



Sales Appointment Confirmation Form

To be completed by the person with Medicare.

Please write your initials in the box below if you want a UCare representative to discuss our Medicare Advantage and Medicare Advantage Prescription Drug Plans with you. By writing your initials in the box, you are also giving UCare permission to have a representative call you.

Please initial here ►

Medicare Advantage and Medicare Advantage Prescription Drug Plans

Medicare Health Maintenance Organization (HMO) —A Medicare Advantage plan that must cover all Part A and Part B health care. In most HMOs, you can only go to doctors, specialists, or hospitals in the plan’s network except in an emergency.

Medicare Special Needs Plan (SNP) — A special type of Medicare Advantage plan that provides more focused and specialized health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or have certain chronic medical conditions.

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

Signing this form does NOT affect the plan you are currently enrolled in, nor will it enroll you in a Medicare Advantage Plan, Prescription Drug Plan, or other Medicare plan.

Beneficiary Signature: _____

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

Name: _____

Address: _____ *Phone number:* _____

Relationship to Beneficiary: _____

UCare Minnesota and UCare Wisconsin, Inc. are Medicare Advantage organizations with Medicare contracts.

Returning this form to UCare

After you have initialed and signed this form, please mail it back to UCare in the enclosed postage-paid envelope. Or send it to: UCare, Attn: Sales, P.O. Box 52, Minneapolis, MN 55440.

To be completed by UCare Representative:

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