

**MEDICARE ADVANTAGE/MEDICARE PART D**  
**CONFLICT OF INTEREST ATTESTATION**

Please check those statements that apply in section I **or** II and then sign below.

**I.      Applies if You Are Free of Any Conflict of Interest**

- I, hereby, certify that I have reviewed [Name of Company]’s conflict of interest policy.
- I, hereby, certify that I am free of any conflict of interest in administering or delivering Medicare benefits.

OR

**II.     Applies if You May Have a Conflict of Interest**

- I, hereby, certify that I have reviewed [Name of Company]’s conflict of interest policy.
- I, hereby, certify that I have disclosed to management any potential conflicts of interest that I may have in administering or delivering Medicare benefits.
- I, hereby, certify that I have obtained management approval to work despite any potential conflict(s) or I have eliminated the potential conflict(s).

To the best of my knowledge and belief, the information contained in this response is true and accurate.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Employer/Name of Company