Sales Appointment Confirmation Form

Please initial below in the box beside the plan type that you want the agent to discuss with you.
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).

☐ **Medicare Advantage (Part C), Medicare Advantage Prescription Drug Plans, and other Medicare Plans**

Medicare Health Maintenance Organization (HMO) —A Medicare Advantage Plan that must cover all Part A and Part B health care. In most HMOs, you can only go to doctors, specialists, or hospitals in the plan's network except in an emergency.

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 affect your current enrollment, nor will it enroll you in a Medicare Advantage Plan, Prescription Drug Plan, or other 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:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact:	
Agent's Signature:	Date:
[Plan Use Only:]	

Astiva Health is an HMO plan with a Medicare contract. Enrollment in Astiva Health depends on contract renewal. ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-866-688-9021. (TTY: 711) ATENCIÓN: Si habla español, los servicios de asistencia lingüística están disponibles sin costo alguno para usted. Llame al 1-866-688-9021 (TTY: 711).

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

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SECTION 1 – ALL FIELDS ON THIS PAGE ARE REQUIRED (UNLESS MARKED OPTIONAL)

Select the plan you want to join:

- ☐ **Astiva Health Savings Plan (HMO) $0 per month 001**
- ☐ **Astiva Health Premier Plan (HMO) $0 per month 010**
- ☐ **Astiva Health C-SNP Deluxe Plan (HMO) $0 per month 007**
- ☐ **Astiva Health C-SNP WOW Plan (HMO) $40* per month 008**

FIRST name:	LAST name:		[Optional: Middle Initial]:
Birth date: (MM/DD/YYYY)	Sex: ☐ Male ☐ Female ☐ Non-Binary	Phone number:	
Permanent Residence Street Address (Don't enter a PO Box):			
City:	[Optional: County]:	State:	ZIP Code:
Mailing address, if different from your permanent address (PO Box allowed): Street address: City: State: ZIP Code:			
Your Medicare information:			
Medicare Number: _ _ _ _ . _ _ _ . _ _ _ _			
Answer these important questions:			
1.Will you have other prescription drug coverage (like VA, TRICARE) in addition to < Plan>? ☐ Yes ☐ No Name of other coverage: Member number for this coverage: Group number for this coverage _____ _____			
2. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No If yes, please provide your Medicaid number: _____			
3. Pre-Enrollment Qualification Assessment Tool If you are enrolling into one of our Special Needs Plan (C-SNP), please complete our Pre-Enrollment Qualification Assessment Tool.			

*Your premium may be paid by Extra Help

IMPORTANT: READ AND SIGN BELOW

• I must keep both Hospital (Part A) and Medical (Part B) to stay in Astiva Health.
• By joining this Medicare Advantage, I acknowledge that Astiva Health will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
• I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
• I understand that when my Astiva Health coverage begins, I must get all of my medical and prescription drug benefits from Astiva Health. Benefits and services provided by Astiva Health and contained in my Astiva Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Astiva Health will pay for benefits or services that are not covered.
• The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
• I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
1) This person is authorized under State law to complete this enrollment, and
2) Documentation of this authority is available upon request by Medicare.

Signature:	Today's date:

If you're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone number:	Relationship to enrollee:

SECTION 2 – ALL FIELDS ON THIS PAGE ARE OPTIONAL

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ I choose not to answer.

What's your race? Select all that apply.

- ☐ American Indian or Alaska
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ White
- ☐ **I choose not to answer**

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Vietnamese ☐ Other

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print

Please contact Astiva Health at 1-866-688-9021. If you need information in an accessible format other than what's listed above. Our office hours are seven days a week from October 1- March 31st 8:00 AM - 8:00 PM 8:00 AM - 8:00 PM Monday - Friday, April 1-September 30 TTY users can call TTY711 number.

Do you work? ☐ Yes ☐ No	Does your spouse work? ☐ Yes ☐ No	
PCP First Name:	PCP Middle Initial:	PCP Last Name:
IPA/Medical Group:	PCP: ID#:	Existing Patient? ☐ Yes ☐ No
Emergency Contact:	Relationship:	Phone Number:

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage ☐ Formulary ☐ Pharmacy Directory ☐ Provider Directory

E-mail address:

PAYING YOUR PLAN PREMIUMS

If enrolling in Astiva Health Plan 001, 010 and 007 with a $0 monthly premium: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail. 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 Astiva Health the Part D-IRMAA.**

If enrolling in Astiva Health C-SNP WOW 008 with a monthly premium: You can pay your monthly plan premium including any late enrollment penalty that you currently have or may owe by mail. 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 RRB. DO NOT pay Astiva Health the Part D-IRMAA.

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

Please select a premium payment option:

☐ Get a bill
☐ 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.)

* For Office Use Only

Agent/broker:		NPN Number:	
Agency:		Effective Date of Coverage:	
ICEP/IEP:	AEP:	SEP (type):	Not Eligible:

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligiblefor an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the MedicareAdvantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is anew option for me. I moved on (insert date) _____
- ☐ I recently was released from incarceration. I was released on (insert date) _____
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____
- ☐ I recently obtained lawful presence status in the United States. I got this status on(insert date) _____
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaidassistance, or lost Medicaid) on (insert date) _____
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get ExtraHelp paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing homeor long term care facility). I moved/will move into/out of the facility on (insert date) _____
- ☐ I recently left a PACE program on (insert date) _____
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____
- ☐ I am leaving employer or union coverage on (insert date) _____
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required tobe in that plan. I was disenrolled from the SNP on (insert date) _____
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I wasunable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Astiva Health at 1-866-688-9021 TTY users should call 711 to see if you are eligible to enroll. We are open 8:00 AM to 8:00 PM seven days a week from October 1-March 31st. 8:00 AM to 8:00 PM Monday-Friday from April 1st - September 30.