Date: _____ **2026 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: This section ONLY applies if you have a Medicare Supplement (Medigap) and Plan on moving to a Medicare Advantage plan. (READ notice in 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 2026** (we do NOT need your medication list; you do NOT need to complete Sections B or C)

☐ **I would like to change Medicare Advantage Plans for 2026** (READ notice in SECTION C below)
Please tell us why? _____Are you okay with changing doctors? ☐ **Yes** ☐ **No**

☐ **I am interested in moving to a Medigap Supplement for 2026** (READ notice in SECTION C below)
Please tell us why? _____

SECTION C: Doctors and Medications

You will receive an email or text from "Plan Enroll" Please follow the link and complete steps to input Doctors and Medications

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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**

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