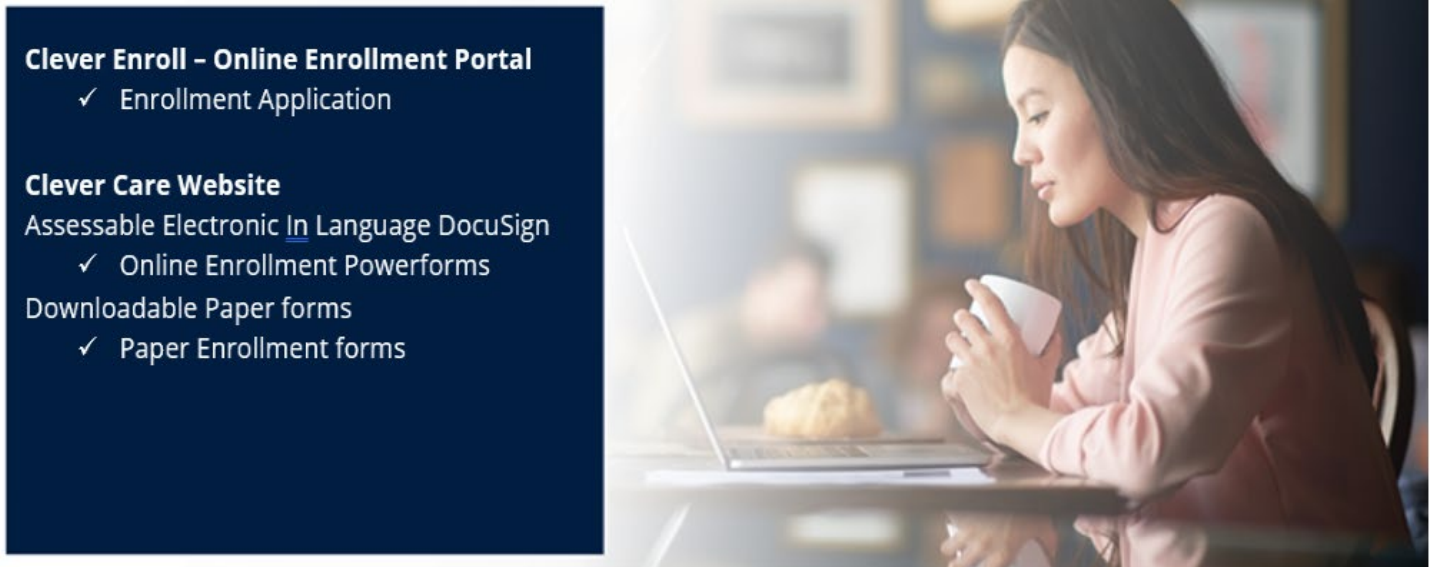


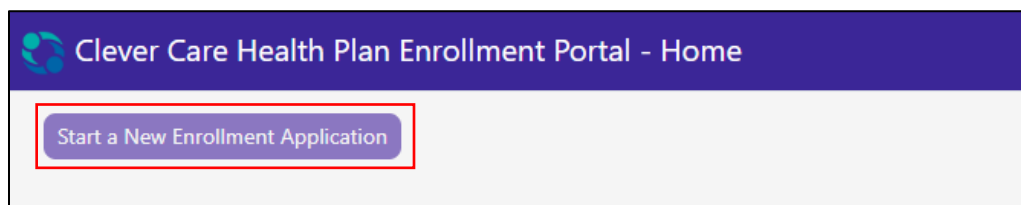
올바르게 작성하기 - 가입 신청서 제출



Clever Enroll - 온라인 가입

Clever Enroll 은 Clever Care 의 온라인 가입 포털입니다. 하나의 포털에서 전자(온라인) 영업 약속의 논의 범위 확인서(SOA), 플랜 가입 신청서, 건강 위험 평가(HRA)를 모두 제출할 수 있습니다.

가입 절차 시작하기. 신규 가입 신청 시작하기(Start a New Enrollment Application) 버튼을 클릭하십시오.



1 단계 - 영업 약속의 논의 범위 확인서(SOA, Scope of Appointment)

1. 플랜 연도를 선택하십시오. 수혜자 이름과 주 거주지 연락처 정보를 입력하십시오.

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 * Beneficiary MI Beneficiary Last Name * Beneficiary Suffix

Beneficiary Preferred Phone Number * Type * ☐ No Phone Number Provided

Street Address * Address 2

Zip Code * City * State *

2. 영업 약속의 논의 범위 확인서(SOA)를 읽으십시오. 상자를 클릭하여 수혜자와 논의할 플랜을 선택하십시오. HMO 상자는 Longevity 및 Value 플랜용입니다. C-SNP 상자는 Total+ 플랜용입니다. 이 확인란과 우편번호(zipcode)에 따라 플랜이 표시됩니다. 빨간색 별표 * 가 있는 질문은 필수 입력란입니다.
3. 수혜자의 전체 이름을 입력하고 영업 약속의 논의 범위 확인서(SOA)에 서명한 날짜를 선택하십시오. 위임장(Power of Attorney) 또는 위임 대리인의 경우 예(Yes) 또는 아니요(No)를 선택하십시오. 예인 경우 이름, 주소, 전화번호, 수혜자와의 관계를 기입하십시오.

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 *

Is an authorized representative signing on behalf of the beneficiary * ☐ Yes ☒ No

4. 첫 번째 필수 질문에 답하십시오. 수혜자와의 만남 2 일 전에 SOA 에 서명했다면 N/A(해당 없음)를 입력하십시오. 워크인(walk-in)으로 인해 SOA 에 당일 서명했다면 Walk-In 을 입력하십시오. (CMS 는 가입 48 시간 전에 SOA 에 서명할 것을 필수 요건으로 합니다.)
5. SOA 에 두 가지 새로운 질문이 추가되었습니다.
 - a. 영업 약속의 논의 범위 확인서(SOA)는 어떻게 기재되었나요?
 - 전자(Electronic), 종이(Paper), 또는 전화(Telephone)
 - b. 영업 약속의 논의 범위 확인서(SOA)가 작성된 날짜는 언제인가요?
 - SOA 가 서명된 날짜를 선택하십시오
6. 초기 연락 방법, 논의된 플랜, 에이전트의 서명 및 서명 날짜를 입력하여 나머지 SOA 를 완료하십시오.

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 가 완료되면 **Submit SOA** 버튼을 클릭하십시오. 메시지가 나타나면 완료(Done)를 클릭하십시오.

Notice

SOA Submitted

Confirmation Code: N00155451936

Done

2 단계 - 플랜 선택(Plan Selection)

1. 이 페이지에는 선택한 플랜 연도의 모든 Clever Care 플랜이 표시됩니다. 수혜자가 가입하려는 플랜까지 아래로 스크롤하십시오.
2. 각 플랜 상자에는 월별 보험료(Monthly Premium)와 '세부 정보 보기(View Details)' 링크가 표시됩니다. 이 링크를 클릭하면 플랜 개요 상세 정보와 다운로드 가능한 문서가 포함된 Clever Care 웹사이트의 새 탭이 열립니다.
3. 또한 의료 서비스, 약국, 혜택 유형에 대한 세부 정보 및 코페이도 확인하실 수 있습니다.
4. "이 플랜 선택(Select This Plan)" 버튼을 클릭하여 플랜을 선택하십시오. 보라색 상자가 선택한 플랜을 둘러싸게 됩니다.
5. 화면 상단으로 스크롤하여 보라색 "가입 신청 시작(Start Enrollment Application)" 버튼을 클릭하십시오.

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

Annual Deductible	Copays	
NA	Tier 1 Copay	\$0 Copay
Initial Coverage Limit	Tier 2 Copay	\$0 Copay
\$5,030.00	Tier 3 Copay	\$35 Copay
True OOP Threshold Amt	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.

3 단계 - 동의

H7607_25_CM1497_C 12112024

1. 검토(Review) 페이지에서 각 섹션을 검토하여 정확성을 확인하십시오.
2. 수혜자에게 동의(Agreement) 섹션을 읽어주십시오. 확인란을 선택하여 디지털 서명을 기록하십시오.
수혜자의 성명과 대리인의 성명을 입력하십시오.
3. 신청서 작성 방법(Source of Application)은 전화(Telephonic) 또는 가입 포털 (Enrollment portal) 중 하나를 선택하십시오.
4. 수혜자가 가입 신청서를 작성하는 데 도움을 준 사람의 이름을 입력하십시오.
5. 수혜자와의 관계를 입력하십시오.
6. 브로커인 경우, 국가 프로듀서 번호(National Producer Number)도 입력하십시오.
7. 초록색 **Enroll Now** 버튼을 클릭하여 가입을 제출하십시오.

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	Enroll Now
---	---------------------------------------	--	-------------------

4 단계 - 확인 번호(Confirmation Number)

1. 최종 성명(final statement)를 읽고 수취인에게 확인 코드(confirmation code)를 제공하십시오.
 - a. 오른쪽 상단에서 가입 신청서를 인쇄하거나 건강 위험 평가(HRA, Health Risk Assessment)를 시작하거나 홈 화면으로 돌아갈 수 있습니다.
 - b. 이 화면은 가입 신청서를 인쇄할 수 있는 **유일한** 화면입니다. 인쇄(print) 버튼을 클릭하고 컴퓨터에 PDF 로 저장(save it as a PDF)하도록 선택하십시오.

Clever Care Health Plan Enrollment Portal - New Enrollment: 2024

Joey Chadwick

Thank You!

PrintHRAHome

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

Clever Care 웹사이트 - DocuSign PowerForms

플랜 가입 신청서를 제출하는 또 다른 방법은 DocuSign 프로세스를 이용하는 것입니다. DocuSign 프로세스에는 전자 서명이 필요합니다. 신청서에 서명하려면 고객이 이해 진술서(statement of understanding)를 읽은 후 확인란을 선택하여 전자 서명을 제공해야 합니다.

참고: DocuSign 양식을 출력하여 팩스나 우편으로 Clever Care 에 보내지 마십시오. DocuSign 이 완료되면 완료(finish) 버튼을 클릭하여 전자적으로 Clever Care 에 자동으로 전송됩니다.

1 단계:

Clever Care 웹사이트 <https://ko.clevercarehealthplan.com/brokers/enrollment-forms/>로 이동하십시오. 아래로 스크롤하여 "Clever Care Power Forms"으로 이동한 후 필요한 언어로 된 가입 양식 링크를 클릭하십시오.

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

2 단계:

에이전트의 이름과 이메일 주소를 입력하십시오.

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: *

3 단계:

화면 오른쪽 상단의 노란색 계속(continue) 버튼을 클릭하여 가입 신청서 작성을 시작하십시오.

Clever Care HEALTH PLAN
Powered by DocuSign

CONTINUE FINISH LATER OTHER ACTIONS ▾

4 단계:

계속해서 고객이 거주하는 카운티의 플랜을 한 가지 선택하고 빨간색으로 표시된 모든 필수 입력란을 작성하십시오.

DocuSign Envelope ID: 3C23D859-A364-498E-93D3-D115A08E7C13

Section 1 All fields on this page are required (unless marked optional)

Select the plan you want to join:

CHOOSE

Clever Care Longevity (HMO) H7607-002		Clever Care Value (HMO) H7607-008	
☐ 001-Los Angeles County	\$0 per month	☐ 001-Los Angeles County	\$0 per month
☐ 002-Orange County	\$0 per month	☐ 002-Orange County	\$0 per month
☐ 003-San Diego County	\$0 per month	☐ 003-San Diego County	\$0 per month
☐ 004-San Bernardino County	\$0 per month	☐ 004-San Bernardino County	\$0 per month
☐ 005-Riverside County	\$0 per month	☐ 005-Riverside County	\$0 per month

Clever Care Total+ (HMO C-SNP) H7607-011	
☐ 001-Los Angeles County	\$18.40 per month
☐ 002-Orange County	\$18.40 per month
☐ 003-San Diego County	\$18.40 per month
☐ 004-San Bernardino County	\$18.40 per month
☐ 005-Riverside County	\$18.40 per month

LAST name:

FIRST name: M.I. (optional):

Birth date: / Sex: ☐ Male ☐ Female

Phone Number: () -

5 단계:

4 페이지에서 고객에게 이해 진술서(statement of understanding)를 읽어 준 다음 작은 확인란을 클릭하십시오. 이것은 수혜자의 전자 서명을 나타냅니다.

Section 1 All fields on this page are required (unless marked optional) *continued*

IMPORTANT: Read and check the box 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 by checking this box ☒ **Required - Signature**, I am certifying that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
 - this person is authorized under State law to complete this enrollment, and
 - documentation of this authority is available upon request by Medicare.

Today's date: 10/24/2024 / /

6 단계:

6 페이지 하단에 가입자와의 관계(Relationship to enrollee), NPN, 효력 발생일(Effective Date), 접수일(Received Date), 신청서가 전화로 작성된 경우(if the application was completed over the phone) 등을 기입하십시오. 그런 다음 브로커는 서명(Sign)  버튼을 클릭하여 신청서에 서명합니다.

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?: ☐ Yes ☒ 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 (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

6 of 7

7 단계:

모든 절차가 완료되면 페이지 상단의 마침(Finish) 버튼을 클릭하십시오. 그러면 신청서가 Clever Care 로 전자적으로 전송됩니다. 그 후 브로커의 이메일 받은 편지함에 확인 이메일과 신청서 사본이 전송될 것입니다.

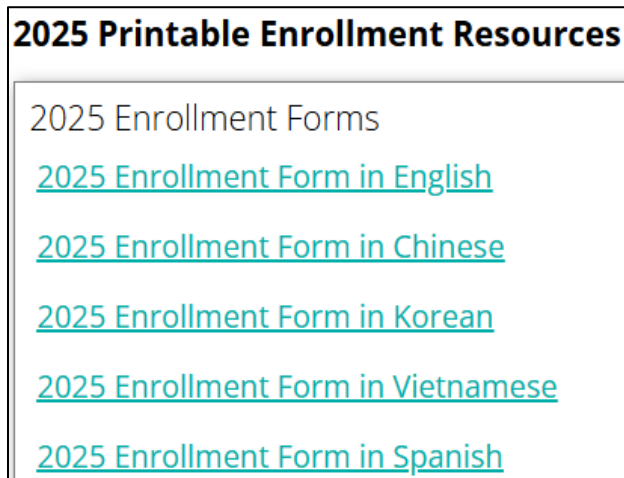
FINISH	FINISH LATER	OTHER ACTIONS ▾
---------------	---------------------	------------------------

Clever Care 웹사이트 - 다운로드 가능한 종이 양식

플랜 가입 신청서를 제출하는 또 다른 방법은 종이 양식을 다운로드하여 작성한 후 수혜자가 서명하고 Clever Care Health Plan 에 팩스 또는 암호화된 이메일을 보내는 것입니다.

1 단계:

Clever Care 웹사이트 <https://ko.clevercarehealthplan.com/brokers/enrollment-forms/>로 이동하여 페이지 하단으로 스크롤하여 "인쇄 가능한 리소스(Printable Resources)"를 클릭한 후 필요한 언어로 된 2025 가입 양식 링크를 클릭하십시오.



2 단계:

페이지 상단에서 다운로드(download) 버튼  또는 인쇄(print) 버튼  을 클릭하여 수혜자가 양식을 인쇄하여 작성할 수 있도록 하십시오.



3 단계:

4 페이지의 섹션 1 에 신청서에 서명하고 날짜를 기입하십시오.

Section 1	
All fields on this page are required (unless marked optional) <i>continued</i>	
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:

4 단계:

종이 신청서를 작성하고 귀하와 수혜자가 모두 서명하면 다음 방법으로 신청서를 제출할 수 있습니다.

1. 선호하는 방법: 신청서를 (657) 276-4757 로 팩스 전송
2. 선택 방법: 암호화된 이메일을 다음 주소로 전송 enrollment@ccmapd.com