KAISER PERMANENTE®

Event Information	
Agent Name	
Date of Evaluation	
Evaluator Name/Title	

National Medicare Sales: Personal Appointment Evaluation Form

A. Pre-Meeting Considerations/Marketing

Item #	Description	Yes, No, NA
1	Was the Scope of Appointment (SOA) properly documented or recorded by the agent prior to the meeting?	Choose an item.
2	Agent did not accept or agree to 'hold' completed enrollment forms and complied with the requirement to not accept enrollment forms for January effective dates in meetings that took place between October 1 and October 14? (Note: Enrollments may be accepted for CY 2026 enrollments during this time frame if a beneficiary has an allowable election period - ICEP or enrolls during a SEP/5-star SEP.)	Choose an item.
3	Agent did not discuss other products not covered in the SOA?	Choose an item.
4	The agent provided gifts? If no, move to next section.	Choose an item.
5	Gifts/giveaways are appropriate, under $15 in total value and cannot be converted to cash?	Choose an item.
6	The agent indicated that there is no obligation to enroll in the plan to be eligible for drawings or gifts?	Choose an item.

Medicare Beneficiary Plan Review Checklist – CMS Required Questions

A. Beneficiary-Specific Information

Item #	Description	Yes, No, NA
7	Agent discussed what kind of health plan does the beneficiary wish to enroll in (such as low premium and higher copay, or vice versa)?	Choose an item.
8	Are the beneficiary's current providers (primary care and specialists) in-network?	Choose an item.
9	Is the beneficiary's current pharmacy in-network? If not, explain that they will need to choose a new pharmacy?	Choose an item.
10	Are the beneficiary's prescriptions on the formulary? If not, explain that they may have to pay the full price of the prescription.	Choose an item.
11	Does the beneficiary require hearing, dental, and/or vision coverage?	Choose an item.
12	Does the beneficiary have any other healthcare needs, such as durable medical equipment or physical therapy?	Choose an item.
13	Is the beneficiary's preferred hospital in-network? If not, explain that they will need to pick a new one.	Choose an item.

14	Are there other preferred facilities that need to be in-network?	Choose an item.
15	Does the beneficiary have any other specific healthcare needs?	Choose an item.

B. Cost and Coverage Review

Item #	Description	Yes, No, NA
16	Agent reviewed premiums, including Part B premium, {insert dollar amount} per month/quarter/year. If applicable, review current premium vs. another plan premium?	Choose an item.
17	Agent reviewed beneficiary cost sharing such as deductibles, copays, and coinsurances. Go over deductible cost, PCP copay, Specialist copay, inpatient hospital copay, and any other copays for services/items the beneficiary needs?	Choose an item.
18	Agent discussed the costs/limitations on dental, vision, and hearing?	Choose an item.
19	Agent reviewed coverage for out-of-network providers and services (e.g., except in emergency or urgent situations, plan does not cover services by out-of-network providers)?	Choose an item.
20	Agent reviewed coverage outside the United States?	Choose an item.

C. Plan Impact and Rules

Item #	Description	Yes, No, NA
21	Agent explained the potential effect that enrolling in this plan will have on other, current coverage, which may in some cases mean that the beneficiary is disenrolled from their current health coverage?	Choose an item.
22	Agent explained that this is not a hearing/dental/vision 'rider' but a full plan?	Choose an item.
23	Agent explained that the plan operates on a calendar year basis, so benefits may change on January 1 of the following year?	Choose an item.
24	Agent explained that the Evidence of Coverage provides all of the costs, benefits, and rules for the plan?	Choose an item.
25	Agent explained how to file a complaint?	Choose an item.
26	Agent informed the beneficiary where they can access the Star Ratings Document?	Choose an item.
27	Agent informed the beneficiary where they can access the Plan's Summary of Benefits?	Choose an item.

D. Special Plan Types (if applicable)

Item #	Description	Yes, No, NA
28	Agent reviewed PPO or PFFS out-of-network coverage?	Choose an item.
29	Agent reviewed need to have a specific chronic condition to qualify for a C-SNP? **Note:** C-SNP plans not available at this time.	Choose an item.

30	Agent reviewed needs to have Medicaid to qualify for a D-SNP?	Choose an item.
31	Agent reviewed needs to require an institutional level of care to qualify for an I-SNP? **Note:** C-SNP plans not available at this time.	Choose an item.
32	Agent reviewed needs to maintain trust/custodial account in order to remain enrolled in an MSA plan?	Choose an item.

E. Enrollment Rights

Item #	Description	Yes, No, NA
33	Agent informed beneficiary of their right to cancel this enrollment as well as the specific date on which cancellation may occur?	Choose an item.

Compliance/Manager Section	
Missed Compliance Elements (Item #)	**Description**
Manager or Supervisor: Please complete the sections below and provide a brief description of action taken regarding the findings noted above	
AGENT CORRECTIVE ACTION / DISCIPLINARY ACTION	
Action Type (also described by CMS as Disciplinary Action Type): **Choose from: none, retrain, manager coaching, verbal warning, selling privileges revoked, suspension, written warning, termination, increased monitoring, other- (describe)** **1.** **2.** **3.**	
Corrective Action Summary	
Completed By : **Date Completed:**	
Additional Comments/Observations/Kudos	