

## Escribir correctamente: presentación de la solicitud

### Clever Enroll - Online Enrollment Portal

- ✓ Enrollment Application

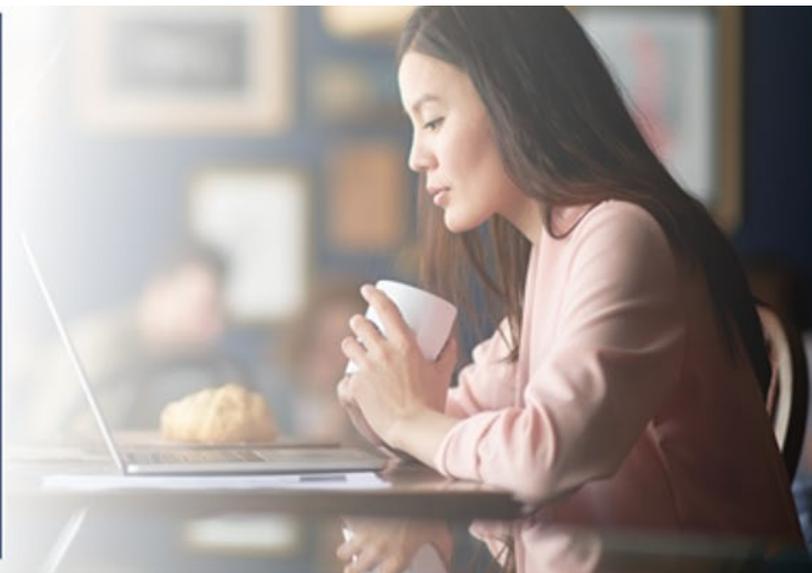
### Clever Care Website

Assessable Electronic In Language DocuSign

- ✓ Online Enrollment Powerforms

Downloadable Paper forms

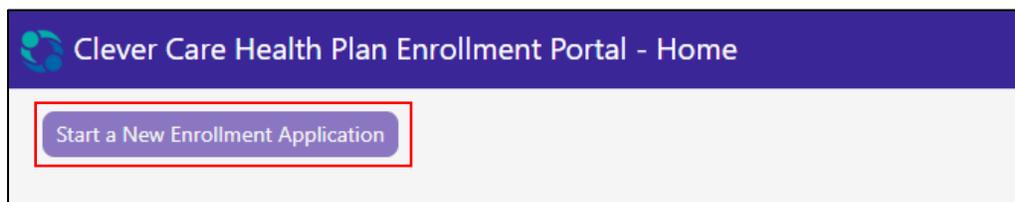
- ✓ Paper Enrollment forms



## Clever Enroll: inscripción en línea

Clever Enroll es el portal de inscripción en línea de Clever Care. En el mismo portal, puede enviar un documento electrónico de Alcance de la cita (Scope of Appointment, SOA), una Solicitud del plan y una Evaluación de riesgos para la salud (Health Risk Assessment, HRA).

**Inicio del proceso de inscripción.** Haga clic en el botón “Iniciar una nueva solicitud de inscripción” (Start a New Enrollment Application).



## Paso 1: Alcance de la cita de ventas

1. Elija el "Año del plan" (Plan Year). Complete la información de contacto con el "Nombre del beneficiario" (Beneficiary Name) y la "Residencia principal" (Primary Residence).

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

Ted Smith

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

(562) 555-2525 Cell

Street Address \* Address 2

1234 Main Street

Zip Code \* City \* State \*

90068 Los Angeles California

2. Lea la sección "Confirmación del Alcance de la cita de ventas" (Scope of Sales Appointment Confirmation). Haga clic en la casilla correspondiente al plan sobre el que hablará con el beneficiario. La casilla HMO es para los planes Longevity y Value. La casilla C-SNP es para nuestro plan Total+. Los planes aparecerán en función de esta casilla de verificación y del código postal. Cualquier pregunta con un asterisco rojo \* es un campo obligatorio.
3. Escriba el nombre completo del beneficiario (Beneficiary or Authorized Representative Signature) y elija la fecha en que se firmó el documento de Alcance de la cita (Signature Date). Elija "Sí" (Yes) si el beneficiario tiene un poder notarial o un representante autorizado, o "No" si no lo tiene. Si la respuesta es sí, complete el nombre del representante, su dirección, su número de teléfono y su relación con el beneficiario.

## 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. Responda la primera pregunta requerida. Si el SOA se firmó 2 días antes de la reunión, elija "N/C" (N/A). Si el SOA se firmó el día de la reunión por no tener una cita previa, elija "Sin cita previa" (Walk-In). (Los Centros de Servicios de Medicare y Medicaid [Centers for Medicare & Medicaid Services, CMS] requieren que el SOA se firme 48 horas antes de la inscripción).
5. Se agregaron dos preguntas nuevas al SOA.
  - a. "¿Cómo se registró el Alcance de la cita de ventas?" (How was the Scope of Sales Appointment captured?)
    - "De forma electrónica" (Electronic), "Por escrito" (Paper) o "Por teléfono" (Telephone).
  - b. "¿En qué fecha se registró el Alcance de la cita de ventas?" (Date the Scope of Sales Appointment was captured?)
    - Elija la fecha en que se firmó el SOA.
6. Complete el resto del SOA ingresando el "Método inicial de contacto" (Initial Method of Contact), los planes analizados (Plan[s] the Agent Represented During this Meeting) y la "Firma" (Signature) y "Fecha de firma" (Agent Signature Date) del agente.



- Haga clic en el botón “Seleccionar este plan” (Select This Plan) para elegir el plan. Una casilla morada rodeará la selección del plan.
- Desplácese hasta la parte superior de la pantalla y haga clic en el botón morado “Iniciar solicitud de inscripción” (Start Enrollment Application).

**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          |            | Benefits Include   |  |
|------------------|------------|--|--|
|                  | In Network | <ul style="list-style-type: none"> <li>Routine Physical</li> <li>Routine Vision and Eyewear Coverage</li> <li>Prescription Drugs</li> <li>Transportation (Non-Emergency)</li> <li>Dental</li> <li>Flexible Health and Wellness Allowance</li> <li>TeleHealth Visits</li> <li>Hearing</li> <li>Acupuncture</li> <li>Eastern Wellness Therapies</li> </ul> |  |
| PCP Copay        | \$0.00     |  |  |
| Specialist Copay | \$0.00     |  |  |
| Deductible       | \$0.00     |  |  |
| OOP Max          | \$1,700.00 |  |  |

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

\*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.

### Paso 3: Acuerdo

- En la página de “Revisión” (Review), revise cada sección para garantizar que los datos sean correctos.
- Lea la sección “Acuerdo” (Agreement) al beneficiario. Marque la casilla para registrar su firma digital. Ingrese el nombre completo del beneficiario (Member’s or Authorized Representative’s Signature) y el nombre completo del agente (Signature of Licensed Medicare Agent).
- Elija el “Origen de la solicitud” (Source of Application), ya sea “Por teléfono” (Telephonic) o “Por portal de inscripción” (Enrollment Portal).
- Ingrese el nombre de la persona que ayudó al beneficiario a completar la solicitud (Individual’s Signature).
- Ingrese la relación con el beneficiario (Relationship to Enrollee).
- Si es un corredor de seguros, también ingrese el número de productor nacional (National Producer Number).

7. Haga clic en el botón verde “Inscribirse ahora” (  ) para enviar la inscripción.

**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 | Relationship to enrollee: * | National Producer Number(Agents/Brokers only): * |
| Joey Chadwick          | Broker                      | 12345678   |



#### Paso 4: Número de confirmación

1. Lea la declaración final y proporcione al beneficiario el código de confirmación (Confirmation Code).
  - a. Puede utilizar los botones de la parte superior derecha “Imprimir” (Print), “Iniciar una HRA” (Start an HRA) o “Página de inicio” (Home).
  - b. Esta es la **ÚNICA** pantalla en la que puede imprimir la solicitud. Haga clic en el botón “Imprimir” (Print) y elija la opción de guardarla como PDF en su computadora.

## 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**

# Sitio web de Clever Care: PowerForms de DocuSign

Otra forma de enviar una solicitud del plan es a través del proceso de DocuSign. El proceso de DocuSign requiere una firma electrónica. Para firmar la solicitud, el cliente debe marcar la casilla después de haber leído la declaración de comprensión para proporcionar su firma electrónica.

**NOTA:** No imprima el formulario de DocuSign ni envíe la solicitud por fax o correo a Clever Care. Una vez que haya completado el DocuSign y haga clic en el botón “Finalizar” (Finish), se enviará automáticamente a Clever Care de forma electrónica.

## Paso 1:

Visite el sitio web de Clever Care en <https://es.clevercarehealthplan.com/brokers/enrollment-forms/>. Desplácese hacia abajo hasta “PowerForms de Clever Care” (Clever Care Power Forms) y **haga clic** en el enlace del formulario de inscripción en el idioma necesario.



## Paso 2:

Complete el nombre (Your Name) y la dirección de correo electrónico (Your Email) del agente.

**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: \*

**Paso 3:**

En la esquina superior derecha de la pantalla, haga clic en el botón amarillo "Continuar" (Continue) para comenzar a completar la solicitud.



Powered by DocuSign

**Paso 4:**

Elija un plan del condado en el que reside el cliente y complete todos los campos obligatorios en rojo.

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:

| Clever Care <b>Longevity</b> (HMO) H7607-002 |                           | Clever Care <b>Value</b> (HMO) H7607-008 |                       |                           |               |
|--|---------------------------|--|-----------------------|---------------------------|---------------|
| <input type="radio"/>                        | 001-Los Angeles County    | \$0 per month                            | <input type="radio"/> | 001-Los Angeles County    | \$0 per month |
| <input type="radio"/>                        | 002-Orange County         | \$0 per month                            | <input type="radio"/> | 002-Orange County         | \$0 per month |
| <input type="radio"/>                        | 003-San Diego County      | \$0 per month                            | <input type="radio"/> | 003-San Diego County      | \$0 per month |
| <input type="radio"/>                        | 004-San Bernardino County | \$0 per month                            | <input type="radio"/> | 004-San Bernardino County | \$0 per month |
| <input type="radio"/>                        | 005-Riverside County      | \$0 per month                            | <input type="radio"/> | 005-Riverside County      | \$0 per month |

| Clever Care <b>Total+</b> (HMO C-SNP) H7607-011 |                           |                   |
|---|---------------------------|-------------------|
| <input type="radio"/>                           | 001-Los Angeles County    | \$18.40 per month |
| <input type="radio"/>                           | 002-Orange County         | \$18.40 per month |
| <input type="radio"/>                           | 003-San Diego County      | \$18.40 per month |
| <input type="radio"/>                           | 004-San Bernardino County | \$18.40 per month |
| <input type="radio"/>                           | 005-Riverside County      | \$18.40 per month |

LAST name:   
 FIRST name:  M.I. (optional):   
 Birth date:  /      Sex:  Male  Female  
 Phone Number: (  -  -  )

**Paso 5:**

En la página 4, pida al cliente que lea la declaración de comprensión y que luego haga clic en la pequeña casilla de verificación. Esto representa la firma electrónica del beneficiario.

**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** (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:
  - 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 D / Y Y Y Y

**Paso 6:**

En la parte inferior de la página 6, complete los campos "Relación con el inscrito" (Relationship to Enrollee), "Número de productor nacional" (National Producer Number), "Fecha de entrada en vigencia" (Effective Date of Coverage) y "Fecha de recepción" (Date Application Was Received), e indique si la solicitud se completó por teléfono (Telephonic Application?). Luego, el corredor de seguros firmará la solicitud haciendo clic en el botón "Firmar" (Sign)  .

| 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:<br>Joey Chadwick  | Relationship to enrollee:<br>Broker   |
| Signature:<br>   | National Producer Number (Agents/Brokers only):<br>12345678                               |
| FMO (if applicable)<br>Ipro   | Telephonic Application?:<br><input type="radio"/> Yes <input checked="" type="radio"/> No |
| Effective date of coverage:<br>01/01/2025   | Date application was received:<br>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.

**Paso 7:**

Una vez que todo esté completo, haga clic en el botón "Finalizar" (Finish) en la parte superior de la página. De esta forma, enviará electrónicamente la solicitud a Clever Care. Luego, el corredor de seguros recibirá una confirmación por correo electrónico y una copia de la solicitud en su bandeja de entrada de correo electrónico.

|               |                     |                        |
|---------------|---------------------|------------------------|
| <b>FINISH</b> | <b>FINISH LATER</b> | <b>OTHER ACTIONS</b> ▾ |
|---------------|---------------------|------------------------|

# Sitio web de Clever Care: formularios para descargar e imprimir

Otra forma de enviar una solicitud del plan es descargar un formulario para imprimir, completarlo, pedirle al beneficiario lo firme y enviar un fax o un correo electrónico cifrado a Clever Care Health Plan.

**Paso 1:**

Visite el sitio web de Clever Care en <https://es.clevercarehealthplan.com/brokers/enrollment-forms/> y desplácese hacia abajo hasta la parte inferior de la página que dice **“Recursos para imprimir”** (Printable Resources) y haga clic en el enlace del formulario de inscripción de 2025 en el idioma necesario.



**Paso 2:**

En la parte superior de la página, haga clic en el botón “Descargar” (Download)  o en el botón “Imprimir” (Print)  para imprimir el formulario y que el beneficiario pueda completarlo.



### Paso 3:

Corrobore que la solicitud esté firmada y fechada en la Sección 1 de la página 4.

| Section 1  |                                      |
|--|--------------------------------------|
| All fields on this page are required (unless marked optional) <i>continued</i>   |                                      |
| <b>IMPORTANT: Read and sign 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 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:<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> |                                      |
| Signature:   | Today's date:<br>M M / D D / Y Y Y Y |
| <b>If you're the authorized representative, sign above and fill out these fields:</b>  |                                      |
| Name:  | Address:                             |
| Phone number:  | Relationship to enrollee:            |

### Paso 4:

Una vez que usted y el beneficiario hayan completado y firmado la solicitud impresa, puede enviarla de las siguientes maneras.

1. **Método de preferencia:** envíe la solicitud por fax al (657) 276-4757
2. Método alternativo: envíe un correo electrónico cifrado a [enrollment@ccmapd.com](mailto:enrollment@ccmapd.com)