For agent use

Scope of Appointment

The Centers for Medicare & Medicaid Services requires agents to document the scope of a marketing appointment prior to any individual 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 the person enrolling in a Medicare plan, or their authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.
(Refer to the following page for product type descriptions.)

- ☐ **Stand-Alone Medicare Prescription Drug Plans (Part D)**
- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Dental/Vision/Hearing Products**
- ☐ **Hospital Indemnity Products**
- ☐ **Medicare Supplement (Medigap) Products**

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'll discuss the products is either employed or contracted by a Medicare plan. They don't work directly for the federal government. This individual may also be paid based on your enrollment in a plan. Signing this form DOESN'T obligate you to enroll in a plan, affect your current or future Medicare enrollment status or automatically enroll you in the plan(s) discussed.*

Beneficiary or Authorized Representative Signature and Signature Date:

Signature:	Date:

If you're the authorized representative, please sign above and print below.

Representative's Name:	Your Relationship to the Beneficiary:

To Be Completed by Agent:

Agent Name: MICHAEL OLDFIELD	Agent Phone Number: 859-533-5195
Beneficiary Name:	Beneficiary Phone Number:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.) HM	
Agent's Signature:	
Plan(s) the Agent Represented During This Meeting:	Date Appointment Completed:

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

CONSENT TO CONTACT

MICHAEL TODD OLDFIELD
COOL FINANCIAL NINJA!

2808 PALUMBO DRIVE
SUITE 204
LEXINGTON, KY 40509

NPN: 17008216
KY DOI: 814418

TODAY'S DATE: ___/___/___

I GIVE PERMISSION FOR MICHAEL TODD OLDFIELD AND/OR HIS STAFF TO CONTACT ME AS NEED BE REGARDING MEDICARE OR ANY HEALTH INSURANCE MATTER. THEY MAY DO SO AT THEIR CONVENEINCE. THIS CONSENT IS GIVEN FOR A PERIOD OF ONE YEAR AND WILL BE AUTOMATICALLY RENEWED UNLESS WITHDRAWN

REGARDS;

[redacted]

Printed Name

[redacted]

Signature

[redacted]

Daytime Phone # Email Address