

How to sign the Scope of Appointment online

1.- Scroll down to the bottom of the page and click "Continue".

Beneficiary or Authorized Representative Signatur Signature: * Click here to sign	Signature Date: 10/02/2024	
If you are the authorized representative, please si		
Representative's Name:	Your Relationship to the Beneficiary:	
To be completed by Agent:		
Agent Name: Wichelle Van Nostrand	Agent Phone: (206) 279 - 4792	
Beneficiary Name:	Beneficiary Phone (Optional):	
Beneficiary Address (Optional):		
Initial Method of Contact: (Indicate here if benefit	ciary 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 not signed by the beneficia was not documented prior to meeting:	ry 48 hours prior to the appointment, provide explanation	n why SOA
The Scope of Appointment is subject to CMS recordate of beneficiary's signature date or the date of 10062_SOA23GENERIC_C	d retention requirements, and is valid for 12 months after the beneficiary's initial request for information. Rev. 08/15/2023	Page 1 of 2
By clicking continue, I acknowledge that I have read an our <u>Enhancy Policy</u> for details on our privacy practices.	d agree to the Adobe <u>larms of Use</u> . See	2

2.- The blue tab on the left will prompt you on what you need to do. First, you will need to add your initials next to the type of products you want me to discuss with you.

Options 🗸	Please sign: Scope of Appo	intment form	Next Required 1	
T	rior to any face-to-face or telephonic appointment sal retween the agent and the Medicare beneficiary (or th	ation Form we agents to document the scope of a marketing appoint less meeting to ensure understanding of what will be dise wathorhead enpresentative). All information provided person with Medicare or his/her authorized representativ	on this	
al Ti a	bove. Please note in who will discuss the pro- hey do not work ectly he Federal government.	n Initials Hospital Indemnity Products	vlan.	
	Beneficiary or Authorized Representative Signature an	d Signature Date:		
	Signature: Click here to sign	Signature Date: 10/02/2024		
1	Signature: [*] Click here to sign If you are the authorized representative, please sign a	-		ł
5	-	-		l
3	If you are the authorized representative, please sign a	bove and print below:		l
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1	If you are the authorized representative, please sign a Representative's Name: To be completed by Agent:	bove and print below: Your Relationship to the Beneficiary:		l
	If you are the authorized representative, please sign a Representative's Name: To be completed by Agent: Agent Name: Wichelle Van Nostrrand	bove and print below: Your Relationship to the Beneficiary: Agent Phone: (20¢) 279 - 4792		l
	Tyou are the authorized representative, please sign a Representative's Name: To be completed by Agent: Agent Name: Wichselfe Van Nostrand Beneficiary Name:	bove and print below: Your Relationship to the Beneficiary: Agent Phone: (206) 2:79 - 4:792. Beneficiary Phone (Optional):		

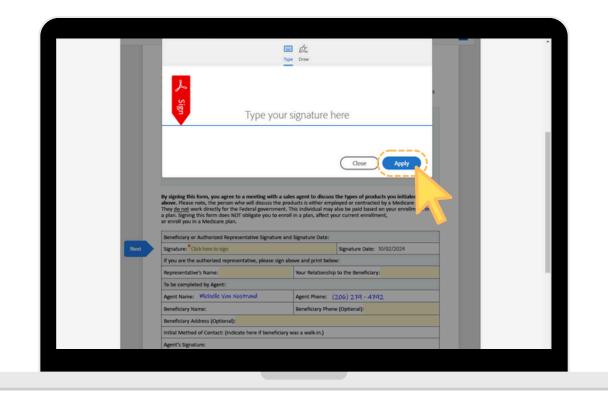
3.- Click on the box you want to fill and they'll let you type or draw your initials in. Then click on "Apply".

Options ~	Please sign: Scope of Ap		Next Required	
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Next	т.	ype your initials		
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4.- Next, click on the signature box to sign.

	The Centers for Medicare and Medicaid Services requi prior to any face-to-face or telephonic appointment sa between the agent and the Medicare beneficiary (or the form is confidential and should be completed by each	les meeting to ensure leir authorized repres	e understanding of what will be discussed sentative). All information provided on thi	d	
	Please initial below beside the type of produ (Refer to page 2 for product type descriptions		rent to discuss.		
	Stand-alone Medicare Prescriptio	•	the collection descends a first desta		
	Medicare Advantage Plans (Part of and Cost Plans		Hospital Indemnity Products Medicare Supplement (Medigap) Products		
	Dental/Vision/Hearing Products				
		d Signature Date:			
Next	Beneficiary or Authorized Represe Signature: "Click here to sign W you are the authorized representative; please sign a Representative's Name:	d Signature Date: Dove ant	Signature Date: 10/02/2024		
Next	Beneficiary or Authorized Represe and an Signature: [®] Click here to sign If you are the authorized representative, please sign a	d Signature Date: Dove ant	Signature Date: 10/02/2024		
Next	Beneficiary or Authorized Represe and an Signature: [®] Click here to sign [®] you are the authorized representative, please sign a Representative's Name:	od Signature Date:	Signature Date: 10/02/2024		
Next	Beneficiary of Authorized Represe Signature: [®] Click here to sign W you are the authorized representative; please sign a Representative's Name: To be completed by Agent:	od Signature Date:	sgnature Date: 10/02/2024		
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Rest	Beneficiary of Authorized Neprese and Beneficiary of Authorized Neprese and Beneficiary Authorized representative, please sign a Representative's Name: To be completed by Agent: Agent Name: Wichielle Van Nostrand Beneficiary Name: Beneficiary Address (Optional): Initial Method of Contact: (Indicate here if beneficiary	d Signature Date: DOVE and Dellow Your Agent none Beneficiary Phone	sgnature Date: 10/02/2024		
Next	Beneficiary of Authorized Neprese) an Beneficiary of Authorized Neprese) an Beneficiary and the authorized representative, packed sign a Representative's Name: To be completed by Agent: Agent Name: Michelle Van Nostraud Beneficiary Name: Beneficiary Address (Optional): Initial Method of Contact: (Indicate here if beneficiary Agent's Signature:	d Signature Date: cover an roeiow Your Agen hone Beneficiary Phone was a walk-in.]	Ignature Date: 10/02/2024		
	Beneficiary of Authorized Neprese) and Beneficiary of Authorized Neprese) and Beneficiary and the authorized representative, please sign a Representative's Name: To be completed by Agent: Agent Name: Wichielle Van Nostrand Beneficiary Name: Beneficiary Address (Optional): Initial Method of Contact: (Indicate here if beneficiary	d Signature Date: DOVE and Dellow Your Agent none Beneficiary Phone	Ignature Date: 10/02/2024		

5.- Type in your name or draw it using your mouse. Then click on "Apply".



6.- The rest of the boxes are optional, you can fill them out if you wish to do so. **Fill out the "representative" boxes if you have a Legal Power* of Attorney making your decisions and signing for you.*

Please initial below beside the type of p	oduct(s) you want the a	gent to discuss.	
(Refer to page 2 for product type descrip		gene to another	
TR Stand-alone Medicare Press	iption	1	
Drug Plans (Part D)	TR.	Hospital Indemnity Products	
and Cost Plans	_TR	Medicare Supplement (Medigap) Products	
Dental/Vision/Hearing Produ	ets		
By signing this form, you agree to a meeting with above. Please note, the person who will discuss th They <u>do not</u> work directly for the Federal governm a plan. Signing this form does NOT obligate you to or enroll you in a Medicare plan.	e products is either emp ent. This individual may	sloyed or contracted by a Medicare plan. also be paid based on your enrollment in	
Beneficiary or Authorized Representative Signatu	re and Signature Date:		
Signature: This Ber		Signature Date: 10/02/2024	-
If you are the authorized representative, please s	ign above and print belo	wc.	
Representative's Name:	Your Relationshi	p to the Beneficiary:	
To be completed by Agent:			
Agent Name: Michelle Van Nostrand	Agent Phone:	(206) 279 - 4792	
Beneficiary Name: Trial Run	Beneficiary Pho	ne (Optional):	
Beneficiary Address (Optional):			
	ciary was a walk-in.)		
Initial Method of Contact: (Indicate here if benefit			
Initial Method of Contact: (Indicate here if benefit Agent's Signature:			
	p Date Appointme	nt Completed:	
Agent's Signature:	p Date Appointme	nt Completed:	
Agent's Signature:	p Date Appointme	nt Completed:	

7.- Once you have finished filling out your form, scroll to the bottom of the page and click the "Click to Sign" button.

Dental/Vision/Hearing Products			
	who are looking to cover needs for dental, vision or hearing. The	rse	
Hospital Indemnity Products			
	Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.		
Medicare Supplement (Medigap) Products			
some or all of the deductible and coinsurance an	Plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and consurance amounts applicable to Medicare-covered services, and sometimes covers them and services that are not covered by Medicare, such as care outside of the courtier. These plans are not		
Do not submit if you do not trust the requesting p fraudulent activity By signing, I agree to this document, the <u>Consume</u> signatures.	/	Acoder Figs	
Advantage Insurance Benefits		90	
Contact Us!			
info@advantageinsurancebenefits.com	Subscribe to get our newsletters!		

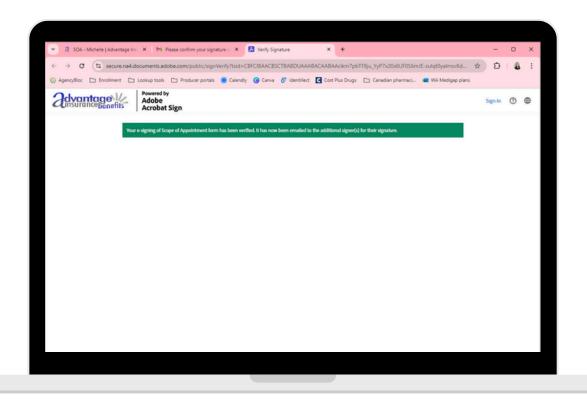
8.- You will need to enter your email address. Then click the "Click to Sign" button.

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	On a mobile device? Complete your form <u>here</u> .
Options ~	
	voos2_sc Enter Your Information X Page 1 of 2
	Please enter your email and then click to sign this document.
	Email
	Standa
	Medica Medica Medica
	Account Mans.
_	Medicare Advantage Plans (Part C) and Cost Plans

9.- If you completed all of the steps correctly, Adobe Sign will email you asking to confirm your signature. Click on the link in that email.

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Mail	0 Compose	← □ ○ B ⊠ № :	1 of 1,017 < 🔪 🔳 🕶
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	 Boomerang-Returned Deleted Messages 	To ensure that you continue receiving our emails, please add <u>addressor.Baddressor</u> to your address book or saf	le TeL

We will receive your completed Scope of Appointment form once you have completed all of the steps and you see this confirmation message:



Thank you!