OUR BUSINESS HOURS ARE MONDAY THROUGH FRIDAY, 8:30 A.M. to 5:30 P.M.
PLEASE ALLOW UP TO 72 BUSINESS HOURS FOR US TO PROCESS YOUR PAPERWORK.

PLEASE FAX COMPLETED FORMS TO (770) 945-6809 OR EMAIL TO INFO@AMSPLANS.COM

TODAY'S DATE	DATE OF BIRTH	SSN
PRINTED NAME	EMAIL	
PHYSICAL ADDRESS		
CITY	COUNTY	ZIP CODE
MAILING ADDRESS - IF DIFFERENT FROM ABOVE		
MOBILE PHONE	PHONE	
HOW DID YOU HEAR ABOUT OUR COMPANY?		

MEDICARE COVERAGE INFORMATION- PLEASE REFER TO YOUR MEDICARE CARDS IF APPLICABLE.

DO YOU CURRENTLY HAVE MEDICARE? ☐ YES ☐ NO	MEDICARE NUMBER
WHAT IS YOUR PART A DATE?	PART B DATE?

DO YOU HAVE ANY OF THE FOLLOWING PLANS? (CHECK PLAN TYPES)

☐ MEDICARE ADVANTAGE (HMO/PPO) ☐ MEDICARE SUPPLEMENT ☐ RX PLAN ☐ RETIREE (Employer) PLAN ☐ INDIVIDUAL/GROUP (Employer) PLAN ☐ NONE OF THE ABOVE

WHAT ARE THE NAME OF THE PLANS CHECKED ABOVE?

DO YOU ALSO HAVE MEDICAID? ☐ YES ☐ NO	MEDICAID NUMBER	DO YOU HAVE VA BENEFITS? ☐ YES ☐ NO

AUTHORIZED REPRESENTATIVE OR POWER OF ATTORNEY INFORMATION - IF APPLICABLE

CONTACT PERSON	PHONE

We do not offer every plan available in every area. Any information we provide is limited to those plans we do offer in each area. Please contact Medicare to get information on all options.

Name:___________________________________

List your prescription medications below. **Do not include Rx that is injected/dispensed at a provider office. Do not include vitamins or OTC items. If a vial, inhaler, etc – please list approximately how many and of what volume are used monthly.** Providing medical and drug information is entirely voluntary. We determine the appropriate Medicare plans based on the information given.

PRESCRIPTION DRUG LIST- PLEASE CALL OUR OFFICE IF YOU HAVE QUESTIONS.

PREFERRED PHARMACY NAME & CITY

MEDICATION NAME	DOSAGE	TAKEN HOW OFTEN	REFILL HOW OFTEN	BRAND/GENERIC
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3525 Lawrenceville Suwanee Rd | Suwanee, Ga 30024| 770-945-5261 | www.amsplans.com

AFFORDABLE MEDICARE SOLUTIONS

We do not offer every plan available in every area. Any information we provide is limited to those plans we do offer in each area. Please contact Medicare to get information on all options.

Name:_____

We can check to ensure your current doctors participate within the plan that we recommend.

PHYSICIAN'S LIST - PLEASE CALL OUR OFFICE IF YOU HAVE QUESTIONS.

PREFERRED HOSPITAL & CITY		
DOCTOR NAME	SPECIALTY	CITY LOCATION

ARE YOU IN NEED OF ANY OF THE FOLLOWING SERVICES?

FINANCIAL PLANNING ☐ RETIRMENT PLANNING ☐

ELDER LAW SERVICES ☐ ASSISTED LIVING PLACEMENT ☐

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 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 each person with Medicare or his/her authorized representative.

Please INITIAL below beside the type of product(s) you want the agent to discuss.
(Refer to page 2 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 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 or future 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: (770) 945-5261
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
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:]	
Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:	

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

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

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