

## 正確書寫 – 提交申請

### Clever Enroll – Online Enrollment Portal

- ✓ Enrollment Application

### Clever Care Website

Assessable Electronic In Language DocuSign

- ✓ Online Enrollment Powerforms

Downloadable Paper forms

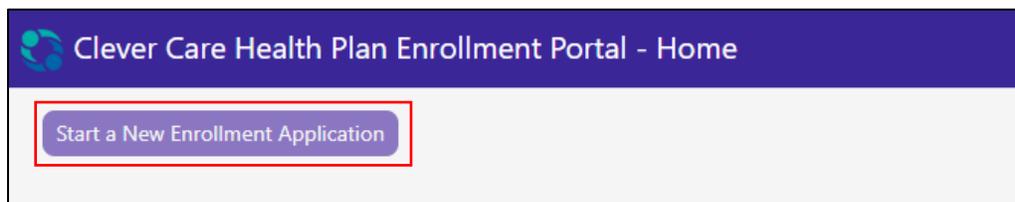
- ✓ Paper Enrollment forms



## Clever Enroll – 線上投保

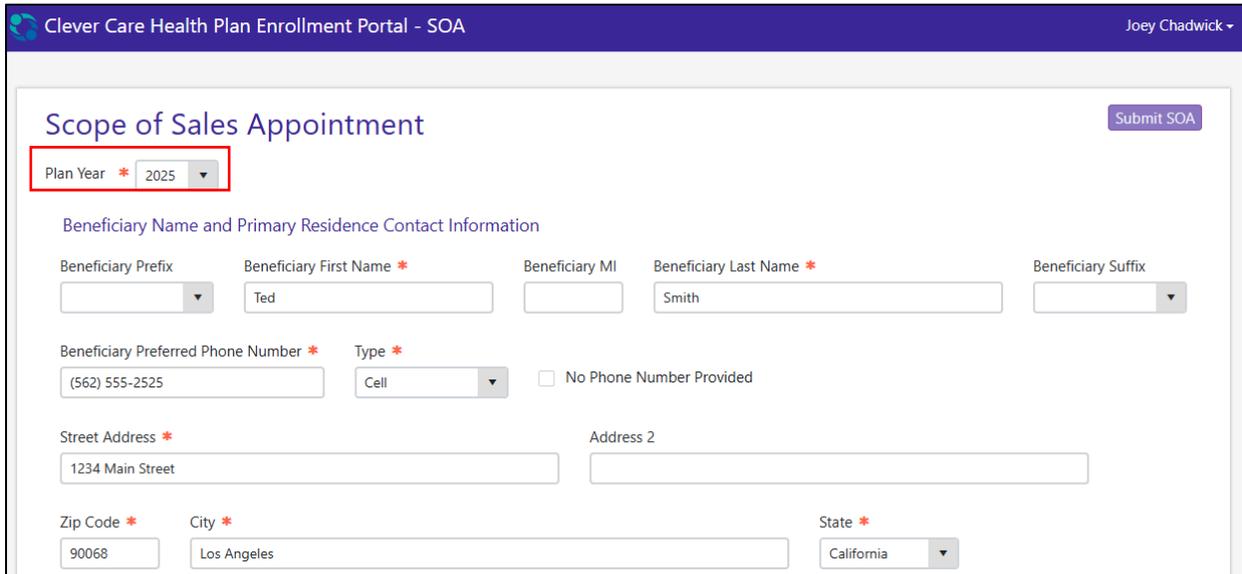
Clever Enroll 是福全健保 (Clever Care) 的線上投保入口網站。您可以在單一入口網站中提交電子預約範圍 (Scope of Appointment, SOA)、計劃申請和健康風險評估 (Health Risk Assessment, HRA)。

**開始投保程序。** 按一下「開始新的投保申請」 (Start a New Enrollment Application) 按鈕。



## 步驟 1 - 銷售預約範圍 (Scope of Sales Appointment)

1. 選擇「計劃年度」 (Plan Year)。填寫「受益人姓名」 (Beneficiary Name) 和「主要居住地」 (Primary Residence) 聯絡資訊。



Clever Care Health Plan Enrollment Portal - SOA Joey Chadwick ▾

### Scope of Sales Appointment Submit SOA

Plan Year \* 2025 ▾

**Beneficiary Name and Primary Residence Contact Information**

Beneficiary Prefix ▾ Beneficiary First Name \* Ted Beneficiary MI Beneficiary Last Name \* Smith Beneficiary Suffix ▾

Beneficiary Preferred Phone Number \* (562) 555-2525 Type \* Cell  No Phone Number Provided

Street Address \* 1234 Main Street Address 2

Zip Code \* 90068 City \* Los Angeles State \* California ▾

2. 閱讀「銷售預約範圍確認書」 (Scope of Sales Appointment confirmation)。按一下方塊以選取您要與受益人討論的計劃。HMO 方塊適用於長壽計劃和超值計劃。C-SNP 方塊適用於我們的全加計劃。將根據此核取方塊和郵遞區號顯示計劃。任何有紅色星號 \* 的問題都是必填欄位。
3. 輸入受益人全名 (Beneficiary or Authorized Representative Signature)，並選擇預約範圍簽署日期 (Signature Date)。對於「授權書」或授權代表，請選擇「是」 (Yes) 或「否」 (No)。如果選擇「是」，請填寫其姓名、地址、電話號碼以及與受益人的關係。

## Scope of Sales Appointment Confirmation

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please select the product types that you would like the agent to discuss \*

### Clever Care Health Plan Medicare Advantage and Prescription Drug Plan (MAPD)

- Medicare Health Maintenance Organization (HMO)** A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
- Medicare Chronic Special Needs Plan (C-SNP)** A Medicare Advantage special needs Plan that is designed for people with chronic conditions.

## Acknowledgement and Signature

Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Beneficiary or Authorized Representative Signature \*

Signature Date \*

12/9/2024



Is an authorized representative signing on behalf of the beneficiary \*

Yes

No

4. 回答第一個必填問題。如果在會面前 2 天簽署了 SOA，請輸入「不適用」(N/A)。如果 SOA 是因未預約而於會面當日簽署，請輸入「未預約」(Walk-In)。(CMS 要求在投保前 48 小時簽署 SOA。)
5. SOA 新增了兩個新問題。
  - a. 銷售預約範圍是如何取得的? (How was the Scope of Sales Appointment captured?)
    - 電子 (Electronic)、紙本 (Paper) 或電話 (Telephone)
  - b. 取得銷售預約範圍的日期? (Date the Scope of Sales Appointment was captured?)
    - 選擇簽署 SOA 的日期
6. 輸入「首次聯絡方式」(Initial Method of contact)、討論的計劃 (Plan(s) the Agent Represented During this Meeting)、代理人的簽名 (Agent Signature) 和簽署日期 (Agent Signature Date)，以完成 SOA 的其餘部分。

### To be Completed by Agent

Agent First Name: Joey                      Agent Last Name: Chadwick                      Agent Phone Number: N/A

If the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting. \*

Walk In

How was the Scope of Sales Appointment captured? \*      Date the Scope of Sales Appointment was captured \*

Paper                      12/9/2024

Initial Method of Contact \*

Walk-in

Plan(s) the Agent Represented During this Meeting \*

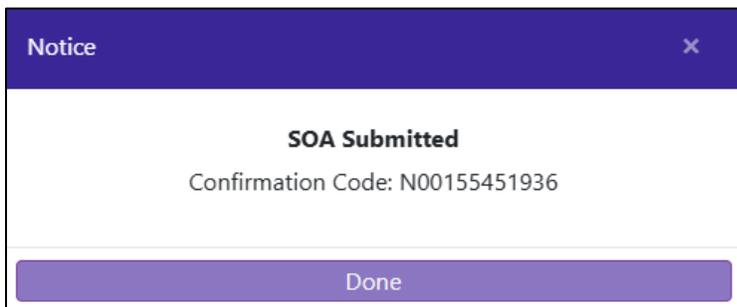
- MA-PD Longevity-002-001
- MA-PD Total +-011-001
- MA-PD Value-008-001

Signature

Agent Signature \*                      Agent Signature Date \*

Joey Chadwick                      12/9/2024                      [Submit SOA](#)

7. SOA 完成後，請按一下「提交 SOA」( [Submit SOA](#) ) 按鈕。此時會顯示訊息，按一下「完成」(Done)。



## 步驟 2 - 計劃選擇 (Plan Selection)

1. 此頁面會顯示您所選計劃年度的所有福全健保 (Clever Care) 計劃。向下捲動至受益人想要投保的計劃。
2. 每個計劃方塊會顯示「月付保費」(Monthly Premium) 和「查看詳情」(View Details) 連結。此連結會在我們的福全健保 (Clever Care) 網站上開啟新分頁，其中包含計劃概覽詳細資料和可下載的文件。
3. 您也會看到「醫療」(Medical)、「藥房」(Pharmacy) 和福利類型的詳細資訊和共付額。
4. 按一下「選擇此計劃」(Select This Plan) 按鈕選擇計劃。紫色方塊會環繞所選擇的計劃。
5. 請捲動至畫面頂端並按一下紫色的「開始投保申請」(Start Enrollment Application) 按鈕。

Clever Care Health Plan Enrollment Portal - New Enrollment: 2024 Joey Chadwick ▾

Scope of Sales Appointment | **Plan Selection** | Applicant Information | Medicare Information | Primary Care Physician | Payment Options | Attestation of Eligibility | Review

Plan Selection (4) Start Enrollment Application

**Clever Care Longevity (HMO) Plan**

Clever Care Longevity (HMO) plan is a comprehensive MA-PD plan.

**Monthly Premium** View Details \$0.00

**Hide Benefits and Co-Pays** Select This Plan

Medical		In Network	
PCP Copay		\$0.00	
Specialist Copay		\$0.00	
Deductible		\$0.00	
OOP Max		\$1,700.00	

Pharmacy		Copays	
<b>Annual Deductible</b>			
NA		Tier 1 Copay	\$0 Copay
<b>Initial Coverage Limit</b>		Tier 2 Copay	\$0 Copay
\$5,030.00		Tier 3 Copay	\$35 Copay
<b>True OOP Threshold Amt</b>		Tier 4 Copay	\$99 Copay
\$8,000.00		Tier 5 Copay	33% Coinsurance
		Tier 6 Copay	\$0 Copay

**Benefits Include**

- Routine Physical
- Routine Vision and Eyewear Coverage
- Prescription Drugs
- Transportation (Non-Emergency)
- Dental
- Flexible Health and Wellness Allowance
- TeleHealth Visits
- Hearing
- Acupuncture
- Eastern Wellness Therapies

\*Your cost-sharing may differ depending on the pharmacy you choose (e.g., standard retail, out-of-network, mail-order) or whether you receive a 30- or 100-day supply. If you live in a long-term care facility (LTC), you pay the same amount as you would at a standard retail pharmacy for a 31-day supply of medication. \*\*Limits and exclusions may apply. Refer to the Evidence of Coverage for a full description of benefits. This information is not a complete description of benefits. Call (833) 388-8168 for more information.

### 步驟 3 - 協議 (Agreement)

1. 在「檢閱」(Review) 頁面上，檢閱每個部分以確保正確無誤。
2. 向受益人閱讀協議部分 (Agreement)。勾選方塊以記錄其數位簽章。輸入其全名 (Member's or Authorized Representative's Signature) 和代理人全名 (Signature of Licensed Medicare Agent)。

3. 選擇「申請的來源」(Source of Application) 是透過「電話」(Telephonic) 或「投保入口網站」(Enrollment portal)。
4. 輸入協助受益人填寫申請表的人員姓名 (Individual's Signature)。
5. 輸入與受益人的關係 (Relationship to Enrollee)。
6. 如果是經紀人, 也請輸入「全國生產商編號」(National Producer Number)。
7. 按一下綠色「立即投保」(  ) 按鈕以提交投保。

**Agreement**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Clever Care Health Plan.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Clever Care will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that when my Clever Care Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Clever Care Health Plan. Benefits and services provided by Clever Care Health Plan and contained in my Clever Care Health Plan 'Evidence of Coverage' document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Clever Care will pay for benefits or services that are not covered.
- I understand that by checking this box  this represents my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  - 1) This person is authorized under State law to complete this enrollment, and
  - 2) Documentation of this authority is available upon request by Medicare.

By Checking this box you are signing this enrollment application and you agree to the above statements \*

Member's or Authorized Representative's Signature *	Signature Date	Signature of Licensed Medicare Agent *	Signature Date
Ted Smith	12/9/2024	Joey Chadwick	12/9/2024

Select Source of Application \* Enrollment Portal  
Telephonic

For individuals helping enroll Enrollment Portal this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Individual's Signature Joey Chadwick	Relationship to enrollee: * Broker	National Producer Number(Agents/Brokers only): * 12345678	<input type="button" value="Enroll Now"/>
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#### 步驟 4 - 確認號碼

1. 閱讀最終聲明, 並向受益人提供確認代碼 (Confirmation Code)。
  - a. 在右上角, 您可以「列印」(Print) 申請表、「啟動 HRA」(Start an HRA) 或前往「主畫面」(Home)。
  - b. 這是可以列印申請表的**唯一**畫面。按一下「列印」(Print) 按鈕, 並選擇將其另存為 PDF 檔至您的電腦。

## Thank You!

[Print](#) [HRA](#) [Home](#)

The Medicare Enrollment Application for Mary Beneficiary is subject to review by Clever Care Health Plan and the Centers for Medicare & Medicaid Services.

Confirmation Code: A00066648656

Thank you for completing your application in Clever Care Health Plan. Processing your application will take 7-10 calendar days.

### Plan Selection

**Clever Care Longevity (HMO) Plan**  
\$0.00 Premium Per Month

### Applicant Information

Mary . Beneficiary  
Female  
02/02/1955

Permanent Residence Address  
3052 N GOODVIEW TR Los Angeles, CA 90068

Contact Information  
Cell: **(626) 555-1234 Texts Allowed**

Preferred Material Language and Format  
(where available)  
Selected language: **English**  
Format: **Large Print**

# 福全健保 (Clever Care) 網站 – DocuSign PowerForms

另一種提交計劃申請的方法是透過 DocuSign 流程。DocuSign 流程需要電子簽章。若要簽署申請表，客戶必須在閱讀理解聲明以提供電子簽章後勾選方塊。

**注意：**請勿列印 DocuSign 表單並將申請表傳真或郵寄至福全健保 (Clever Care)。完成 DocuSign 並按一下「完成」(Finish) 按鈕後，就會自動以電子方式傳送至福全健保 (Clever Care)。

## 第 1 步：

前往福全健保 (Clever Care) 的網站：<https://zh.clevercarehealthplan.com/brokers/enrollment-forms/>。向下捲動至「福全健保 (Clever Care) Power Forms 表單」(Clever Care Power Forms)，並按一下所需語言的投保表格連結。



## 第 2 步：

填寫代理人的姓名 (Your Name) 和電子郵件地址 (Your Email)。

**PowerForm Signer Information**

Fill in the name and email for each signing role listed below. Signers will receive an email inviting them to sign this document.

Please enter your name and email to begin the signing process.

**Broker**

Your Name: \*

Your Email: \*

**Begin Signing**

### 第 3 步:

按一下畫面右上角的黃色「繼續」(Continue) 按鈕，開始填寫申請表。



### 第 4 步:

繼續選擇客戶居住郡的計劃，並填寫所有紅色的必填欄位。

A screenshot of the application form. At the top, it says 'DocuSign Envelope ID: 3C23D859-A364-498E-93D3-D115A08E7C13'. Below that is a section header 'Section 1' with the note 'All fields on this page are required (unless marked optional)'. The main heading is 'Select the plan you want to join:'. There are three sections of plan options, each with radio buttons and a 'CHOOSE' button on the left. The first section is 'Clever Care Longevity (HMO) H7607-002' with five options for different counties, all at '\$0 per month'. The second section is 'Clever Care Value (HMO) H7607-008' with five options for different counties, all at '\$0 per month'. The third section is 'Clever Care Total+ (HMO CSNP) H7607-011' with five options for different counties, all at '\$18.40 per month'. Below the plan options are fields for 'LAST name:', 'FIRST name:', 'M.I. (optional):', 'Birth date:', 'Sex: Male Female', and 'Phone Number:'. The 'LAST name', 'FIRST name', 'Birth date', and 'Phone Number' fields are highlighted with red boxes.

### 第 5 步:

在第 4 頁，請客戶閱讀理解聲明，然後按一下小核取方塊。這代表受益人的電子簽章。

<b>Section 1</b>	All fields on this page are required (unless marked optional) <i>continued</i>
<b>IMPORTANT: Read and check the box below:</b>	
<ul style="list-style-type: none"> <li>• I must keep both Hospital (Part A) and Medical (Part B) to stay in Clever Care Health Plan.</li> <li>• By joining this Medicare Advantage Plan, I acknowledge that Clever Care will share my information with Medicare, who may use it to track my enrollment, make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.</li> <li>• I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).</li> <li>• I understand that when my Clever Care Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Clever Care Health Plan. Benefits and services provided by Clever Care Health Plan and contained in my Clever Care Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Clever Care will pay for benefits or services that are not covered.</li> <li>• The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.</li> <li>• I understand that by checking this box <input checked="" type="checkbox"/> <b>Required - Signature</b> (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:             <ol style="list-style-type: none"> <li>1. this person is authorized under State law to complete this enrollment, and</li> <li>2. documentation of this authority is available upon request by Medicare.</li> </ol> </li> </ul>	
Today's date: 10/24/2024 D / Y Y Y Y	

**第 6 步:**

在第 6 頁底部，填寫與投保人的關係 (Relationship to enrollee)、全國生產商編號 (National Producer Number)、生效日期 (Effective Date of Coverage)、接收日期 (Date Application was Received)，以及是否透過電話完成申請 (Telephonic Application?)。然後，經紀人將按一下簽署 (Sign) 按鈕  簽申請表。

For individuals helping enrollee with completing this form only	
Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.	
Name: Joey Chadwick	Relationship to enrollee: Broker
Signature: 	National Producer Number (Agents/Brokers only): 12345678
FMO (if applicable) Ipro	Telephonic Application?: <input type="radio"/> Yes <input checked="" type="radio"/> No
Effective date of coverage: 01/01/2025	Date application was received: 10/24/2024

**PRIVACY ACT STATEMENT**  
 The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MAPx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

**第 7 步:**

完成所有事項後，按一下頁面頂部的「完成」(Finish) 按鈕。如此將以電子方式將申請表傳送至福全健保 (Clever Care)。經紀人隨後會在電子郵件收件匣中收到電子郵件確認和申請表副本。

[FINISH](#)[FINISH LATER](#)[OTHER ACTIONS](#) ▾

## 福全健保 (Clever Care) 網站 – 可下載的紙本表格

提交計劃申請的另一種方法是下載紙本表格、填寫表格、讓受益人簽名，並以傳真或加密的電子郵件傳送給福全健保 (Clever Care Health Plan)。

### 第 1 步：

前往福全健保 (Clever Care) 網站 <https://zh.clevercarehealthplan.com/brokers/enrollment-forms/>，然後向下捲動到頁面底部，顯示「可列印資源」(Printable Resources) 的地方，並按一下所需語言的 2025 年投保表的連結。

**2025 Printable Enrollment Resources**

- 2025 Enrollment Forms
  - [2025 Enrollment Form in English](#)
  - [2025 Enrollment Form in Chinese](#)
  - [2025 Enrollment Form in Korean](#)
  - [2025 Enrollment Form in Vietnamese](#)
  - [2025 Enrollment Form in Spanish](#)

### 第 2 步：

在頁面頂端，按一下下載 (Download) 按鈕  或列印 (Print) 按鈕  列印表格，以便受益人填寫。



### 第 3 步：

確保在第 4 頁第 1 部份中簽署申請表並註明日期。

**Section 1**All fields on this page are required (unless marked optional) *continued***IMPORTANT: Read and sign below:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Clever Care Health Plan.
- By joining this Medicare Advantage Plan, I acknowledge that Clever Care will share my information with Medicare, who may use it to track my enrollment, make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Clever Care Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Clever Care Health Plan. Benefits and services provided by Clever Care Health Plan and contained in my Clever Care Health Plan “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Clever Care will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1. this person is authorized under State law to complete this enrollment, and
  2. documentation of this authority is available upon request by Medicare.

**Signature:****Today's date:**

M M / D D / Y Y Y Y

**If you're the authorized representative, sign above and fill out these fields:**

Name:

Address:

Phone number:

Relationship to enrollee:

**第 4 步:**

您和受益人完成書面申請並簽名後，即可以下列方式提交申請。

1. **首選方法:** 將申請表傳真至 (657) 276-4757
2. **選擇性方法:** 將加密電子郵件傳送至 [enrollment@ccmapd.com](mailto:enrollment@ccmapd.com)