CoxHealth
Medicare Advantage
by Cox HealthPlans

PO Box 5750
Springfield, MO 65801-5750
CoxHealthMedicareAdvantage.com

Consent to Contact and Information Request

Name: _____

Address: _____ **City**: _____

State: _____ **Zip:** _____

Phone: (_____)_____ **Email:**_____

I would like to:

☐ Talk with a licensed sales representative about the CoxHealth Medicare Advantage Plan

☐ Receive information in the mail about the CoxHealth Medicare Advantage Plan

This Consent to Contact Form is optional.

By providing the information above and signing this, you are agreeing to have sales agent discuss the CoxHealth Medicare Advantage (HMO) plan. 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, and they may be compensated based on your enrollment in a plan. This form will expire one year from the date signed.

Signing this does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment status, nor will it automatically enroll you in the plan discussed.

Signature (optional) _____ Date _____