1555 North RiverCenter Drive
Suite 206
Milwaukee, Wisconsin 53212

Main: 414-223-4847
Toll-free: 1-800-777-4376
www.iCareHealthPlan.org

iCare
INDEPENDENT CARE HEALTH PLAN

2021 Scope of Sales Appointment Confirmation Form

For use with all plans insured by Independent Care Health Plan (*i*Care)

The Centers for Medicare and Medicaid Services requires agents, brokers and consultants 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.

I understand that today I am speaking with a sales broker or agent, or a licensed *i*Care Medicare Benefits Consultant (MBC) about an *i*Care Medicare plan. Please initial below beside which plan you want the agent to discuss.

The plan we are speaking about today is:

_____ *i*Care Medicare Plan (HMO D-SNP) H2237-001

_____ *i*Care Family Care Partnership (HMO D-SNP) H2237-007

These plans are Medicare Advantage plans with Part D prescription drug coverage that have a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, people who have long-term care needs, and people who have certain chronic medical conditions.

By signing this form, you agree to a meeting with a broker/sales agent or *i*Care Medicare Benefits Consultant to discuss the plan 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. It does not impact your current or future Medicare enrollment status. *i*Care will not automatically enroll you in a plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____ **Date:** _____

If you are the authorized representative, please sign above and below.

Representative's Name: _____

Your Relationship to the Beneficiary: _____

To be completed by Broker, Agent, or *i*Care Medicare Benefits Consultant:

Agent/Broker/MBC Name:	Agent/Broker/MBC Phone:
Agent/Broker/MBC Company Name and Address:	
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact:	
Agent/Broker/MBC's Signature:	
Date of Appointment:	

Brokers, Agents and MBCs, please note: A new SOA is required if, during an appointment, the beneficiary requests information regarding a different plan type than previously agreed upon. Scope of Appointment documentation is subject to CMS record retention requirements. When applicable, please submit a copy of this form when submitting an election form on behalf of a beneficiary.

Independent Care Health Plan (*i*Care), which insures *i*Care Medicare Plan (HMO D-SNP) and *i*Care Family Care Partnership (HMO D-SNP), is an HMO with a Medicare contract and a contract with the State Medicaid program. Enrollment in *i*Care Medicare plans depends on *i*Care's contract renewal. Questions? Call 1-800-777-4376 (TTY:711) for more information. *i*Care Family Care Partnership is available to anyone who has both medical assistance from the State and Medicare, and is functionally eligible as determined by the State Long-Term Care Functional Screen. For more information about long-term care options available to you contact the Aging & Disability Resource Centers. The Resource Center can also assist you with information about eligibility and enrollment.

Independent Care Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-777-4376 (TTY: 1-800-947-3529).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-777-4376 (TTY: 1-800-947-3529).