COX HEALTHPLANS
CoxHealth
THINKING HEALTH FORWARD

PO Box 5750
Springfield, MO 65801-5750

Cox HealthPlans
Agent Enrollment Checklist

Agent: _____ Date: _____

Scope of appointment? ☐ Yes ☐ No Pre-Enrollment Checklist Reviewed? ☐ Yes ☐ No

Name of person(s) meeting with: _____

Is there a POA or Legal Representative to make decisions on your behalf? ☐ Yes ☐ No

First Name: _____ M.I.: _____ Last Name: _____

Telephone #: _____ Relationship: _____

☐ You must have both Medicare Parts A & B to enroll in this plan.

☐ You must reside in the plan's service area to enroll and maintain eligibility in this plan.

☐ Per Medicare Guidelines, you may only enroll and disenroll during specific times of the year.

☐ Reviewed how to file a complaint.

☐ Reviewed right to cancel and specific date through which cancellation may occur.

☐ Enrollment into this Medicare Advantage plan is dependent on contract renewal.

☐ Benefits

- Deductible
- PCP Co-pays
- Specialist Co-pays
- Hospital Co-pays
- Other Co-pays
- Referrals to Specialists
- Use of Network Providers
- Use of Network Pharmacies
- PCP Selection
- Pharmacy Co-pays
- Pharmacy Deductibles
- Formulary Tiers
- Pharmacy Out-of-Pocket
- Extra Help Eligibility
- Dental
- Vision
- Hearing
- Over the Counter
- Fitness
- Wellness Rewards
- Coverage outside the U. S.
- DME or Physical Therapy Needs
- Other Specific Healthcare Needs

It has been explained to me that plan members must use plan (network) providers for routine care and that specialty care may require a referral from a network primary care provider.

The person that is discussing plan options with you may be a contracted agent or employee with Cox HealthPlans and may receive compensation on your enrollment into this plan.

By signing this form, you acknowledge that you attest the information listed above has been explained to you.

Beneficiary Signature	**Date**	**Beneficiary Telephone #**
POA / Legal Representative	**Date**	**Agent**