

Medicare Permission to Contact (PTC)

Permission to Contact Regarding Medicare Plans

By completing and signing this form, you are giving permission to:

Agent Name: _____

and/or

Agency Name: _____

to contact you about Medicare Advantage Plans, Medicare Prescription Drug Plans, and/or Dual Special Needs Plans.

Beneficiary Information

Full Name:

Permanent Residence Address:

City, State, Zip Code:

Phone Number:

Email Address (Optional):

Preferred Method of Contact (Check all that apply):

- ☐ Phone
- ☐ Email
- ☐ Text Message

Preferred Time to Contact:

- ☐ Morning
- ☐ Afternoon
- ☐ Evening

Products of Interest

Please contact me regarding:

- ☐ Medicare Advantage Plans (Part C)
- ☐ Medicare Prescription Drug Plans (Part D)
- ☐ Medicare Dual Special Needs Plan (D-SNP)
- ☐ Other Medicare-related information

Permission Statement

I understand that:

- By providing the personal information above, I grant permission for a licensed insurance sales representative to contact me via phone, email, or mail to discuss Medicare health plans, products, or educational information.
- I understand that signing this form is voluntary, does not obligate me to enroll in a plan, and will not affect my current or future Medicare enrollment. The person discussing plan options is contracted by Medicare, not the federal government, and may be paid based on enrollment.

Signature:

Date:

Agent Use Only

Lead Source:

☐ Website

☐ Referral

☐ Business Reply Card

☐ Educational Event

☐ Seminar

☐ Other: _____

Date Permission Received:

Agent Name:

Agent ID/NPN:

Retention Period: Keep according to Amer and CMS record retention requirements.