

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 | |
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| 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: | | |
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| | 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 |
| 1 | If you are the authorized representative, please sign a Representative's Name: | bove and print below: | | 1 |
| 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): | | |

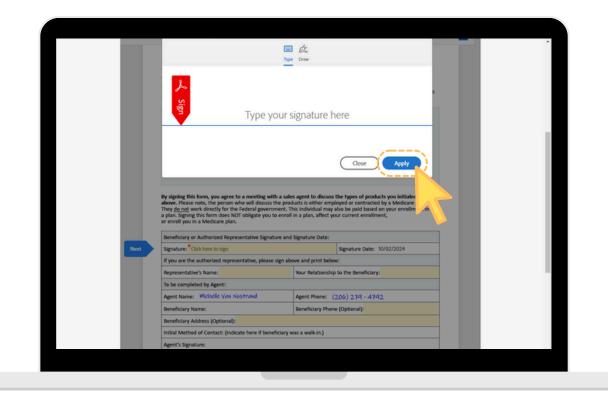
3.- Click on the box you want to fill and they'll let you type or draw your initials in. Then click on "Apply".

| 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 | | |
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| 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 | | |
| Next | Beneficiary of Authorized Neprese) an Signature: "Click here to sign Yr you'ne' one autorized representative, paese sign a Representative's Name: To be completed by Agent: Agent Name: Wichselle Van Nostrand Beneficiary Name: Beneficiary Address (Optional): | d Signature Date: DOVE and Dellow Your Agent none Beneficiary Phone | sgnature Date: 10/02/2024 | | |
| 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 | | | |
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| | 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! | | |

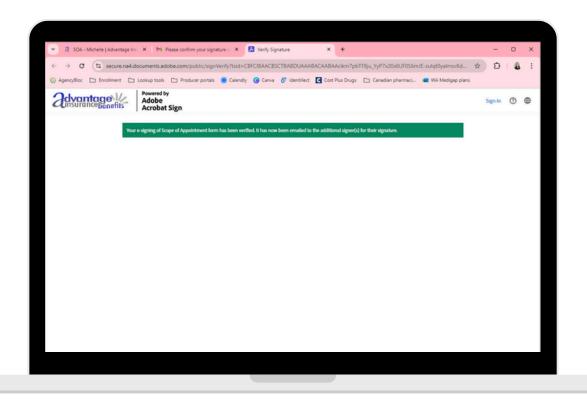
8.- You will need to enter your email address. Then click the "Click to Sign" button.

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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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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!