SALES REPRESENTATIVE SUMMARY OF ENROLLMENT

TSR NAME: _____ **MARKETING REPRESENTATIVE:** _____

APPLICANT NAME: _____ **MARITAL STATUS:** _____

ADDRESS: _____

TEL No: _____ **EMAIL:** _____

EMERGENCY CONTACT NAME: _____

TEL No.: _____ **RELATIONSHIP:** _____

PCP (PROVIDER) NAME: _____ **PROVIDER ID#:** _____

MEDICAL GROUP NAME: _____

Please circle what applies to you: New to Medicare? ☐ ☐ Does the applicant have Medi-Cal? ☐ ☐

MEDICARE # _____ **MEDI-CAL #** _____

Who was present at the time of sign-up? _____

What location did you enroll the applicant? _____

How long did you work with the prospect? _____

Which Health Plan was discussed during this appointment? _____

Is applicant presently with any other HMO plan? ☐ ☐ If yes, HMO name: _____

I understand that I will have a primary doctor and the referral process to specialist _____

I understand the benefits the health plan offers _____

I understand that my medications covered by the plan will be obtained from network pharmacies _____

_____ _____

Enrollee Signature Date

Applicant's concerns if any: _____

_____

MEDICATIONS / PRESCRIPTIONS:

_____ _____ _____

_____ _____ _____

_____ _____ _____