

COMMUNICATION CONSENT · 2026

Permission to Contact

Use this form to document how BizCoWorks Insurance and the specifically identified licensed agent or entity may contact you about the Medicare-related request you initiated.

1 YOUR INFORMATION

NAME

TELEPHONE

EMAIL ADDRESS

ZIP CODE

2 WHO MAY CONTACT YOU

Identify the entity or licensed agent you are authorizing. This consent should not be treated as permission for unrelated organizations to market to you.

AUTHORIZED ENTITY

LICENSED AGENT / REPRESENTATIVE (IF KNOWN)

3 HOW WE MAY CONTACT YOU

☐ Telephone call

☐ Text / SMS

☐ Email

PURPOSE / TOPIC OF CONTACT

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Consent and authorization record.

4 CONSENT

I am requesting contact regarding Medicare-related education, coverage review, scheduling, or enrollment assistance. I authorize the entity and/or licensed agent identified on this form to contact me using the communication methods I selected. I understand that providing this permission does not require me to enroll in a plan and does not affect my current or future Medicare enrollment. I may ask that future marketing contact stop. If my information would be shared with another Third Party Marketing Organization for Medicare marketing or enrollment, separate prior express written consent should be obtained for that receiving organization.

BENEFICIARY / AUTHORIZED REPRESENTATIVE SIGNATURE

DATE

AUTHORIZED REPRESENTATIVE NAME / RELATIONSHIP (IF APPLICABLE)

5 INTERNAL DOCUMENTATION

BENEFIT ADVISOR / STAFF NAME

DATE / TIME CONSENT RECEIVED

SOURCE

NOTES / REVOCATION OR CONTACT PREFERENCE UPDATES

Compliance note: Final consent language, retention period, TCPA/FCC requirements, TPMO disclosures, and carrier/FMO requirements should be approved before production use.