Date: _____ **2025 AEP Personal Information Sheet (one per person)**

Agent Name: _____

Are you a current client? ☐ Yes ☐ No **If not, how did you hear about us** _____

Name_____**DOB**_____**Phone**_____

Address_____**City**_____ **State**_____**Zip**_____

County_____ , USA **Email**_____ **Tobacco Use last 12 months?**_____

SECTION A: Fill out this section ONLY if you have a Medicare Supplement (Medigap) and Part D Drug Plan

Medicare Supplement Company Name_____ **Plan(F, G, etc.)**_____(on your Insurance Card)
(NOTE: Your Med Supp is not analyzed during AEP; you can apply to change plans anytime, subject to health underwriting questions)

Current Prescription Drug Plan Name_____(on your Insurance Card)

Are you considering changing to a Medicare Advantage Plan? ☐ **Yes** (Complete SECTIONS C and D below)
☐ **No** (Complete SECTION C below))

SECTION B: Fill out this section ONLY if you have a Medicare Advantage Plan

Medicare Advantage Plan Name _____(on your Insurance Card)

☐ **I've reviewed my Annual Notice of Change (ANOC) and wish to STAY on my current plan for 2025** (we do NOT need your medication list; you do NOT need to complete Sections A, C or D)

OR

☐ **I would like to change Medicare Advantage Plans for 2025** (Complete SECTIONS C and D below)
Please tell us why? _____Are you okay with changing doctors? ☐ **Yes** ☐ **No**

SECTION C: Prescription Medications (REQUIRED to complete your drug analysis)

☐ Mark here if you take NO medications ***OR*** ☐ My current medication list is attached (REQUIRED even if your medications have not changed)

Current Pharmacy or Mail Order name (VERY IMPORTANT) _____

SECTION D: Fill out this section ONLY if you want to change Medicare Advantage plans ***OR*** move from your Medicare Supplement (Medigap) to Medicare Advantage

Primary Care Dr. Name_____Phone_____

Specialist Name/Type_____Phone_____

Specialist Name/Type_____Phone_____

Optometrist/Practice Name_____Phone_____

Dentist/Practice Name_____Phone_____

☐ **Mark here if you do NOT have access to a computer and internet**

Return form to HealthCare Benefit Services
Mail: 6638 W. Ottawa Ave, Suite 120, Littleton, CO 80128
Fax: 720-287-7055, Email: info@HBSLTC.com (Email is not a secure form of communication)
Phone: 303-973-6636 or **800-295-5860**

Current Medication List

Your Name:_____ **Date**:_____

Complete Drug Name from Bottle/Container	**Dosage / Container Size** See list below	**Form** See list below	**Quantity Per Refill**	**Refill Frequency** See list below	**Generic OK** (Y)es or (N)o	**Using GoodRx*** (Y)es or (N)o
EXAMPLES						
Metoprolol Succinate ER	50mg	Tab	90	Q	Y	N
Albuterol Sulfate HFA	90mcg/8.5g	Inhaler	1	M	Y	Y

FORM: Tab Cap Inhaler Drops Patch Injection Vial Lotion Cream Ointment Gel

DOSAGE/SIZE: Be sure to list BOTH dosage and container size for Inhalers, Drops, Lotions, Creams, Ointments and Gels

REFILL FREQUENCY: (M)onthly (Q)uarterly (SA)Semi-Annually (A)nnually (BM)Every 2 months

DO NOT list "AS NEEDED" – Complete Refill Frequency with one of the above options

*Answer (Y)es if using GoodRx or any other discount drug plan to fill medication

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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 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 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 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:
Beneficiary Name:	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
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 *

A Coordinated Care plan with a Medicare Advantage contract and a Medicare-approved Part D sponsor