

2027 Permission to Contact Confirmation Form

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This form documents your request and permission for the agency and/or licensed insurance agent identified below to contact you regarding Medicare and Medicare-related health plan information. This form gives permission to contact you only. The specific product categories that may be discussed during a personal Medicare marketing appointment are documented separately on the Scope of Appointment (SOA).

MY PERMISSION TO BE CONTACTED

I request and give permission for the agency and/or licensed agent named on this form to contact me about Medicare and Medicare-related health plan information using the contact method(s) I select below. This permission applies only to the agency/agent identified on this form. I may ask not to be contacted at any time.

How I want to be contacted

Select one or more:

☐

Phone

☐

Email

☐

Text message

Beneficiary contact information

Beneficiary name:

Phone number:

Email address:

Authorized representative (if applicable):

Relationship:

Agency / licensed agent authorized to contact me

Agency name:

Licensed agent:

Beneficiary or authorized representative permission

Signature / electronic attestation:

Date:

CMS permits beneficiary-requested or beneficiary-consented contact. Unless you revoke it earlier, this request may be used for follow-up contact for up to 12 months within the purpose of this request. A separate SOA is required before a personal Medicare marketing appointment and controls which health care product categories may be discussed.

CMS contact rule reference: 42 CFR 422.2264(a)(3) and 423.2264(a)(3).

This PTC documents permission to make contact; it intentionally does not list plan/product categories. Those selections belong on the separate SOA.

2027 Scope of Appointment Confirmation Form

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The Centers for Medicare & Medicaid Services requires the scope of a personal marketing appointment to be agreed upon and documented before the appointment begins so the beneficiary (or authorized representative) and licensed agent understand which healthcare-related products may be discussed. For an in-person personal marketing appointment, the scope must be documented in writing.

Choose ONE of the following methods. For the easiest option, initial ALL PRODUCTS if you want to discuss every product category listed below.

	ALL PRODUCTS LISTED BELOW
I agree to discuss ALL of the healthcare-related product categories listed below during this appointment.	

— OR — If you do not want to discuss all products, initial ONLY the individual categories you agree to discuss.

	STAND-ALONE MEDICARE PRESCRIPTION DRUG PLANS (PART D) Prescription Drug Plans (PDPs) add Part D prescription drug benefits to Original Medicare and certain other Medicare arrangements.
	MEDICARE ADVANTAGE PLANS (PART C), COST PLANS AND OTHER MEDICARE HEALTH PLANS May include HMO, PPO, HMO-POS, PFFS, Special Needs Plans (SNP), Medical Savings Account (MSA), MA-PD, and Medicare Cost Plans, when available.
	DENTAL / VISION / HEARING PRODUCTS Supplemental products that may provide benefits for dental, vision, or hearing services. These products are separate from Medicare.
	HOSPITAL INDEMNITY / SUPPLEMENTAL HEALTH PRODUCTS Supplemental insurance products that may pay fixed or specified benefits based on covered medical services or events. These products are separate from Medicare.
	MEDICARE SUPPLEMENT (MEDIGAP) PRODUCTS Medicare Supplement insurance helps pay certain deductibles, coinsurance, and other gaps in Original Medicare, depending on the policy selected.

By signing this form, you agree to meet with a licensed sales agent to discuss only the product categories you affirmatively selected above. The agent does not work directly for the federal government and may be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll, affect your current or future Medicare enrollment, or automatically enroll you in a Medicare plan.

Beneficiary or authorized representative signature and signature date

Signature: _____ Signature date: _____

Beneficiary name: _____ Beneficiary phone: _____

Authorized representative (if applicable): _____ Relationship to beneficiary: _____

To be completed by licensed agent / plan representative

Licensed agent/plan representative: _____ Agent phone: _____

Beneficiary address: _____ Initial method of contact: _____

Plan(s) represented during meeting: _____ Appointment type: ☐ In Person ☐ Phone ☐ Virtual

Agent signature: _____ Date appointment completed: _____

SOA received date/time: _____ Appointment ID (if used): _____

Scope of Appointment documentation is subject to applicable CMS record-retention requirements.