	05/01/2004
Part B End Date:	NA
Part D Effective Date:	01/01/2006
Part D End Date:	NA
LIS for Proposed Effective Date?	No
LIS Percentage:	What is this?
Maintaining Dual / LIS SEP Available?	Yes
Current Plan Type:	HMO
Current Drug Coverage:	Yes

RETURN TO MEDICARE ELIGIBILITY SEARCH

Sales & Marketing Tools

Plan Search (/content/jarvis/en/secure/tools/plan_search.html)

Sales Materials (/content/jarvis/en/secure/tools/sales-materials.html)

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Your Drugs (7 of 7 Covered) Edit Your Drug List

tamsulosin hcl CAP 0.4MG

- **You Pay** $0 Initial Coverage Cost
- 30 per Month, refill Every 1 Month
- Tier 1*, $0 Copay

hydrochlorothiazide TAB 12.5MG

- **You Pay** $0 Initial Coverage Cost
- 30 per Month, refill Every 1 Month
- Tier 1*, $0 Copay

losartan potassium TAB 100MG

- **You Pay** $0 Initial Coverage Cost
- 30 per Month, refill Every 1 Month
- Tier 1*, $0 Copay
- Quantity Limit of 30 TABS every 30 days*

amlodipine besylate TAB 5MG

- **You Pay** $0 Initial Coverage Cost
- 30 per Month, refill Every 1 Month
- Tier 1*, $0 Copay

warfarin sodium TAB 5MG

- **You Pay** $0 Initial Coverage Cost
- 30 per Month, refill Every 1 Month
- Tier 1*, $0 Copay

digoxin TAB 0.25MG

- **You Pay** $10.00 Initial Coverage Cost
- 30 per Month, refill Every 1 Month
- Tier 2*, $10 Copay

metoprolol tartrate TAB 100MG

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New Client Intake Form

Name: Mike Clay

Address: _____

City: _____

State: _____ ZIP: _____

Mailing address: ☐ Yes ☐ No

County: _____

Phone: 316-747-2662

Medicare ID: 7FXP YX2TH23

A: _____ / _____ **B:** _____ / _____

Medicaid ID: _____

Medicaid level: _____

Social Security: _____

DOB: 5 / 30 / 39

Security Question: _____

Email: _____

Doctors:

Current patient? ☐ Yes ☐ No

PCP Name: Lemons

PCP Number _____

PCP Address _____

Pronab Sensarma

PO Box 1816
Dodge 67039
2025018129

Drugs:

Pharmacy: _____