

2010 Sales Appointment Confirmation Form

To be completed by the Medicare-eligible person. Please initial the box(es) below beside the plan type that you want the agent to discuss with you. If you do not want the agent to discuss a plan type with you, please leave the box empty. (Please note that an agent may also discuss a Medicare Supplement policy with you.)

Medicare Advantage (Part C), Medicare Advantage Prescription Drug Plans and other Medicare Plans	
<input type="checkbox"/>	<p>HealthPartners[®] Freedom Plan (Cost) — A type of health plan. In a Medicare Cost plan, if you get services outside of the plan’s network without a referral, your Medicare-covered services will be paid for under the Original Medicare Plan (your Cost plan pays for emergency services, or urgently needed services). <i>This plan is offered in the entire state of Minnesota and Barron, Burnett, Douglas, Dunn, Pierce, Polk, St. Croix and Washburn counties in Wisconsin.</i></p>
<input type="checkbox"/>	<p>HealthPartners[®] Classic Plan (HMO) —A Medicare Advantage plan that must cover all Part A and Part B healthcare. In most HMOs, you can only go to doctors, specialists, or hospitals in the plan’s network except in an emergency. <i>This plan is offered in Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Rice, Scott, Sherburne, Washington, Wright and zip code 55371 of Mille Lacs counties in Minnesota.</i></p>

By signing this form you are agreeing to a sales meeting with a contracted representative of HealthPartners to discuss the specific types of products you initialed above. HealthPartners contracts with Medicare. The person that will be discussing plan options with you is contracted with HealthPartners and is not a representative of the Federal government. He or she may be compensated based on your enrollment in a plan.

Signing this form does NOT affect your current enrollment, nor will it enroll you in a Medicare Advantage Plan, Prescription Drug Plan, or other Medicare plan.

Beneficiary Signature: _____

Authorized Representative: _____

If you are an authorized representative, you must sign above and provide the following information:

Name _____ **Relationship to Beneficiary** _____

Address _____ **Phone Number** _____

To be completed by Agent:

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact:	
Agent’s Signature:	Date:
	Time:

After the above scheduled appointment, please include a copy of this signed and completed form with the beneficiary’s enrollment application.