



Scope of Sales Appointment Confirmation (SOA 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.

Please initial below beside the product you agree to discuss with a licensed sales agent.

<input type="checkbox"/> Medicare Advantage Plans (Part C) with Prescription Drug Coverage (Part D)
A Medicare Advantage Plan (Part C) covers all Part A and Part B services. Most Medicare Advantage Plans include prescription drug coverage (Part D). HealthSun Health Plans are Medicare Advantage Plans with prescription drug coverage.

By signing this form, you agree to meeting with a sales agent to discuss the product you initialed above. Please note, the person you will be meeting with is a licensed sales agent either employed or contracted by HealthSun Health Plans. The agent does not work for the Federal government. The agent may also be paid based on your enrollment in the plan. **Signing this form does NOT obligate you to enroll in our plan, your current or future Medicare enrollment status will not be impacted, and automatic enrollment will not occur.**

Beneficiary or Authorized Representative:

Signature: _____ **Date:** _____
Print Name: _____ **Phone Number:** _____
Address: _____

Relationship to the Beneficiary: _____
(If you are the authorized representative)

Agent required to complete:

Agent Name:	ID:	Agent Phone:
Agent Signature:		Appointment Date:
HealthSun Plan(s) presented: <input type="checkbox"/> HealthAdvantage (HMO) 001 <input type="checkbox"/> HealthAdvantage (HMO) 012 <input type="checkbox"/> HealthAdvantage (HMO) 013 <input type="checkbox"/> MediMax (HMO) 006 <input type="checkbox"/> MediMax (HMO) 014 <input type="checkbox"/> MediSun Plus (HMO D-SNP) 015 <input type="checkbox"/> MediSun Plus (HMO D-SNP) 016		
Initial Method of Contact: <input type="checkbox"/> 1 Walk-in Medical Center <input type="checkbox"/> 2 Walk-in Event <input type="checkbox"/> 3 Walk-in Appointment <input type="checkbox"/> 4 Plan Lead/Consent-to-Contact <input type="checkbox"/> 5 Inbound Call Business Reply <input type="checkbox"/> 6 Inbound Call Broker Referral <input type="checkbox"/> 7 Inbound Call Other Referral <input type="checkbox"/> 8 Other Method of Contact (<i>documentation required</i>): _____		
Referral Broker information (If applicable):		
Broker Name:	ID:	Phone:
Other Notes (optional):		