MEDICARE ADVANTAGE/MEDICARE PART D
QUALIFIED HEALTH PLANS
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 and/or Qualified Health Plans 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 and/or Qualified Health Plans 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