

正確填寫 — 申請提交指南

Clever Enroll - Online Enrollment Portal

- ✓ Enrollment Application

Clever Care Website

Assessable Electronic [In Language DocuSign](#)

- ✓ Online Enrollment Powerforms

Downloadable Paper forms

- ✓ Paper Enrollment forms

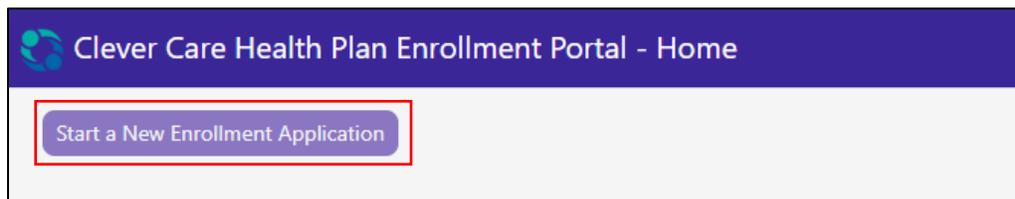


聯邦免責聲明： Clever Care Health Plan, Inc. 是一項與 Medicare 簽有合約的 HMO 和 HMO C-SNP 計劃。投保需視合約續約情況而定。

Clever Enroll - 線上註冊

Clever Enroll 是福全健保 (Clever Care) 的線上投保平台。您可以在同一個平台提交電子版銷售預約範圍確認書 (SOA)、計劃申請表和健康風險評估 (HRA)。

開始投保流程。 點擊開始新的投保申請按鈕。



第 1 步- 銷售預約範圍確認書

1. 選擇計劃年度。填寫受益人姓名和主要住所聯絡資訊。

Clever Care Health Plan Enrollment Portal - SOA Joey Chadwick ▾

Scope of Sales Appointment Submit SOA

Plan Year * 2026 ▾

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。點擊方塊，選擇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。慢性病特殊需求 (C-SNP) 計劃方塊適用於我們的全加計劃和舒息計劃。根據此核取方塊與郵遞區號，系統會顯示可用的計劃。任何帶有紅色星號 (*) 的問題都是必填欄位。
3. 輸入受益人的全名，並選擇銷售預約範圍確認書的簽署日期。如果是授權書或授權代表，請選擇是或否。如果「是」，請填寫他們的姓名、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.

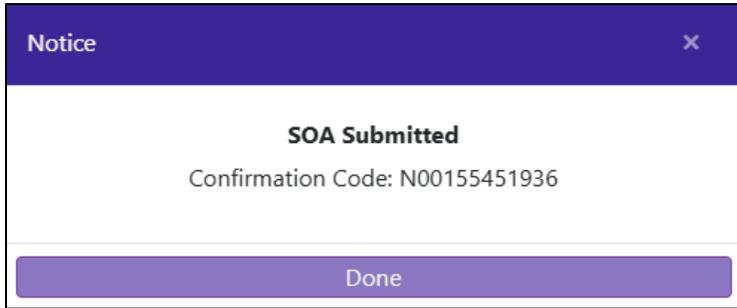
Acknowledgement and Signature

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

7. 銷售預約範圍確認書完成後，點擊 **Submit SOA** 按鈕。會出現訊息，點擊「完成」。



第 2 步 - 計劃選擇

1. 此頁面將顯示您所選年度的所有福全健保 (Clever Care) 計劃。向下捲動到受益人要投保的計劃。
2. 每個計劃的複選框都會顯示每月保費和「查看詳細資料」鏈接。該鏈接將在我們的福全健保網站上開啟一個新的網頁選項卡，其中包含計劃概述詳細資訊和可下載的文件。
3. 您還將看到醫療、藥房和福利類型的詳細資訊和共付費用。
4. 點擊「選擇此計劃」按鈕來選擇計劃。紫色方框將圍繞選擇的計劃。
5. 捲動到螢幕頂部，然後點擊紫色的「開始註冊申請」按鈕。

The screenshot shows the 'Clever Care Health Plan Enrollment Portal - New Enrollment: 2026' interface. The user is logged in as 'Joey Chadwick'. The 'Plan Selection' step is active, showing a list of plans. The 'Clever Care Longevity (HMO) Plan' is selected, highlighted with a purple border. The monthly premium is \$0.00. The plan details include medical and pharmacy cost-sharing information and a list of benefits included.

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 \$5,030.00	Tier 2 Copay \$0 Copay
True OOP Threshold Amt \$8,000.00	Tier 3 Copay \$35 Copay
	Tier 4 Copay \$99 Copay
	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.

第 3 步 - 協議

1. 在「審閱」頁面，審閱每個部分以確保準確性。
2. 向受益人宣讀協議部分。勾選方塊以記錄他們的數位簽名。輸入受益人的全名和代理人的全名。
3. 選擇「申請來源」，可選擇「電話申請」(Telephonic) 或「註冊門戶網站」(Enrollment portal)。
4. 請輸入協助受益人填寫申請表的協助者姓名。
5. 輸入與受益人的關係。
6. 如果是經紀人，請輸入全國經紀人編號。
7. 點擊綠色 **Enroll Now** 按鈕提交註冊。

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

Enroll Now

第 4 步 - 確認號碼

1. 閱讀最終聲明並向受益人提供確認碼。
 - a. 在右上方，您可以列印申請表、開始 健康風險評估 (HRA) 或前往主畫面。
 - b. 這是 **唯一** 可以列印申請表的畫面。點擊列印按鈕，選擇以 PDF 格式保存到您的電腦。

Clever Care Health Plan Enrollment Portal - New Enrollment: 2026 Joey Chadwick

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

福全健保網站 - DocuSign PowerForms

提交計劃申請表的另一種方式是通過 DocuSign 流程。 DocuSign 流程需要電子簽名。要簽署申請表，客戶需要在閱讀理解聲明後勾選提供電子簽名的方塊。

注意：請 勿 列印 DocuSign 表格並傳真或郵寄申請表給福全健保。 DocuSign 完成後，點擊「完成」按鈕，它會自動以電子方式發送給福全健保。

第 1 步：

進入福全健保的網站 <https://zh.clevercarehealthplan.com/brokers/enrollment-forms/>。向下滾動到 "Clever Care Power Forms"，**點擊** 所需語言的申請表格鏈接。

2025 Power Forms	2026 Power Forms
2025 Broker Enrollment Form in English	2026 Broker Enrollment Form in English
2025 Broker Enrollment Form in Chinese	2026 Broker Enrollment Form in Chinese
2025 Broker Enrollment Form in Korean	2026 Broker Enrollment Form in Korean
2025 Broker Enrollment Form in Vietnamese	2026 Broker Enrollment Form in Vietnamese
2025 Broker Enrollment Form in Spanish	2026 Broker Enrollment Form in Spanish

第 2 步：

填寫代理人的姓名和電子郵件地址。

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: *

第 3 步：

在螢幕右上角點擊黃色的繼續按鈕，開始填寫申請表。



第 4 步：

繼續選擇一個計劃，並填寫紫色的所有必填欄位。

A screenshot of the DocuSign form. At the top, it says 'DocuSign Envelope ID: 66402198-5795-46D2-82C0-CD36C31F31A4'. Below this is a section header 'Section 1' with the text 'All fields on this page are required (unless marked optional)'. The main heading is 'Select the plan you want to join:'. There are four radio button options: 'Clever Care Longevity (HMO)', 'Clever Care Value (HMO)', 'Clever Care Total+ (HMO C-SNP)', and 'Clever Care Breathe+ (HMO C-SNP)'. Each option has a plan ID and a '\$0 per month' cost. Below the options are three text input fields: 'LAST name:', 'FIRST name:', and 'M.I. (optional):'. A 'Next' button is visible on the left side.

第 5 步：

在第 4 頁，請客戶閱讀理解聲明，然後點選小複選框。這代表受益人的電子簽名。

A screenshot of the DocuSign form. At the top, it says 'Section 1' with the text 'All fields on this page are required (unless marked optional) continued'. Below this is a section header 'IMPORTANT: Read and check the box below:'. There are several bullet points of text. The last bullet point has a red box around a checkbox and the text 'Required - Signature'. Below the text is a date field 'Today's date: 10/24/2024'.

第 6 步：

在第 6 頁底部，填寫與投保人的關係、NPN、生效日期、收到日期，以及是否透過電話完成申請。然後，經紀人點擊簽名方框，在申請表上簽名。

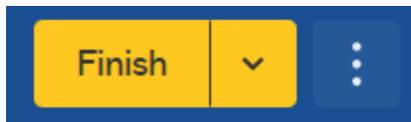
For individuals helping enrollee with completing this form only	
Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.	
Name: Joseph chadwick	Relationship to enrollee: Broker
I understand that by checking this box <input checked="" type="checkbox"/> this represents my signature.	National Producer Number (Agents/Brokers only): 12345678
FMO (if applicable): <input type="text"/>	Telephonic Application?: <input type="radio"/> Yes <input checked="" type="radio"/> No
Effective date of coverage: 01/01/2026	Date application was received: 11/01/2025

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.

第 7 步：

完成所有步驟後，點擊頁面右上方的「完成」按鈕。這將以電子方式將申請表發送到福全健保。然後，經紀人會在您的電子郵箱中收到一封確認電子郵件和一份申請表的副本。



福全健保網站 - 可下載的紙質表格

另一種提交計劃申請表的方法是下載一份紙質表格，填好後讓受益人簽名，然後用傳真或加密電子郵件發給 福全健保。

第 1 步：

請至福全健保網站 <https://zh.clevercarehealthplan.com/brokers/enrollment-forms/>，向下捲動至「可列印資源」(Printable Resources) 頁面底部，點選所需語言的 2025/2026 年投保表連結。

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](#)

2026 Printable Enrollment Resources

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[2026 Enrollment Form in Korean](#)
[2026 Enrollment Form in Vietnamese](#)
[2026 Enrollment Form in Spanish](#)

第 2 步：

在頁面頂部，點擊下載按鈕  或列印按鈕  列印表格，以便受益人填寫。



第 3 步：

確保已在第 4 頁的第 1 部分簽署申請表，並註明日期。

Section 1All 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：

紙質申請表填寫完成並經您和受益人簽名後，您可以透過以下方式提交申請表。

1. **首選方式：** 傳真申請表至 (657) 276-4757
2. **可選方式：** 加密電子郵件至 enrollment@ccmapd.com