

# Humana Medicare MarketPOINT Paperless Application

10

October 2012



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# Introduction to MAPA

This module will introduce you to the **Medicare Advantage Paperless Application (MAPA)**. It will be your guide for downloading information, completing applications, and uploading information to the server.

MAPA is installed on your laptop. It can be used throughout the day as you work with your customers **without** being connected to the internet. The only times when you will need an **internet connection** are:

- At the beginning of your day when you download the updated plan data, current day appointments, contacts and contact sets from the server to the laptop.
- At the end of your day when you upload completed applications, disposition and update contact information from the laptop to the server.

**Note:** If you have any difficulty with the MAPA program during a sale, complete a paper application at that time and contact CSS **after** your sales call. Do not contact CSS during your sales call.

**CSS –**  
**888-224-2700 Louisville**  
**800-435-7661 Green Bay**

**Enrollment Department –**  
**800-992-2551**

**Agent Support**  
**866-921-6245**

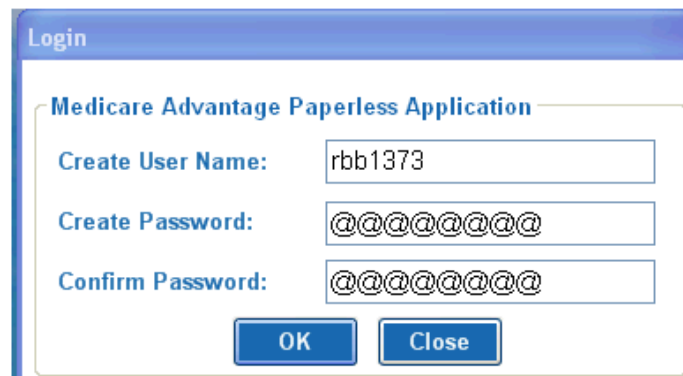
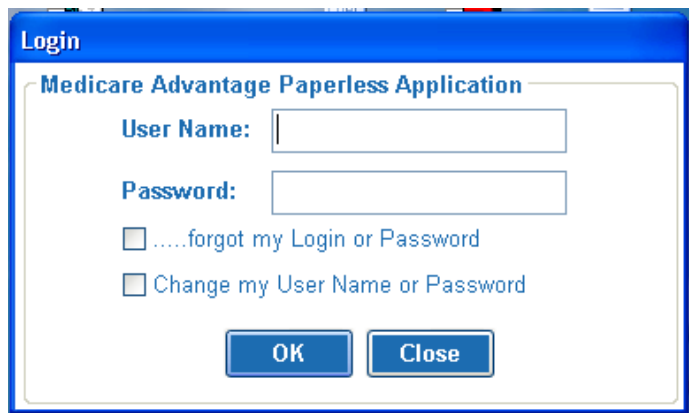
# Log in

First time users will be instructed to create a MAPA user ID and password.



Create a user id and password that will be easy to remember.

Each time a new version of MAPA is installed you will need to change the password.

A Windows-style dialog box titled "Login" for the "Medicare Advantage Paperless Application". It has three input fields: "Create User Name:" with the text "rbb1373", "Create Password:" with "aaaaaaaaaa", and "Confirm Password:" with "aaaaaaaaaa". There are "OK" and "Close" buttons at the bottom.A Windows-style dialog box titled "Login" for the "Medicare Advantage Paperless Application". It has two input fields: "User Name:" and "Password:". Below the fields are two checkboxes: ".....forgot my Login or Password" and "Change my User Name or Password". There are "OK" and "Close" buttons at the bottom.

## Everyday login:

Enter the **User ID** and the **Password** that you created and click **OK**.

## NOTE: To change your password:

Put a check mark in the **Change my.. Password** box.

Click **OK**

Enter your new password and then confirm the new password.

# MAPA Workbench

When you enter the MAPA program, the **Medicare Advantage Paperless Application** main screen is displayed allowing you to:

- Connect to Humana to get behind the firewall so you can **synchronize, download, and upload.**
- Select the type of application
- Search for contacts that you have down loaded and applications
- Select the language for your application
- Delete an incomplete application
- Clone, or copy, an application
- Create an application for a contact by using enroll
- Create a blank application for a new contact
- Scroll over calendar date to see what appointments you have scheduled
- Close the program.

Once you download this calendar will show you any appointment you have on that day for the current month.

**MAPA Workbench** HUMANA  
Guidance when you need it most

**Connect To Humana**

**Exit MAPA**

**Upload** **Download**

**MAPA Home** **Synchronize**

☐ Disable State Selection

**Application Type**

**Language** ☒ English ☐ Spanish

**Plan Type** ☒ Humana ☐ CarePlus

☐ AEF ☐ Group ☐ Individual

☐ OSB ☐ Member Authorization

☐ SOA ☐ FSB ☐ REAL For Me

☐ Medicare Supplement

☐ Single ☐ Husband and Wife

**October, 2011**

Sun	Mon	Tue	Wed	Thu	Fri	Sat
25	26	27	28	29	30	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31	1	2	3	4	5

☐ Today: 10/18/2011

**Contact Search**

Search By: **All** First:  **Go** **Create Blank App**

Appt Time	Last Name	First Name	Address	City	State	Zip	Phone

**Application Search**

Search By: ☒ All ☐ Complete ☐ Incomplete **Clone App** **Upload App** **Delete App**

Type	Last Name	First Name	Address	City	State	Zip	Phone	Status
Authorization	diamop	Blew	1515 West lak...	louisville	KY	40299	(502) 666 6633	Complete
FSB	Whale	Blue	1515 Wet and ...	Louisville	KY	40299	(502) 666 5545	Complete

# Connect to Humana

You will want to start and end your workday by **Connecting to Humana** so you can:

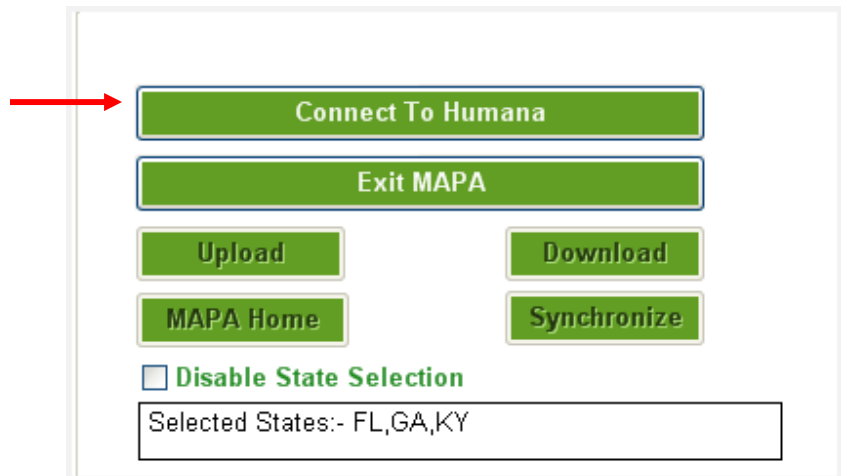
**Synchronize** - updates back end tables and plan data

**Download** - pulls in the and agent information.

**Upload** - takes completed applications and sends them to billing and enrollment,

**MAPA Home** – allows you to check the status of applications

The first step for synchronizing, downloading and uploading information is to click **Connect to Humana**

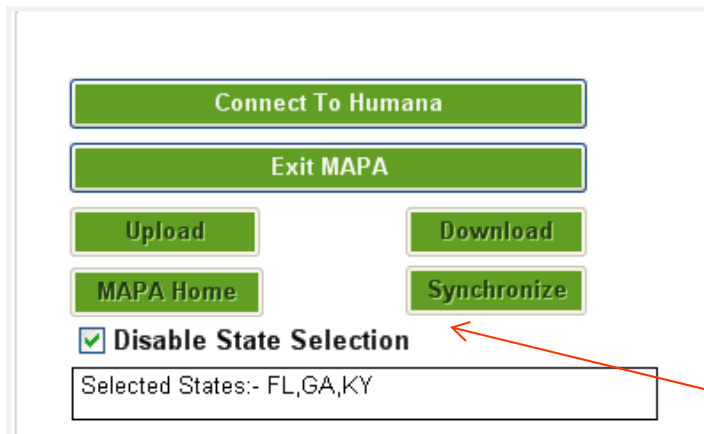


Click on the **Connect to Humana** button,  
Enter your **Agent Portal user ID**  
and password

A Windows-style dialog box titled 'Humana Login'. It contains the text 'Please enter your Secured Logons User ID and Password'. Below this, there is a 'Login' label. Two input fields are present: 'User Name' with the text 'rbb1373' and 'Password' with masked characters '@@@@@@'. At the bottom are 'Cancel' and 'Agent Login' buttons.

Meca agents  
will their agent  
portal user ID  
and Password

# Connect to Humana



## State Selection:

If an agent is licensed in 6 or more states they must select the states they need during downloading.

- Only 6 states can be downloaded at a time
- To save the state selections so they do not need to be selected at each download - check the **Disable State Selection** box
- State selection must be completed with every download if the state selection is not disabled or the agent is licensed in less than 6 states
- The state must be download to receive plan data

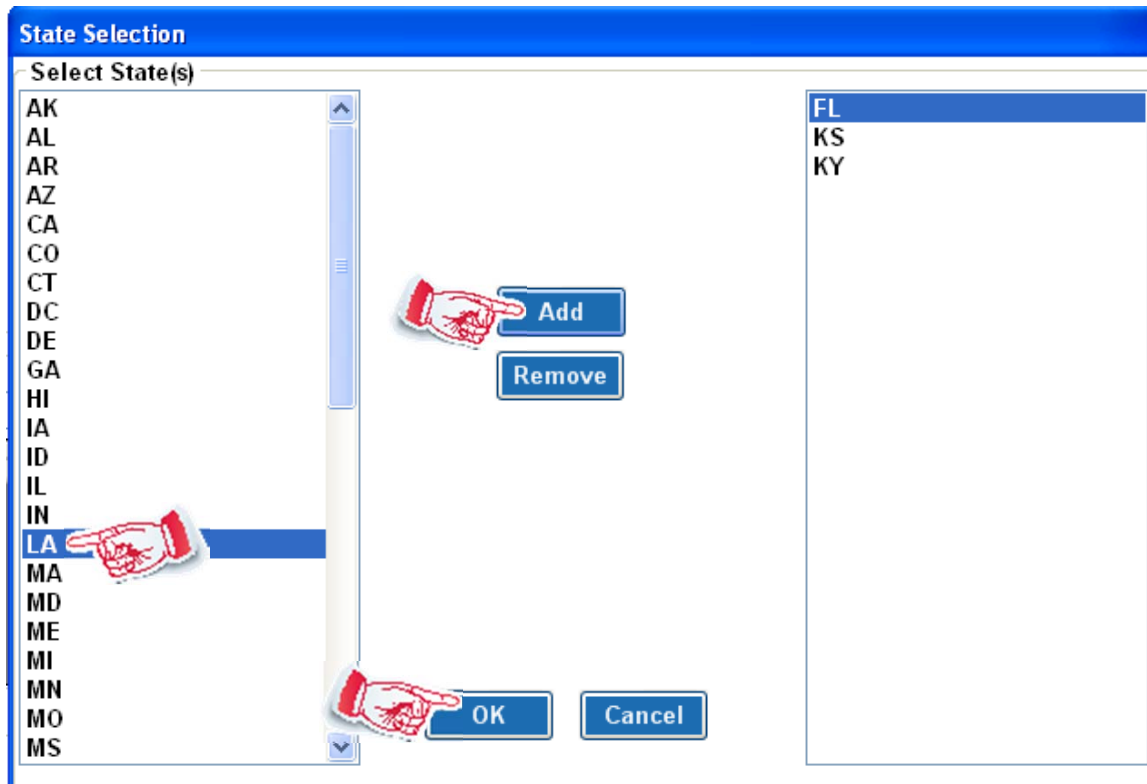
### Add selection:

Click on Connect to Humana

Click on state

Click Add

Once completed click OK

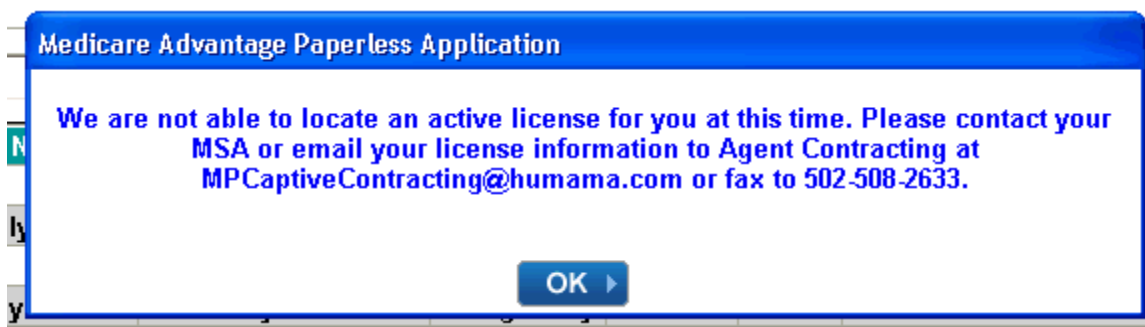


# Connect to Humana cont.

## Error Messages

In order to get plan data and the zip code tables you **MUST** have an active licenses listed in Solar. Without It you may get one of the error messages below

**License information missing in Solar:** you will receive the message below instructing you to call Agent contracting



**Licensed for more than one territory but User Access is not updated**





# Error messages continued

There may be times when you try to **connect to Humana** and receive an error message.

What do the error messages mean?

**If SOLAR is down or AXTA is down**

"Unable to Connect to Humana at this time, Please try again later."

**IF there is any timed out or SL is down**

"SL or Login does not respond, Please try again later"

**IF the password is incorrect**

"Incorrect Password"

**IF there is a license issue, but may be SOLAR is up and running**

License message - "you are not licensed, appointed, certified, please contact ASU, MSA, etc, etc."

# Error messages continued

To check system status when an error message is received  
Click on **Information** from the MAPA landing page

**Maintenance information will be listed**

**User information reviews which password should be used to connect to Humana**

# Synchronize

## When to Synchronize:

- First time users need to update plan data and zip code tables before creating their first application.
- Any time operations sends an email advising of plan changes.
- Every Monday morning.
- To activate synchronize you need to first **Connect to Humana**.

It is very important to Synchronize before Downloading

The screenshot shows the MAPA Workbench interface. At the top, there is a green header with the MAPA Workbench logo and the Humana logo. Below the header, a welcome message reads: "Welcome Rebecca Boston! Please remember to Synchronize and DOWNLOAD!". A yellow box with a red border contains the text: "The MAPA home Page will remind you to Synchronize". Below this, a panel contains several buttons: "Disconnect", "Exit MAPA", "Upload", "Download", "MAPA Home", and "Synchronize". A red arrow points to the "Synchronize" button with the text "Click on synchronize". To the right of the "Synchronize" button, a yellow box with a red border contains the text: "When this says disconnected you are read to synch". Below the button panel, there is a checkbox labeled "Disable State Selection" and a text box labeled "Selected States:-KY". At the bottom left, a status bar shows "Synchronizing Data. Please Wait..." with a progress indicator and "Downloading GetAllMarkets Data". At the bottom right, a small dialog box titled "MAPA" displays the message "Database Synchronized successfully" with an "OK" button.

***You need to Synchronize plan data once a week.***

# Synchronize

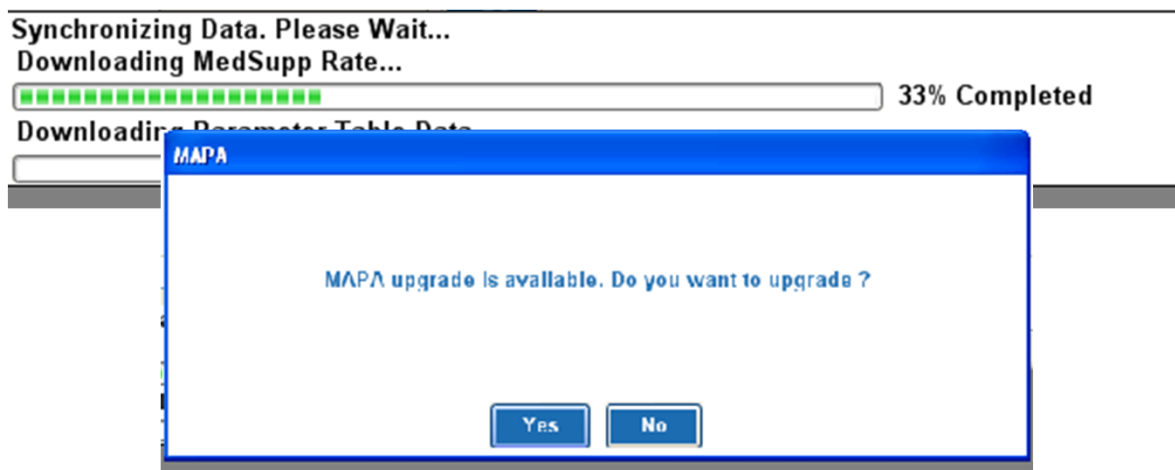
## SyncOnce : Automatic MAPA version update

New MAPA versions will be pushed during the Synchronization step

- Connect to Humana
- Click synchronize
- Click YES do you want to upgrade

Meca agents - Agent portal User Id and password

Delegated agents - Agent portal User Id and password



SyncOnce will allow deferment of the download 3 times

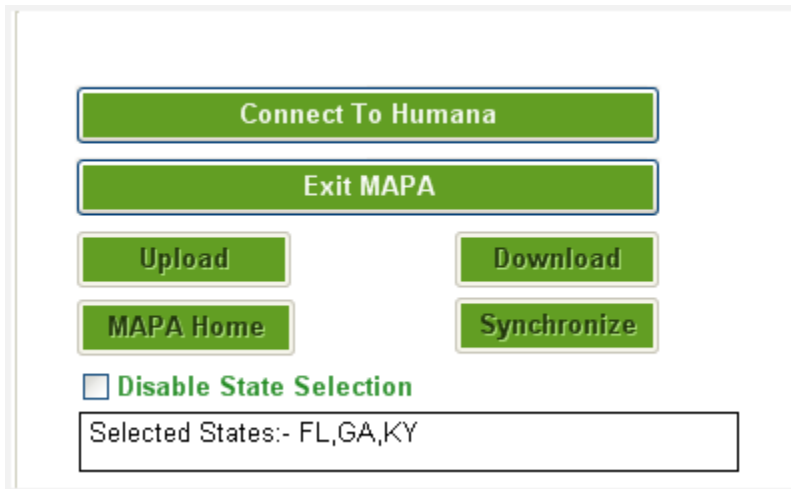
During the 4<sup>th</sup> synchronization the system will automatically  
Install the new version

# Download

To activate **Download** you need to first **Connect to Humana**

**Downloading will insure that all the plan data listed is correct.**

*You must download everyday*



Connect To Humana

Exit MAPA

Upload Download

MAPA Home Synchronize

☐ Disable State Selection

Selected States:- FL,GA,KY

Click on Connect to Humana



Humana Login

Please enter your Secured Logons User ID and Password

Login

User Name rbb1373

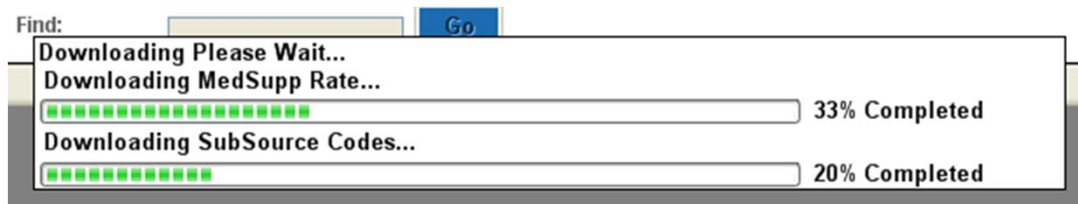
Password @@@@

Cancel Agent Login

Meca agents - Agent portal User ID and password

Delegated agents - Agent portal User ID and password

Once you enter your User ID and password and connect to Humana the download option will activate



Find: Go

Downloading Please Wait...

Downloading MedSupp Rate... 33% Completed

Downloading SubSource Codes... 20% Completed

# Creating an Application

To create an application:

Select – Language  
Plan Type  
Application Type

The screenshot shows a form titled 'Application Type' with two main sections: 'Language' and 'Plan Type'. The 'Language' section has two radio buttons: 'English' (selected) and 'Spanish'. The 'Plan Type' section has a list of options: 'Humana' (selected), 'CarePlus', 'AEF', 'OSB', 'SOA', 'Medicare Supplement', 'Group', 'Member Authorization', 'FSB', 'REAL For Me', 'Single', and 'Husband and Wife'. Red arrows point from the text 'To create an application:' to the 'Language' section, and from 'Select – Language' to the 'Plan Type' section.

<b>Application Type</b>		
<b>Language</b>		
<input checked="" type="radio"/> English	<input type="radio"/> Spanish	
<b>Plan Type</b>		
<input checked="" type="radio"/> Humana	<input type="radio"/> CarePlus	
<input type="radio"/> AEF	<input type="radio"/> Group	<input type="radio"/> Individual
<input type="radio"/> OSB	<input type="radio"/> Member Authorization	
<input type="radio"/> SOA	<input type="radio"/> FSB	<input type="radio"/> REAL For Me
<input type="radio"/> Medicare Supplement		
<input type="radio"/> Single	<input type="radio"/> Husband and Wife	

## Types of Applications:

**AEF – Abbreviated Enrollment Form** - use this application only when your member is making a plan to plan change (the contract numbers will be the same)

**OSB – Optional Supplemental Benefits** – use this application when you are enrolling a member in an OSB after you have uploaded the original application and before the 30 day window

**SOA – Scope of Appointment** – use application when you have an extra person at your appointment, your member wants a different presentation or you are creating a future appt.

**FSB – Free Standing Benefits** – use this application to enroll someone in the dental or vision plan that is not tied to the Medicare plans.

**Individual** - use this application for your basic MA enrollments

**Group** – use this application only for members that are associated with the groups you are eligible to write.

**Medicare Supplement** – use this app for all med supp products – not all states are allowed to submit electronically at this time

**Member Authorization** – this form is used to give Humana the permission to contact a Medicare member about other products

**Real for Me** – This application is used to request Real powered by Humana news and updates also to request a free copy of Retirement for Dummies and Well Being for Dummies

# Creating an Application

To create an application:

Select – Language  
Plan Type  
Application Type

then

The screenshot shows a form titled 'Application Type' with the following sections:

- Language:** Radio buttons for English (selected) and Spanish.
- Plan Type:** Radio buttons for Humana (selected) and CarePlus.
- Application Type:** Radio buttons for AEF, OSB, SOA, Medicare Supplement, Group, Member Authorization, FSB, and REAL For Me.
- Demographics:** Radio buttons for Single (selected) and Husband and Wife.

Click on **Create Blank Application**.

The screenshot shows the MAPA Workbench interface. The 'Create Blank App' button is circled in red. The interface includes a sidebar with buttons like Disconnect, Exit MAPA, Upload, Download, MAPA Home, and Synchronize. The main area displays the application selection form from the previous screenshot. A calendar for October 2012 is visible on the right, and a contact search bar is at the bottom.

# Scope of Appointment

In conducting marketing activities and MA or part D plan sponsor may not market any health care product during a marketing appointment beyond the

**Scope of Appointment** agreed upon by the beneficiary and documented by the plan, **prior to the appointment**. Distinct lines of plan business include Medigap, MA and PDP products.

If another type of Medicare product needs to be discussed at the request of the beneficiary, during your appointment a **second scope of appointment** form must be completed. At this time you can **use the SOA form located on the MAPA workbench page**.

## Remember:

- 1) A beneficiary can not agree to the scope over the phone (unless it is recorded) and then sign the form at the beginning of the sales appointment.
- 2) When using the paper scope of appointment form, it must be completed and returned prior to the appointment.

**EFFECTIVE IMMEDIATELY** - if an agent can not execute a SOA in advance of the appointment and must have the beneficiary sign the SOA at the start of the appointment, the agent must also note on the front of the SOA form the reason why. The note must be initialed and dated by the agent.

- 3) A beneficiary may sign a scope of appointment form at a marketing presentation for a follow up appointment. Use the SOA on the MAPA workbench

*The 48 hr rule will not apply at this time*

- 4) In the instance where a beneficiary visits a plan sponsor or agent office on his/her own accord the plan sponsor or agent should complete a scope of appointment form and secure the beneficiary's signature prior to discussing any plans. Use the SOA on the MAPA workbench.

*The 48 hr rule will not apply at this time.*

- 5) During an in home appointment a Scope of Appointment is needed for everyone interested in the plan.

If a paper scope of appointment is completed while in the field it must be returned to the market immediately so it can be scanned. SOAs are kept on file for 10 yrs



# Scope of Appointment

To create an SOA for a new beneficiary click the **Create Blank SOA**.

The screenshot shows the MAPA application form. On the left, there are buttons for 'Connect to Humana', 'Exit MAPA', 'Upload', 'Download', 'MAPA Home', and 'Synchronize'. Below these is a 'Disable State Selection' checkbox and a 'Selected States: -KY' dropdown. In the center, the 'Application Type' section has radio buttons for 'English' (selected), 'Spanish', 'Humana' (selected), 'CarePlus', 'AEF', 'Group', 'Individual', 'OSB', 'Member Authorization', 'FSB', 'REAL For Me', and 'Medicare Supplement'. A red arrow points to the 'SOA' radio button. On the right, there is a calendar for October 2012 with the 3rd highlighted. At the bottom right, the 'Create Blank SOA' button is circled in red. Below the form is a table header with columns: Appt Time, Last Name, First Name, Address, City, State, Zip, and Phone.

- The scope of appointment can not be fully completed until the appointment is completed.
- The scope of appointment will remain on the MAPA Main page until the agent logs back in and updates the form with the status of the appointment. If the application is completed from the SOA, the information will update automatically
- Once the information is added the application will send with the next upload

Application Search

Search By: ☒ All ☐ Complete ☐ Incomplete

Copy App Clone App

Type	Last Name	First Name	Address	City	State	Zip	Phone	Status
CarePlus Individual	stanley	bat	1515 naper lane	nashville	FL	33497	(555) 222-2333	Incomplete
SOA	wonka	willie	1515 chocolate road	louisville	KY	40299	(502) 111-1111	Pending Application
SOA	craker	cheese	1515 willow rd	louisville	KY	40299	(502) 266-6666	Pending Application
FSB	fields	william	1514 warlock street	louisville	KY	40299	(502) 225-3321	Complete
FSB	salzman	dennis	1515 don lane	louisville	KY	40299	(502) 555-5555	Complete

# Scope of Appointment

The SOA is in “*pending application*” status and does not upload until the following is true

If the application **is not completed** from the Scope of Appointment:

The agent will log back into the system and add:

- Application ID
- Date Appointment completed
- Plans agent represented

If the application **is created** from the Scope of Appointment the appointment information will pre fill into the completed scope

- Application ID
- Date Appointment completed
- Plans agent represented
- Date of Birth
- Medicare ID number

When these fields are completed the Medicare ID and Date of Birth become required

To be Completed by the agent after the scheduled appointment

Application ID Number:

☐ Did not enroll  
☐ Appointment not completed

Date Appointment Completed:

Plan(s) the Agent Represented:

Medicare Claim Number

Re-Enter Medicare Number

Date Of Birth (MM/DD/YYYY)

# Scope of Appointment

Initial Method of Contact:

Unexpected additional attendee

Medicare Claim Number: 123456789a

Re-Enter Medicare Number: 123456789a

Use drop down to select initial Method of contact.

In MAPA you have the **OTHER** option for why an SOA was not completed **prior** to the appointment. Please use this option and enter the reason in the text field provided for why you could not execute the SOA in advance of the appointment. Your signature on the review and sign page will be sufficient for meeting the initial and date requirement stated above.

Office Use Only

Plan Representative: Boston, Rebecca

Agent #: 1407608

Representative Phone: (502) 580-8579 (###) ###-####

Source: Referral - General

Sub Source: Client Referral

House Member: Head

Type: Prospect

Sub Type:

☐ Current Date/Time

Appointment Date: 09/17/2009

Time of Appointment: 03:45 PM

Add your phone number – cell or office is OK to use

Check **Current Date /Time** if you are creating an SOA at the same time you are going to present.

When creating a SOA for **future appointment** enter the date and time of the appointment.

**If Scope is for follow-up appointment, MAPA will not allow user to schedule prior to 48hrs out from current date/time.**

Click **Save** when all the information is completed – then **Review and Sign**

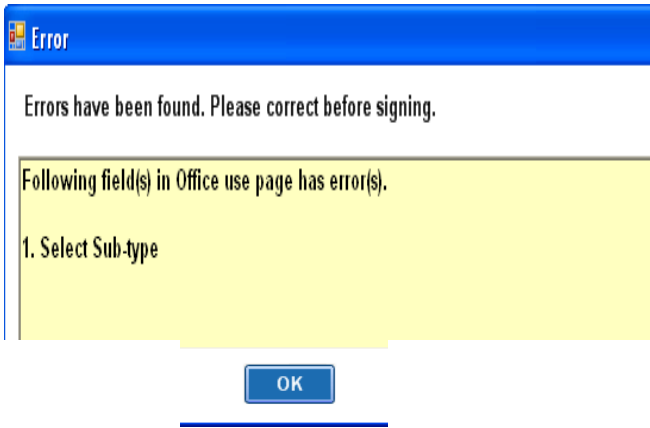
Application Saved

Application S6MTRL85G5QH33VY Successfully Saved!

OK

# Scope of Appointment

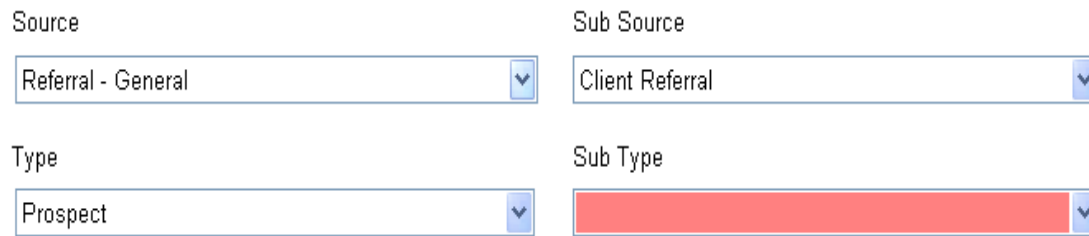
## Review and Sign



An error dialog box with a blue header bar containing an icon and the word "Error". The main text reads: "Errors have been found. Please correct before signing." Below this is a yellow box containing the text: "Following field(s) in Office use page has error(s)." and "1. Select Sub-type". At the bottom is a blue button labeled "OK".

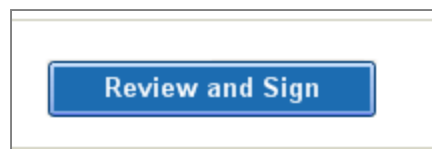
Error page will appear if any required fields have been left blank – click OK

The fields that need to be corrected will show up in Red – correct it and save again



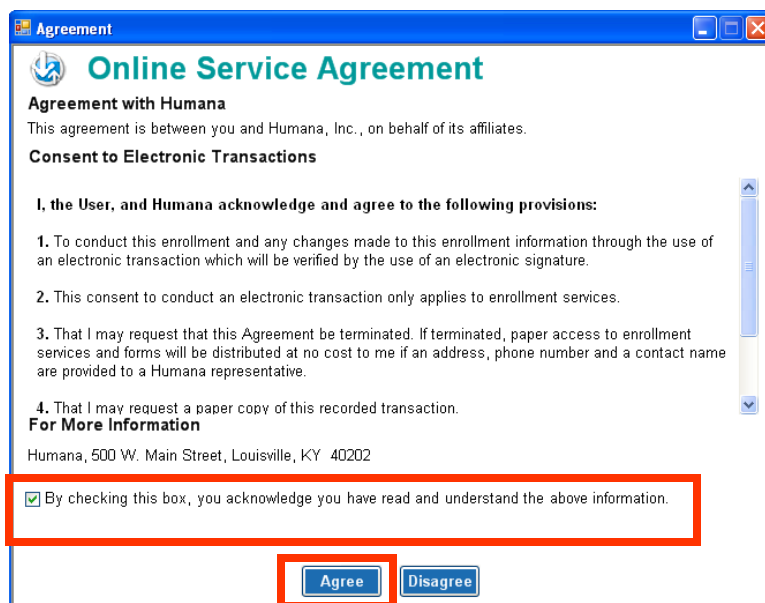
A form with four dropdown menus. The first two are labeled "Source" and "Sub Source". The last two are labeled "Type" and "Sub Type". The "Sub Type" dropdown menu is highlighted in red.

Source	Sub Source	Type	Sub Type
Referral - General	Client Referral	Prospect	



A blue button labeled "Review and Sign" inside a white box with a thin black border.

Once errors are corrected click Review and Sign




A window titled "Agreement" with a blue header bar. The main content is titled "Online Service Agreement" and "Agreement with Humana". It contains text about the agreement and a list of provisions. At the bottom, there is a red box containing a checked checkbox and the text: "By checking this box, you acknowledge you have read and understand the above information." Below this is a blue button labeled "Agree" and a grey button labeled "Disagree".

Read the Service Agreement to the client and put a check mark in the Acknowledgment Box.

Click Agree

# Scope of Appointment Form Summary

Once you click Review and Sign, go over the completed SOA to make sure all the Information is listed correctly

 **Scope of Appointment Form Summary**

**Client Information**

Zip Code  
40299

County  
JEFFERSON,KY

Zip and county listed correctly

☐ Stand - alone Medicare Prescription Drug Plans (Part D) 

Correct plan selected for the presentation

**Medicare Prescription Drug Plan (PDP)** - A stand-alone drug plan that adds prescription drug coverage to the Original Medicare Plan, some Medicare Cost Plans, some Medicare Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

☒ Medicare Advantage (Part C), Medicare Advantage Prescription Drug Plans, and other Medicare Plans

**Medicare Health Maintenance Organization (HMO)** - A Medicare Advantage Plan that must cover all Part A and Part B health care. In most HMOs, you can only go to doctors, specialists, or hospitals in the plan's network except in an emergency.

Last Name  
Fish

First Name  
Freddy

MI

Address 1  
1515 Smelly Street

Address 2 / APT #

City  
Louisville

State  
KY

Zip  
40299

County  
JEFFERSON,KY

Phone  
(026) 666-6666 (###) ###-####

Member information correct

Initial Method of Contact:  
Unexpected additional attendee

Medicare Claim Number  
123456789a

Re-Enter Medicare Number  
123456789a

**Office Use Only**

Plan Representative  
Boston,Rebecca

Agent #  
1407608

Representative Phone  
(502) 580-8579 (###) ###-####

Source  
Referral - General

Sub Source  
Client Referral

House Member  
Head

Type  
Prospect

Sub Type  
A

☐ Current Date/Time

Appointment Date  
09/18/2009

Time of Appointment  
03:45 PM

Verify appointment date if not the same day

**PLEASE READ THIS IMPORTANT INFORMATION:** By signing this form you are agreeing to a sales meeting with a sales agent to discuss the specific types of products you initiated above. The person that will be discussing plan options with you is either employed or contracted by a Medicare health plan

**Release of Information:** Signing this form does NOT affect your current enrollment, nor will it enroll you in a Medicare Advantage Plan, Prescription Drug Plan, or other Medicare plan.

# Scope of Appointment Form Summary

## Sign the application

**Note – you the agent must sign the SOA**

Signature

Signature of Applicant or Authorized Legal Representative (including valid Power of Attorney, Legal Guardian, etc)

☒ Client Sign **Click in the circle next to who is signing to activate the signature pad**

☐ Agent Sign

☐ Witness Sign

Signature Date

Signature Date

Signature Date

**Capture Signature**

**Clear Signature**

Once you click OK on capture signature the signature date will populate

Signature of Witness/Translator or Person assisting in completion of form (other than agent)

Witness/Translator Last Name:

Witness/Translator First Name:

Relation:

**If a witness is signing you must enter the name and relationship of the witness**

If you are the **authorized Legal Representative (POA)**, you must provide the following information:

Last Name:

First Name:

MI:

Address1:

Address2:

City:

State:

Zip:

Phone:

Relation to Applicant:

**Complete this information for the Power of Attorney**

**Return To Application**

**Click Save and Close When every thing is completed**

**Save and Close**

**Create Application**

**Sales agents are not permitted to sign the enrollee's name for them!! This is the equivalent to forging their signature.**

# Scope of Appointment - reload to create application

Once you have **completed** the **presentation** and the beneficiary has decided to **purchase** the **plan** the agent needs to **reload the SOA** and create that application from there. This will make sure the SOA is tied to the application.

## Reload the SOA

From the **MAPA workbench** page click on the application you need to reload. Once highlighted click **Load APP**


Application Search

Search By: ☒ All ☐ Complete ☐ Incomplete

Clone App Load App Delete App

Type	Last Name	First Name	Address	City	State	Zip	Phone	Status
SOA	Fish	Freddy	1515 Smelly Street	Louisville	KY	40299	(026)-666-6666	Complete
Individual	MAPATESTU	GL	622 W 300 N	DECATUR	IN	46733	(219)-747-536	Incomplete

The SOA will open on the main page

 **Sales Appointment Confirmation Form**

**To be Completed by person with Medicare.**

Please check the box beside the plan type you want the agent to discuss with you. If you do not want the agent to discuss a plan type with you, please leave

Client Information

Zip Code: 40299 County: JEFFERSON, KY

☐ Stand - alone Medicare Prescription Drug Plans (Part D)

**Medicare Prescription Drug Plan (PDP)** - A stand-alone drug plan that adds prescription drug coverage to the Original Medicare Plan, some Medicare Cost Plans, some Medicare Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

☒ Medicare Advantage (Part C), Medicare Advantage Prescription Drug Plans, and other Medicare Plans

**Medicare Health Maintenance Organization (HMO)** - A Medicare Advantage Plan that must cover all Part A and Part B health care. In most HMOs, you can only go to doctors, specialists, or hospitals in the plan's network except in an emergency.

Close Save Review and Sign

Scroll to the bottom and Click on **Review and Sign**

# Scope of Appointment reload to create application

Once you click Review and Sign the application will open to the signed page scroll to the bottom and click on the **Create Application** button

Agent Sign

Signature Date: 09/16/2009

Witness Sign

Signature Date

Signature of Witness/Translator or Person assisting in completion of form (other than agent)

Witness/Translator Last Name: \_\_\_\_\_

Witness/Translator First Name: \_\_\_\_\_

Relation: \_\_\_\_\_

If you are the authorized Legal Representative (POA), you must provide the following information:

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address1: \_\_\_\_\_

Address2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) - -

Relation to Applicant: \_\_\_\_\_

Return To Application Close Create Application

The **Application Types** box will appear – select the correct application then click **OK**

The application will open to the **Eligibility Determination Page**

SOA Application Types

Please select a Application Type

Code	Description	SelectApplication
IND	Individual Application	<input checked="" type="checkbox"/>
AEF	Abbreviated Enrollment Form	<input type="checkbox"/>

Cancel OK



# Scope of Appointment reload to create application

Complete the Application

**Eligibility Determination**

Please select a plan type

☐ MAPD ☐ MA ☐ PDP

Are you enrolling using a SEP?

☐ Yes ☐ No Note: Click Yes to select SEP reason

If you received a **DMS lead** that HAS an **SOA** with it, please enter "**DMS Scope**" in that box

Signature

Seminar Enrollment

SOA ID:

☐ Seminar Enrollment

Signature of Applicant or Authorized Legal Representative

☐ Client Sign

Signature Date

Signature of Witness/Translator or Person assisting in completion of form (other than agent)

If the application was completed during a seminar, please check the box that says Seminar Enrollment.

ApplicationID

Application SC7TV7C3QFIK27HC Successfully Saved!

☐ Check here if this is a test application

A **Test application box** has been added to all applications.

Check marking this box will keep the application from fully uploading

The Test application will appear in your application list until you complete an upload process at which time it will be removed

Type	Last Name	First Name	Address	City	State	Zip	Phone	Status
SOA	craker	cheese	1515 willow rd	louisville	KY	40299	(502) 256 6666	Complete
FSB	fields	william	1514 warlock street	louisville	KY	40299	(502) 225 3321	Complete
SOA	candy	hard	1515 west main	louisville	KY	40299	(502) 666 6696	Test
FSB	Spitman	Rogger	1515 dog lane	louisville	KY	40299	(502) 666 6666	Complete
FSB	Spitman	Rogger	1515 dog lane	louisville	KY	40299	(502) 666 6666	Complete

# Scope of Appointment

Below are situations that will help you with the SOA process so that they know WHEN to make manual corrections/changes/updates for current those appointments left active in CDS

## Scenario 1:

<b>Creating SOA from existing CDS contact - Not Scheduled/Not on Calendar</b>
Creating SOA from Existing Contact with Application - NOT on calendar:
Upon UPLOAD - MAPA will create a DONE appointment on the date and time as specified in the Scope of appointment form. An activity will be created that links to the SOA. Policy will link to SOA.
Creating SOA without Application from existing contact:
Upon Upload, MAPA will create an ACTIVE appointment as specified on the SOA form with link to SOA data.


## Scenario 2:

<b>Downloading contact from CDS - ON calendar</b>
Creating SOA with Application from existing contact ON calendar:
Upon UPLOAD, MAPA will create DONE appointment on the Date/Time as specified in the SOA form. MAPA will create an activity link and policy link to the SOA form. The ORIGINAL APPOINTMENT WILL BE LEFT ACTIVE WITH NO UPDATES. ONLY NEW INFORMATION WILL BE INSERTED.
Creating SOA without Application from existing contact ON calendar:
Upon UPLOAD, MAPA will create an ACTIVE appointment as specified in the SOA form. MAPA will create link to SOA data in CDS. THE ORIGINAL APPOINTMENT WILL BE LEFT ACTIVE WITH NO UPDATES. ONLY NEW INFORMATION WILL BE INSERTED.

## Scenario 3:

<b>Creating a BLANK SOA form - not created from any existing contact.</b>
Creating BLANK SOA with Application:
Upon UPLOAD, MAPA will create a DONE Appointment on the date and time as specified in the SOA form. MAPA will create an activity link to SOA, policy link to SOA.
Creating BLANK SOA without an Application:
Upon UPLOAD, MAPA will create an ACTIVE appointment as specified in the SOA form with link to SOA data in CDS.

# Eligibility Determination – Individual Application

 **Eligibility Determination**

**Please select a plan type**  
☐ MAPD      ☐ MA      ☐ PDP  
Select the plan type the member wants to enroll in. The plan you select here will determine plans that you receive on the application.

**Are you enrolling using a SEP?**  
☐ Yes      ☐ No      Note: Click Yes to select SEP reason  
The zip code and County are only needed if YES is selected for the SEP  
The option will remain Gray if the selection is NO

Zip Code

County

SEP Reason Codes

SEP Reason Code

Date of SEP event:

SEP Other:

**Part A and Part B dates**

**Hospital Insurance Part A**

**Medical Insurance Part B**

**Date Of Birth**

These dates are taken from the Medicare card. The dates and DOB will help determine the election period options you receive.

**Select a plan year**  
☐ 2011      From Jan 1<sup>st</sup> thru Oct 15<sup>th</sup> the plan year will be greyed out      ☐ 2012      The plan year only needs to be selected from Oct 15<sup>th</sup> thru the end of Nov.

**Determine Eligibility**  
Click here to get election period options

**Select an Election Period if not enrolling using a SEP**  
☐ ICEP    ☐ IEP    ☐ SEP    ☐ AEP    ☐ OEPI      **Proposed Effective Date**  
  
Once you have the information completed click Determine Eligibility and the system will activate the election codes that are available.

Select the correct election period and click continue.

# Eligibility Determination – Individual Application

**Eligibility Determination**

Please select a plan type

☒ MAPD    ☐ MA    ☐ PDP

Are you enrolling using a SEP? Selecting YES requires the county Zip code and Sep reason code

☒ Yes    ☐ No    Note: Click Yes to select SEP reason

Zip Code: 40299    County: BULLITT, KY    **SEP Reason Codes**

SEP Reason Code:    Date of SEP event:    SEP Other:

Some SEP reason will require a date

This is only used if you select other as the SEP code

If **SEP** is the election period you must select  
The reason for the SEP

Note: Only use other as a last resort option for the SEP selection

Select SEP Reason Code

ReasonCode	Description	Select a Reason
CHR	One-time SEP for Initial Enrollment into a Chronic Care SNP plan	<input type="checkbox"/>
COS	SEP for individuals enrolled in cost plans that are nonrenewing their contracts	<input type="checkbox"/>
CRE	SEP for individuals who are not adequately informed of a loss of creditable coverage or never had creditable coverage	<input type="checkbox"/>
ERR	SEP for individuals whose enrollment or non enrollment in a Part D plan is erroneous due to an action, inaction or error by a federal employee	<input type="checkbox"/>
ESR	SEP for individuals with ESRD whose entitlement determination was made retroactively	<input type="checkbox"/>
GEP	SEP for individuals who enroll in Part B during the Part B General Enrollment Period	<input checked="" type="checkbox"/>
LEC	I am either losing coverage I had from an employer or union or leaving employer or union coverage	<input type="checkbox"/>
LIS	I receive extra help paying for Medicare prescription drug coverage	<input type="checkbox"/>
LLS	I am no longer eligible for extra help paying for my Medicare prescription drugs	<input type="checkbox"/>

OK Cancel

If you select a reason code that is not available for this time period the system will tell you the SEP is not available and to select about election period

MAPA

This SEP is not available at this time. Please select another one or select a different election period.

OK

# Demographic Tab – Individual Application

Complete the client's **Demographic** information for this section of the application. Some fields will not allow data entry; the data is tied to choices made during the process and can not be changed.

- Enter the **Zip Code** – this will activate the County field.
- Using the drop down, select the **County** – this will activate the Available Plans.
- Using the drop down in **Available Plans** select the plan option.
- if a **Rider** is available it will show up – to select click in the box next to the one you want

**Demographics** Medicare Card Clinical Qualifying Plan Specific Payment Agent Only

Client Information

Zip Code: 40299 County: BULLITT, KY Date Of Birth: 01/01/1936 Note – everything on the demographic tab will write to CDS

Available Plans: HumanaChoicePPO H1806-001

Riders

☐ MYOPTION ENHANCED DENTAL

☐ MYOPTION VISION

Last Name: First Name: MI: Address 1: Address 2 / APT #: City: State: KY Zip: 40299 County: BULLITT, KY Phone: (###) ###-####

Mailing Address : ☐ Check here if the Mailing Address is the same as the Residential Address

Address 1: Address 2/Apt#: City: State: Zip:

Email Address (Optional):

Preferred Method of Communication: ☐ Telephone ☐ Email ☒ Mail

Person to notify in case of emergency (nearest relative or friend) - (Optional)

Last Name: First Name: Relationship To Applicant: Phone: (###) ###-####

**Return to Plan Determination** **Back** **Close** **Save** **Next**

The available plans loaded will be determined by the MA MAPD or PDP option selected on the elig page. If plan is not showing go back and make a new selection

If the member wants to select an Optional Supplemental benefit At the time of the Medicare enrollment put a check next to the correct option – NOTE: if the member already has a rider and wants to keep it It must be marked on the application

The residential address must be a physical address no PO BOX

Check the same as Residential Address box or a new address must be entered

This is how the member prefers the agent to contact them. this will write to the Keywords box in CDS

The emergency contact will write to the key relations tab in CDS.

Once each section is completed, you can change pages by clicking the **Next** button or use the **tabs** located at the top of the page.

# Demographic Tab – Individual Application

## Chronic Care Special Needs Plan

1 - Use the drop down arrow under Available plans and select the plan

Demographics Medicare Card Clinical Qualifying Plan Specific Payment Agent Only

Client Information

Zip Code 40299 County BULLITT, KY Date Of Birth 01/01/1936

Available Plans

--Select a Plan--

Humana Gold Plus HMO SNP-DB H1036-121C

Humana Gold Plus HMO SNP-DB H1036-121C

Humana Gold Plus HMO SNP-OA H1036-122C

Humana Gold Plus HMO H1036-053A

Humana Gold Plus HMO SNP-DE H1036-103A

HumanaChoicePPO SNP-OA R5826-051

HumanaChoicePPO R5826-018

HumanaChoicePPO R5826-005

Humana Gold Choice PFFS H1804-145

HMO SNP-OA : is for Osteoarthritis  
HMO SNP-DB : is for Diabetes

2 - You must answer **yes** to this question or you are **not eligible** to enroll in the SNP plan

Osteoarthritis

Have you been diagnosed and are currently being treated for Osteoarthritis?

Yes No

Demographics Medicare Card Clinical Qualifying Plan Specific Payment Agent Only

Client Information

Zip Code 33316 County BROWARD, FL Date Of Birth 12/25/1932

Available Plans

Humana Gold Plus HMO SNP-DB H1036-121C

Riders

Last Name

First Name MI

Address 1

Address 2 / APT #

City State Zip

County Phone

BROWARD, FL

33316

(###) ###-####

Now complete the application

# Medicare Card Tab: Individual Application

This section requires the client's **Medicare** information. Complete the individual's Medicare information as it appears on the Medicare card. Some fields will not allow data entry unless their section requires information.

If the client does not have Medicaid, you would leave the choice as 'No'. You would not be able to enter information into the Medicaid # box unless you selected 'Yes' as the answer to the Medicaid question.

**Note:** For nursing home, if yes, **Date** refers to the date the client entered the facility.

Demographics	Medicare Card	Clinical Qualifying	Plan Specific	Payment	Agent Only
<p>Medicare Health Insurance</p> <p>Last Name: <input type="text" value="stanley"/> First Name: <input type="text" value="flat"/> M.I.: <input type="text"/></p> <p>Please take out your Medicare card to complete this section. Please fill in these blanks so they match your red, white and blue Medicare card.</p> <p>Medicare Claim Number: <input type="text" value="123456789a"/> Re-Enter Medicare Claim: <input type="text" value="123456789a"/></p> <p>Effective Date: <input type="text" value="10/01/2011"/> <b>Medicare Claim Number is required. It is entered twice for validation.</b></p> <p>Sex: <input type="radio"/> Male <input type="radio"/> Female</p> <p>Hospital Insurance Part A: <input type="text" value="10/01/2011"/> Medical Insurance Part B: <input type="text" value="10/01/2011"/></p>					
<p>CareOne (HMO) H1019-010</p> <p>Contract Number: <input type="text" value="H1019"/> PBP: <input type="text" value="010"/></p> <p>Language Preference for Member Services: <input type="text" value="English"/></p> <p>Please contact our Member Services Department at 1-800-794-5907 if you need information in another format or language. We are open 7 days a week, from 8 a. m. to 8 p. m. From February 15 until the following Annual Election Period (AEP), you may leave us a voice mail message after hours, Saturdays, Sundays and holidays and we will return</p>					
<p>Are you enrolled in your state Medicaid program? <input type="radio"/> Yes <input type="radio"/> No</p> <p>If Yes, Medicaid #: <input type="text"/></p> <p>Medicaid Effective Date: <input type="text"/></p>					
<p>Are you a resident in a long-term care facility, such as a nursing home? <input type="radio"/> Yes <input type="radio"/> No</p> <p>If "yes", please provide the following information:</p> <p>Date Entered: <input type="text"/> Name of Institution: <input type="text"/></p> <p>Address 1: <input type="text"/> Address 2/Apt#: <input type="text"/></p> <p>City: <input type="text"/> State: <input type="text"/> Zip: <input type="text"/> Phone ###-###-####: <input type="text"/></p> <p><b>If you answer yes to any question you must provide any information requested in order to complete the Application.</b></p>					
<p>Return to Eligibility Determination Back Close Save Next</p>					

Note – the language preference will write to the Smart Pad in CDS.

- the part A and B dates, Medicare effective date will write to the Benefits tab under policies.



# Clinical Qualifying tab – Individual Application

This tab will only open if you selected a Special Needs Plan on the Demographic Tab.

**1 - Qualifying questions** – you must answer **yes** or **not sure** to qualify for the plan.

**2 - Medical questions** - You must enter any drugs that the member is taking for the special needs illness.

**3 - Physicians** – you must enter either the primary care physician or the specialist – it is ok to have both but not necessary.

**Demographics** **Medicare Card** **Clinical Qualifying** **Plan Specific** **Payment** **Agent Only**

**Pre-qualification Assessment for Osteoarthritis**

Last Name:  First Name:  MI:

Address 1:  Address 2 / APT #:

City:  State:  Zip:  Medicare Cl#:

**Clinical Qualifying Questions**

1. Have you ever been told by your physician that you have osteoarthritis or degenerative joint disease? ☒ Yes ☐ No ☐ Not Sure

2. Do you take any medications to help control the pain in your joints as a result of osteoarthritis or degenerative joint disease? ☐ Yes ☐ No ☒ Not Sure

**Medical Questions**

1. What medications for Osteoarthritis are you currently taking?

Please list your Primary Care Physician:

Name:  Address:

City:  State:  Zip:  Phone:

Please list any specialist physicians you see regularly:

Name:  Address:

City:  State:  Zip:  Phone:

**Return to Eligibility Determination** **Back** **Close** **Save** **Next**

Click next to continue on



# Plan Specific Tab: Individual Application

This section is requesting information for the particular **plan** the client has selected.

With the numerous plans, the specific options for each will look different on the screen.

For example, the **PDP** form to the right asks if the client has prescription drug coverage. You would not be able to enter Carrier information unless you selected 'Yes' as the answer to the question.

Demographics Medicare Card Clinical Qualifying **Plan Specific** Payment Agent Only

Some individuals may have other drug coverage, including private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs. **Will you have other prescription drug coverage in addition to this plan for which you are applying?** ☐ Yes ☐ No

If yes, please list your other coverage and your identification(ID) number(s) for this coverage

If yes, Carrier Name Policy # ID# for this coverage

Medicare Card Clinical Qualifying **Plan Specific** Payment Agent Only

Once enrolled, will you have other medical health coverage? ☐ Yes ☐ No

If yes, complete the following:

Carrier Name Carrier Address 1 Carrier Address 2

City State Zip Code Policy #

Once enrolled, will you or your spouse (if married) work? ☐ Yes ☐ No

Do you have end-stage renal disease? ☐ Yes ☐ No

If you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.

Some individuals may have other drug coverage, including private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs. **Will you have other prescription drug coverage in addition to this plan for which you are applying?** ☐ Yes ☐ No

If yes, please list your other coverage and your identification(ID) number(s) for this coverage

Name of other coverage Group # for this coverage ID# for this coverage

Rx BIN Rx PCN Carrier Phone Number (###) ###-####

Name of chosen Primary Care Physician (PCP), clinic or health center: Identification # of Chosen Primary Care Physician (PCP), clinic or health center:

Are You an Established Patient of the Physician You Selected? ☐ Yes ☐ No

PCP Type

The **PPO** plan to the left will ask about group health coverage, end-stage renal disease and additional prescription drug coverage.

Again, changes to future plans will cause this section to change as needed.

If you say **YES** to any question you must provide the additional information

**RX BIN, RXPCN, Carrier Phone – optional fields.**

The PCP selection is optional (but suggested) for PPO  
PCP selection is required for HMO

# Payment Tab –Individual Application

If the plan selected does not have a premium amount a payment option still **must** be selected in case there is a penalty added to the plan

This section is requesting information on how plan **payments** will be handled. Select the appropriate **Payment Option** and continue to the next section.

You must have the same payment option for both the Humana plan and the rider

Demographics

Medicare Card

Clinical Qualifying

Plan Specific

Payment

Agent Only

This amount will NOT reflect any penalty or assistance the member may receive.

Monthly Premium

Your Monthly Payment for your Humana Plan will be no more than: \$ 131.00

The cost of the 2 plans will be added together

Total Premium 155.00

Your Optional Supplemental Premium 24.00

Please select a premium payment option. SSA and/or RRB deduction will not be an option if your total premium is greater than \$200. You can pay your monthly plan premium and/or late enrollment penalty by mail using a Coupon Book, Electronic Funds Transfer, or Automatic Credit Card Charge. You can also choose to pay your premium and/or late enrollment penalty by automatic deduction from your Social Security or Railroad Retirement Board Benefit Check each month. If you qualify for extra help with your Medicare prescription plan coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.


Payment Options


☐ Social Security Benefit Check Deduction If the premium deduction is \$200.01 the SSA option is not allowed


☐ Railroad Retirement Board Benefit Check Deduction (You must currently be receiving a Railroad Retirement Board benefit check in order to qualify for this payment option)

☐ Coupon Book

Credit Card Name

☐ Visa 

☐ MasterCard 

☐ Discover 

Card Number

Expiration Date

☐ Automatic Withdrawal

Bank Name

Routing Number

Account Number

Account Type

☐ Checking ☐ Savings

Select your payment option – Then read the information that appears is the box below.  
NOTE SSA is the preferred method of payment for Humana

If your bank has a specific ACH R/T number, in addition to the check routing number, example shown below, please enter the ACH R/T number instead."

Your Name  
1234 Oak  
Anytown, USA

1001

19-0/1230

PAY TO THE ORDER OF

\$

DOLLARS

ACH R/T 123456789

FOR

123456789 000123456789\* 1001

ABA Check Routing Number 123456789

Account Number 000123456789

Check Number 1001

ACH Routing/Transit Number 123456789

Return to Plan Determination

Back

Close

Save



Next

# Payment Tab –Individual Application

## Zero premium plans

Even with a Zero premium plan a payment option must be selected

This will be stored on file and only used if it is determined there is a late enrollment penalty

Demographics	Medicare Card	Clinical Qualifying	Plan Specific	Payment	Agent Only
<b>Monthly Premium</b>					
Your monthly payment for your CarePlus Plan will be no more than: \$ <input type="text" value="0.00"/>					
payment option still needed 					
<b>PLEASE SELECT A PREMIUM PAYMENT OPTION.</b> If you have selected a plan with zero monthly premium and we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay from your Social Security or Railroad Retirement Board (RRB) benefit check each month.					
<b>Payment Options</b>					
<input type="radio"/> Social Security Benefit Check Deduction					
<input type="radio"/> Railroad Retirement Board Benefit Check Deduction (You must currently be receiving a Railroad Retirement Board benefit check in order to qualify for this option.)					
<input type="radio"/> Get a bill					
<input type="radio"/> Electronic Funds Transfer from your bank account each month:					
Depository Bank Name	Routing Number	Account #	Account Holder Name		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
					

# Agent Only Tab: Individual Application

This section supplies information about the agent associated with this application

## Field Definitions

**Affinity Partner** – use the drop down arrow to select.

**Affinity Partner Location** – only used if partner is Wal-Mart or Guidance center – would be store number.

**Affinity TID** – This will pre fill when an affinity partner is selected

**Referring Agent** – only used if this was a broker referral, must be added before app is signed.

**Source and Sub Source** – for CDS refers to where the lead came from.

**House Member** – use to determine head of house or spouse - for CDS use.

**Type and Sub Type** – use client and A.

**Disposition** - use the drop down arrow and select the sold reason.

**Enrollment reason** – mark the enrollment period which allows the member to enroll – if **SEP** is selected you will need to also select the SEP reason.

**Campaign** – refers to the Affinity partner key code – this is located on your calendar activity if you down load this will pre fill – if using blank app you will need to take out the default and add the correct code.

**Products discussed** – Mark all products you talked about during your visit. This should match your Scope of Appointment.

**Proposed effective date** – defaults to the first of the following month you are in. You can change the date to reflect no more then 3 moths out.

**Tier 1** – tells what the original source of the lead was

**Tier 2-** Tells where the beneficiary heard about the plans

**Location** – where the application was signed

# Agent Only Tab: Individual Application

Plan Representative, Date and Rep # - will pre fill

Office Use Only

Plan Representative Boston, Rebecca	Location	REP # 17532	Affinity Partner -Select A Partner--
Date 07/01/2009		Affinity TID -	Affinity Partner Location
Referring Agent	Agent #	Campaign 0305046921	

Use the drop down arrow to select the correct Partner – if no affinity partner, select None

When an affinity partner is selected the Affinity TID will populate

Each affinity partner has a Campaign number to go with it – if creating a blank application you will need to remove the default and add the correct one – the code will be listed as the key code on your calendar

The GR and BN will pre fill

GR 235464	BN 010	
Source Referral - General	Sub Source Client Referral	House Member Head
Type Client	Sub Type A	
Disposition Sold - MAPD	Disposition 2 SNP / Dual-Eligible	Disposition 3 Diabetes

## Source, Type and Disposition

- The source field is a high level look at where the lead came from. This will pre populate is added in CDS.
- Use the drop down arrow to make the correct selections.
- Disposition 2 and 3 build off of disposition one
  - Not all of the second dispositions have a third option to go with it. If there is not one available, it will say no disposition available.
  - You must select disposition 1 and 2 in order to continue on

☒ ICEP
 ☒ IEP
 ☐ SEP
 ☐ AEP
 ☐ OEPI

Proposed Effective Date

11/01/2010

The system pre –fills the enrollment option with the selection made on the Plan Eligibility screen

The **proposed effective date** will default to the first of the month following month.

# Agent Only Tab: Individual Application

## Source Information

### Tier 1:

What was the original source of the lead ( how did the client learn about Humana)

- Medicare campaign/seminar/ad
- TIPS campaign/seminar/ad
- Veterans campaign/seminar/ad, etc.

### Tier 2:

Where they heard about the plan DMS call, HGC, WLMT, Veteran Referral, Self-Referral, etc.

### Location:

- where the application was completed.
- may not be where the lead was sent which would be Tier 2
- In home appt was scheduled but directed to WLMT for convenience, etc.



The screenshot shows a web form titled "Source Information". It contains two sections. The first section is labeled "What was the source for this sale?" and has two dropdown menus: "Tier 1: --Select Source--" and "Tier 2: --Select Source--". The second section is labeled "What was the location for this sale?" and has a single dropdown menu: "--Select Location--".

# Agent Only Tab: Affinity Partners

Delegated agents only need to select **NONE**

Office Use Only

Plan Representative: Boston, Rebecca Location: REP #: Affinity TID: Referring Agent: Agent #: Attachments: AM001 AM002 AM006

Affinity Partner: Home Instead Senior Care Home Instead Senior Care Humana Guidance Center ICAN Indiana Inspher Insurance Integrat Kelsey

Use the drop down arrow to select the correct Partner – Delegated agents will use the word NONE

Affinity Partner: WalMart Affinity Partner Location: Search StoreID

If the affinity partner is Wal mart or Humana Guidance Center the store number must be listed

If you don't know the Store ID:

- Click on the Search Store ID button
- Leave ID blank and click Search
- Enter State and City of the store

Was this Sale originated from a WalMart Store?

Store ID: Leave Store ID Blank

No Search

Was this Sale originated from a WalMart Store?

State: City:

No Search

If the affinity partner is a Humana Guidance Center the location must be entered

Affinity Partner: Health Compare Health Plan One Health Plan Services Healthy American Hershend Fam Entertainment Humana Guidance Center Indiana Farm Bureau Inspher

Affinity Partner: Humana Guidance Center Affinity Partner Location:

STOREID	ADDR1	CITY	STATE
10613	8648 Skillman Street	Dallas	TX
10615	2257 S 108th Street	West Allis	WI
10616	227 Willow Bend	Crystal	MN
10617	11316 Montgomery Road	Cincinnati	OH
10618	7666 Nob Hill Road	Tamarac	FL
10619	12100 E Colonial Dr	Orlando	FL
10620	215 Englewood Road, Suite A	Kansas City	MO
10621	3189 W Vine Street	Kissimmee	FL
10622	7945 S Harlem	Burbank	IL
10623	5943 E McKellips Rd Ste 106	Mesa	AZ
10624	8975 W Charleston Blvd	Las Vegas	NV
10626	7915 N Hale Ave	Peoria	IL
10627	7400 Gall Blvd	Zephyrhills	FL
17673	1000 N Green Valley Parkway, Suite 720	Las Vegas	NV
17674	2025 W. Henderson	Columbus	OH
17693	1915 SNOW ROAD	PARMA	OH
17694	4438 Western Avenue	Knoxville	TN
10614	711 W. Wheatland Road	Duncanville	TX
10625	1000 N Green Valley Parkway, Suite 720	Henderson	NV

# Agent Only Tab - Individual Application

Products Discussed (Please select ALL that apply)

<input type="checkbox"/> All	<input type="checkbox"/> Other
<input checked="" type="checkbox"/> MA/MAPD	<input type="checkbox"/> PDP
<input type="checkbox"/> MedSupp	

This selection is used as a reminder for you. It will **write to the keywords section**. The products discussed should match your SCOPE.

Once you have completed all the fields, **click Save**.

ApplicationID

Application **6MTRL846AI13GCI** Saved Successfully!

When saved, the **Application number** will appear

Click OK

Once you have saved the information, you are ready to Review and Sign.

Every time you click **Review and Sign** you will be asked about entering a **Referring Agent** – This is only used for Broker referrals.

Referring Agent

Do you want to enter Referring Agent?

Every time you click **Review and Sign** you will be asked if this sale originated from **WalMart** – If Yes enter the store ID  
If No leave ID blank and click no

WalMart

Was this Sale originated from a WalMart Store?

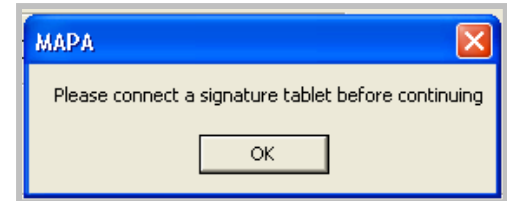
Store ID



# Review and Sign - Errors

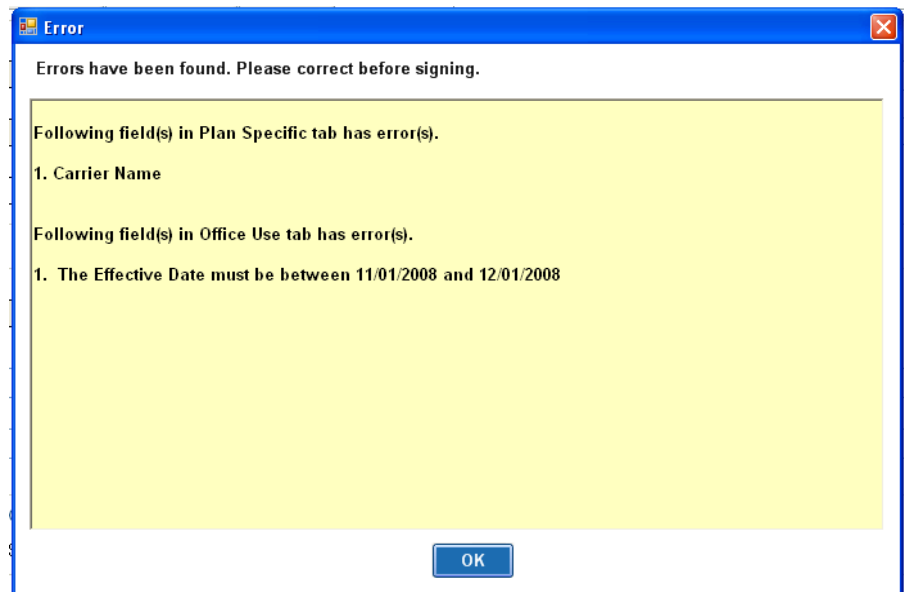
If you have **not connected your signature tablet** to your laptop, the program will prompt you to do so at this time. When it is time to sign on the tablet screen, use the attached stylus.

**DO NOT USE AN INK PEN ON THE PAD!**



When you click on the **Review and Sign** button, the program reviews the information on the application and creates a **list of items that need to be corrected** for the application to be accepted.

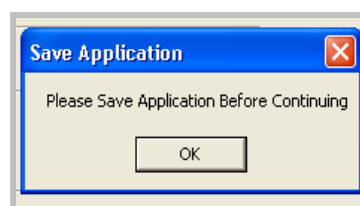
If there are **errors**, a window will appear listing the errors that need to be corrected before continuing to the next section. Clicking on **OK** will take you to the first section with errors so you can begin correcting the application.



**Errors** on all the sections will be **highlighted** with a **red background**. As you correct the error, the red highlight will disappear.

A snippet of a form showing two date fields. The first is labeled "Effective Date: Hospital Insurance (Part A)" and the second is "Medical Insurance (Part B)". Both date input boxes contain the text "/01/" and are highlighted with a red background.

Once the errors have been corrected, the program will prompt you to **Save the Application Before Continuing**. Click the **Save** button to save the application, then click the **OK** button to continue to the signature section.



# Service Agreement – Individual Application

- The online service agreement must be read by or read to the member.
- This states they understand everything is being completed electronically. They agree to the terms and conditions.

**If the member does not agree to the Service Agreement you must complete a paper application.**

The screenshot shows a web browser window titled "Agreement". The main heading is "Online Service Agreement" in green. Below it is "Agreement with Humana". The text states: "This agreement is between you and Humana, Inc., on behalf of its affiliates." followed by "Consent to Electronic Transactions". A list of six provisions follows, detailing the use of electronic transactions, termination, and modification. Below the provisions is a section "For More Information" with the address "Humana, 500 W. Main Street, Louisville, KY 40201". At the bottom, there is a checkbox labeled "By checking this box, you acknowledge you have read and understand the above information." and two buttons: "Agree" and "Disagree". A yellow callout box with a red border contains the text "Have the member put a check in the box and Then click AGREE". Red arrows point from this callout box to the checkbox and the "Agree" button.

**Online Service Agreement**

**Agreement with Humana**

This agreement is between you and Humana, Inc., on behalf of its affiliates.

**Consent to Electronic Transactions**

I, the User, and Humana acknowledge and agree to the following provisions:

1. To conduct this enrollment and any changes made to this enrollment information through the use of an electronic transaction which will be verified by the use of an electronic signature.
2. This consent to conduct an electronic transaction only applies to enrollment services.
3. That I may request that this Agreement be terminated. If terminated, paper access to enrollment services and forms will be distributed at no cost to me if an address, phone number and a contact name are provided to a Humana representative.
4. That I may request a paper copy of this recorded transaction.
5. To be bound by this agreement as stated by law throughout the term of this Agreement.
6. This agreement may be modified at any time if Humana provides notice.

**For More Information**  
Humana, 500 W. Main Street, Louisville, KY 40201

☐ By checking this box, you acknowledge you have read and understand the above information.

**Agree** **Disagree**

Have the member put a check in the box and Then click AGREE


Once the agreement is completed, you will be taken to the **Review and Sign** page.

# Application Review: Individual Application

When the program recognizes that the pad is connected to the laptop, the program will then display a **Summary** page listing all the information that has been entered on the application. Scroll through the application and review the accuracy of the information with the client.

**You are reviewing the application for spelling errors and incorrect information**

**If an error is found, click return to application to correct**

 **Individual Application Review and Sign**

---

**Client Information**  
Zip Code  
  
County  
  
Date Of Birth  
  
Available Plans  
  
**Riders**  
☒ MYOPTION ENHANCED DENTAL  
☒ MYOPTION VISION

**Last Name**  
  
**Address 1**  
  
**City**  
  
**State**  
  
**Zip**

**First Name**  
  
**MI**  
  
**Address 2 / APT #**  
  
**County**  
  
**Phone**  
 (###) ### ####

**Mailing Address (if different from Street Address)**  
**Address 1**  
  
**Address 2 APT #**  
  
**City**  
  
**State**  
  
**Zip**

**Email Address, if available, will be used as a means to communicate various Humana related information (Optional)**  
**Email Address (Optional)**  
  
**Preferred Method of Communication**  
☒ Telephone ☐ Email ☐ Mail  
**Person to notify in case of emergency (nearest relative or friend) - (Optional)**  
**Last Name**  
  
**First Name**  
  
**MI**  
  
**Relationship To Applicant**  
  
**Phone**  
 (###) ### ####

**Application Review continued on next page...**

# Application Review – Individual Application

The system has already scanned the application to ensure it was complete.

Medicare Health Insurance		
Last Name <input type="text" value="McPherson"/>	First Name <input type="text" value="Flubber"/>	M.I. <input type="text" value=""/>
<div>Please complete the information to the right exactly as it appears on your Medicare card.</div> <div>Please contact Humana at 1-800-833-2367 (TDD 1-877-833-4486) if you need information in another format or language than what is listed below. Our office hours are 8a.m. to 8p.m. local time, seven days a week.</div>	Medicare Claim Number <input type="text" value="123456789a"/>	Re-Enter Medicare Claim <input type="text" value="123456789a"/> Medicare number is correct
	Sex: <input checked="" type="radio"/> Male <input type="radio"/> Female	Effective Date: Hospital Insurance (Part A) <input type="text" value="01/01/1998"/>
		Medical Insurance (Part B) <input type="text" value="01/01/1998"/>
HumanaChoicePPO R5826-008		
Contract Number <input type="text" value="R5826"/>	PBP <input type="text" value="008"/>	Language Preferences <input type="text" value="English"/>
Are you currently enrolled in your state Medicaid program? <input type="radio"/> Yes <input checked="" type="radio"/> No		
If Yes, Medicaid # <input type="text" value=""/>		
Medicaid Effective Date <input type="text" value=""/>		
Are you currently a resident in a nursing home or other long-term care facility? <input type="radio"/> Yes <input checked="" type="radio"/> No		
If Yes, complete the following:		
Date Entered <input type="text" value=""/>	Name of Facility <input type="text" value=""/>	
Address 1 <input type="text" value=""/>		Address 2 <input type="text" value=""/>
City <input type="text" value=""/>	State <input type="text" value=""/>	Zip <input type="text" value=""/>
Phone ###.###.#### ( ) - <input type="text" value=""/>		
<div><b>PLEASE READ THIS IMPORTANT INFORMATION</b></div> <div><b>You must read this to the member</b></div> <p>communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.</p> <p>on health care benefits. If you have health coverage from an employer or union, joining you. If you have questions, visit their website, or contact their office listed in their</p> <p><b>By completing this enrollment form, I agree to the following:</b></p> <p>Humana ChoicePPO or Humana MyCare is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform Humana of any prescription drug coverage that I have or may not in the future. I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may</p> <p><b>Release of Information:</b></p> <p>By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Humana will release my information (including prescription drug event data) to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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.</p> <p>I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), the 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 Humana or Medicare.</p> <p><b>I have Read and Understand the Statements Above.</b></p>		

# Application Review – Individual Application

All applications are verified by Humana. Remember to advise your member that Humana will be calling in a few days to do the verification

O/B

NMO (New Member Orientation)  
Would you like to attend NMO?

☐ Yes ☐ No

Reason for not attending:

--Select Reason--  
Not Interested  
No Seminars Available for Location Selected  
Member has already attended.  
Member Undecided  
Other

Select Yes or No for NMO – if no you must select the reason why

Electronic Materials

Please select the materials you would like to receive by email instead of paper and enrollment confirmation in order to begin receiving selected materials. Please note that you must register on MyHumana.com once you've received your ID cards regardless of your selections below.

☒ Medical/Dental (Explanation of Benefit or Smart EOB)  
☐ Annual Notification of Change and Evidence of Coverage\*  
☐ Dental Explanation of Benefits (EOB)\*  
☐ Your Smart Summary  
☒ Notification of Request for Other Insurance

Put a check mark next to everything the member would like to receive Electronically.

Materials Used:

☐ MAPD Power Point Presentation  
☐ MA Power Point Presentation  
☐ PDP Power Point Presentation  
☐ Summary of Benefits  
☐ Value Added Services  
☐ Let's Talk Brochure  
☐ Benefit and Provider Leaflet  
☐ Compensation sheet

Put a check mark next to everything you used during the presentation This will upload to the smart pad

Comments

These comments will post on the smart pad in CDS

# Capturing Signatures: Client

After your client, or someone acting as the Power Of Attorney (POA) for the client, has read and understood the summary of the selected plan, obtain a signature

**Click in the circle next to Client Sign to activate the signature pad**

The screenshot shows a web-based signature capture interface. At the top, it says "Signature" and "Signature of applicant or authorized legal representative (including valid Power of Attorney)". There are two radio buttons: "Client Sign" (selected) and "Witness Sign". A red arrow points to the "Client Sign" radio button with a yellow box containing the text "Click here to activate the signature pad". Below the radio buttons are two signature pads. The top pad shows a handwritten signature "Stanley Euer". To the right of the top pad is a "Signature Date" field showing "10/01/2008" and a "Capture Signature" button. Below the top pad is a "Signature Date" field with a date picker and a "Clear Signature" button. Below the "Witness Sign" radio button is a signature pad for the witness. Below the witness signature pad are fields for "Witness/Translator Last Name:" and "Relation:". A red arrow points from the "Capture Signature" button to a modal window titled "Signature" that appears on the right. The modal window contains the text "Client Signature Captured" and an "OK" button, which is highlighted with a red box.

Signature  
Signature of applicant or authorized legal representative (including valid Power of Attorney)

☒ Client Sign Click here to activate the signature pad

☐ Witness Sign

Signature Date: 10/01/2008 Capture Signature

Signature Date: Clear Signature

Signature of Witness/Translator or person assisting in completion

Witness/Translator Last Name:

Relation:

Client Signature Captured OK

**Note:** If the digital signature pad fails to capture the signature, complete a paper application and contact CSS for a replacement Signature pad.

Put the signature tablet in a position where the **client** can comfortably sign on the tablet screen. The tablet screen will light-up and your client can sign on the tablet using the attached stylus.

The diagram shows a green rectangular signature tablet. At the top left is a "CLEAR" button and at the top right is an "OK" button. In the center is a large rectangular area with a dashed line and an "X" at the start, indicating where the client should sign.

CLEAR OK

X \_ \_ \_ \_ \_

# Capturing Signatures: Client

As your client signs on the dotted line, his/her signature will appear in the **Signature** window on the laptop screen.

If the client does not like the appearance of their signature, they can try again after the signature on the tablet screen is cleared.

The signature can be cleared in one of two ways:

Clear Signature

- ☐ The client can tap on **CLEAR** on the tablet, or
- The agent can click on the **Clear Client Signature** button on the laptop

When the client is satisfied with their signature, the signature can be captured in one of two ways:

Capture Signature

- ☐ The client can tap on **OK** on the tablet, or
- ☐ The agent can click on the **Capture Client Signature** button on the laptop screen.

Once the signature is captured, a **Client Signature Captured** message will appear and the client's **Signature Date** will automatically be entered into the field. Click on the **OK** button to go to the next step.

The screenshot displays a software interface for capturing a signature. At the top, a label 'Signature' is followed by the instruction 'Signature of applicant or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc)'. Below this, a 'Client Sign' button is visible. A rectangular box contains a handwritten signature that reads 'Stanley River'. To the right of the signature box, there is a 'Signature Date' field with the date '10/01/2008' entered. A 'Capture Signature' button is located to the right of the date field. Below these elements, a larger window displays the message 'Client Signature Captured' in blue text, with an 'OK' button at the bottom.

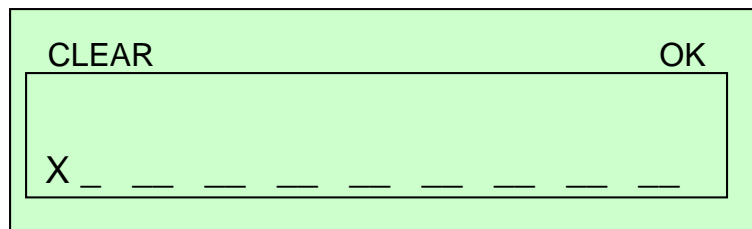
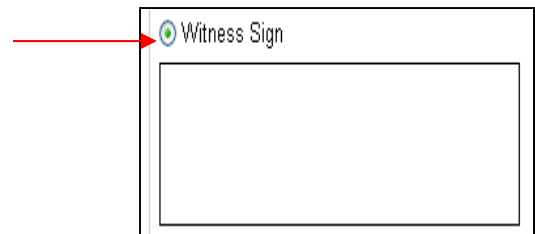
**Sales agents are not permitted to sign the enrollee's name for them!! This is the equivalent to forging their signature.**

# Capturing Signatures: Witness

Usually, a witness signature will not be necessary for the application. Some situations where a witness signature would be captured are when:

- The applicant wishes for someone else (family member, friend) to sign the application as a witness
- The applicant cannot physically completely sign their name (i.e., they sign an 'X' on the tablet)

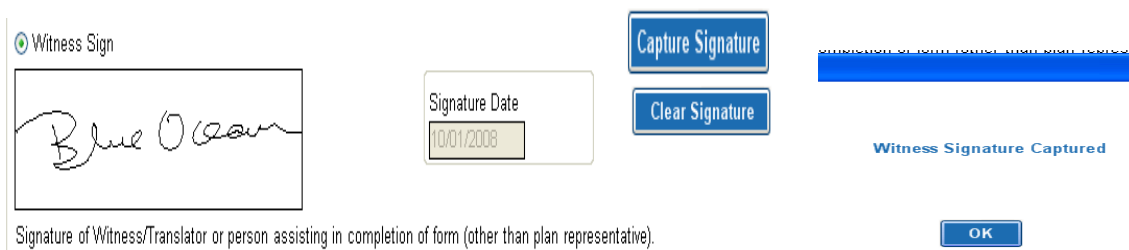
By clicking the **Witness/Translator Sign** radio button the Capture Client Signature and Clear Client Signature buttons change to **Capture Witness Signature** and **Clear Witness Signature**, respectively. The signature tablet is ready for the witness' signature.



If the witness does not like the appearance of their signature, they can try again after the signature on the tablet screen is cleared. The signature can be cleared in one of two ways:

- Tab clear on the signature pad
- The agent can click the clear witness signature button

Once the witness signature is captured, a **Witness Signature Captured** message will appear and the witness' **Signature Date** will automatically be entered into the field. Click on the **OK** button to close the message box.





You will now be prompted to enter the **Witness First Name**, **Witness Last Name** and **Relation to Applicant** in the fields under the witness' signature.

Witness/Translator Last Name:	Witness/Translator First Name:
<input type="text"/>	<input type="text"/>
Relation:	
<input type="text"/>	

If someone is acting as the **POA**, that person will sign in place of the member and their personal information will need to be entered in the fields at the bottom of the application.

### You as the agent are not the authorized representative

If you are the authorized legal representative, you must sign above and provide the following information.

Last Name:	First Name:	MI:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address1:	Address2:	
<input type="text"/>	<input type="text"/>	
City:	State:	Zip:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone:	Relation to Applicant:	
<input type="text"/>	<input type="text"/>	
GR:	BN:	
<input type="text"/>	<input type="text"/>	
Verifier	Verification #	<input type="radio"/> O/B <input type="radio"/> I/B <input type="radio"/> M/O
<input type="text"/>	<input type="text"/>	
Reason for not verifying		
<input type="text"/>		

When both signatures have been captured and the witness' information has been entered in the appropriate fields, you are ready to call for verification.

# Verification

Outbound verification is the only method available.

When completing an in home application:

- advise the member that Humana will be calling in a few days to complete the verification. Prepare member for call

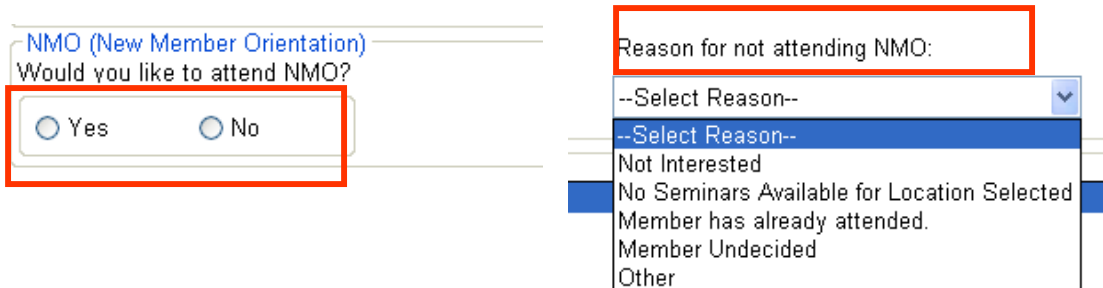
 O/B This default will automatically be selected

## New Member Orientation

New member orientation will go into more detail about "how" to use your plan and give valuable info on different programs that we have.

Select **Yes** or **No**. If no you must use the drop down and select a reason why.

This will write to the Smart Pad in CDS.



NMO (New Member Orientation)  
Would you like to attend NMO?

☒ Yes ☐ No

Reason for not attending NMO:

--Select Reason--  
--Select Reason--  
Not Interested  
No Seminars Available for Location Selected  
Member has already attended.  
Member Undecided  
Other

Selecting **Yes** will not enroll the member in an orientation class.

# Saving the Application

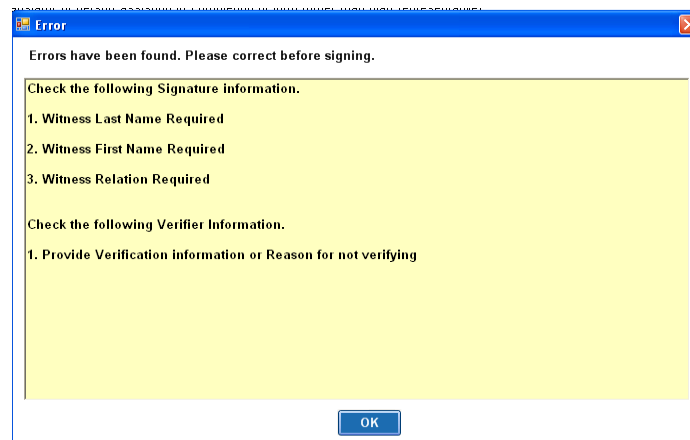
To ensure your application signature is **Saved**, you must hit the **Save and Close** button located at the bottom of the application.

If you click the **X** in the upper corner, the signature will not save.

Click on the **Save and Close** button to save the application.



If you make a mistake or forget something on the review and sign page you will see the error box showing what corrections need to be made.

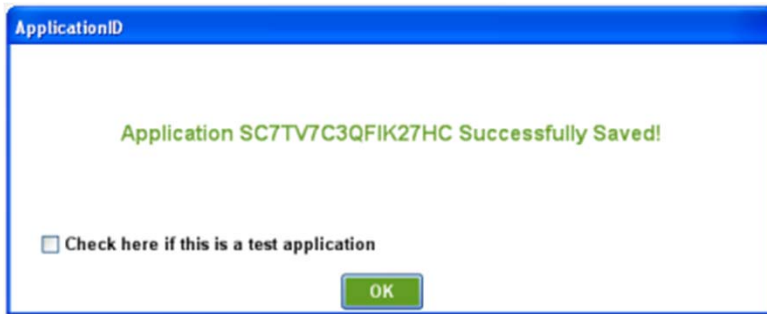


A message box will indicate the application has been saved.

Your application is now completed.  
Once you click **OK**, you will return to the MAPA Workbench.

# Saving the Application

A Test application box has been added to all applications.



ApplicationID

Application SC7TV7C3QFIK27HC Successfully Saved!

☐ Check here if this is a test application

OK

Check marking this box will keep the application from fully uploading

The Test application will appear in your application list until you complete an upload process at which time it will be removed

Type	Last Name	First Name	Address	City	State	Zip	Phone	Status
SOA	craker	cheese	1515 willow rd	louisville	KY	40299	(502) 266-6666	Complete
FSB	fields	william	1514 warlock street	louisville	KY	40299	(502) 225-3321	Complete
SOA	candy	hard	1515 west main	louisville	KY	40299	(502) 666-6696	Test
FSB	Spitman	Rugger	1515 dog lane	louisville	KY	40299	(502) 666-6666	Complete
FSB	Spitman	Rugger	1515 dog lane	louisville	KY	40299	(502) 666-6666	Complete

# Medicare Supplement Application

MAPA allows you to write an application for a **Single** person or a **Husband and Wife** at the same time

Application Type
Language

☒ English
☐ Spanish

Plan Type

☒ Humana
☐ CarePlus

☐ AEF
☐ Group
☐ Individual

☐ OSB
☐ Member Authorization

☐ SOA
☐ FSB
☐ REAL For Me

☒ Medicare Supplement

☒ Single
☐ Husband and Wife

This function has been disabled

Click **Create Blank App** for a new client

Contact Search

Search By:  Find:

Appt Time	Last Name	First Name	Address	City	State	Zip	Phone	
Jul 27 2009 1:00PM	DEW	BOBBY	2330 ORANGEWO...	DURHAM	NC	27705	(919)-383-5075	<input type="button" value="Enroll"/>
Jul 27 2009 4:00PM	MONEY	LOMA	632 PIPERS GAP RD	MOUNT AIRY	NC	27030	(336)-786-4622	<input type="button" value="Enroll"/>
Jul 27 2009 8:00AM	Test	Bear	110 Beal St.	Bardstown	KY	40004	(502)-348-367	<input type="button" value="Enroll"/>

If you create a blank application for a client that already exist in your system you **WILL** create a duplicate record.

Once **enrollment** type **selected** you will get the **Rate calculator** to see if the client is eligible.

**Rate Calculator**

Humana Insurance Company of Kentucky, 2432 Fortune Drive, Lexington, KY 40509

Zip Code:

County:

State:

Medical Insurance (Part B):

Effective Date:

Date of Birth:

Gender:
☐ Male
☒ Female

Available Plans:


# Medicare Supplement Application

**Note – not all states allow electronic submission. If Available Plans show no plans available your state does not allow electronic submission**

Other states will be activated for it as DOIs approve Humana's electronic enrollment process.

## How to start:

Enter the **zip code** and the **county** of the member

 **Rate Calculator**

IF Electronic applications have not been Approved in your state you will have no plan Data available

Humana Insurance Company of Kentucky, 2432 Fortune Drive, Lexington, KY 40509

Zip Code:

40299

County:

BULLITT, KY

State:

KY

Medical Insurance (Part B):

10/01/2011

Effective Date:

11/01/2011

Date of Birth:

10/02/1943

Gender:

☐ Male ☒ Female

Available Plans:

Humana Medicare Supplement Plan B

The effective date is usually the first of the following month. The effective date can be changed (up to 3 months out) (except WV which only allows enrollment month prior to effective date)

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

Are you applying for coverage during your Medicare Supplement Open Enrollment Period?

☒ Yes ☐ No

Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed acceptance?

☐ Yes ☒ No

All applicants must answer these questions, unless applying during a Medicare Supplement Open Enrollment Period or qualify for guaranteed acceptance.

Did you have Medicare coverage prior to age 65?

☐ Yes ☒ No

Have you used tobacco products within the last 12 months?

☐ Yes ☒ No

If your application is accepted, and you answered NO to both questions, you qualify for the Preferred rates.

Answer all the questions that are not greyed out. As questions are answered other questions will activate

Confidential and Proprietary to Humana Inc.  
Humana Internal Use only

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For Training Purposes Only. Not CMS Approved  
07/23/2012

# Medicare Supplement application

## New Questions added to Rate Calculator

- ✓ FL, KY, NH, PA, TN, WA, and WI will have the BMI questions displayed in the Medical Questions section ONLY and are ONLY enabled and required outside of open enrollment and guaranteed issue
- ✓ All other States (not mentioned above) will display in the Premium Determination Section and will ALWAYS be enabled and required.
- ✓ NOTE: The following states will NEVER display the BMI questions: CT, MA, NY, VT

 **Rate Calculator**

Humana Insurance Company of Kentucky, 2432 Fortune Drive, Lexington, KY 40509

Please list any prescription drugs (full medication name) you are currently taking or have taken within the past 12 months. If you are not currently taking nor have you taken any medications within the past 12 months please write NONE.

Note: RX file is required. if not medications type NONE

None

Height (ft)

Height (in)

Weight (lbs)

BMI

5

6

135

21.8

How to enter BMI:

- 1) Enter height in feet only
- 2) Enter height in inches only
- 3) Enter weight

BMI will automatically calculate

# Medicare Supplement application

Once your **Zip** and **Plan** are set :

**Fill out the questioner - depending on your answer to a question will depend on the next question you need to ask**

**Ex: if you say yes to the medical assistance through the State Medicaid program**

**You will need to answer the A and B – if you say no A and B will grey out and you will go to the next question**

OTHER COVERAGE INFORMATION	
Are you covered for medical assistance through the State Medicaid program?	<input type="radio"/> Yes <input type="radio"/> No
<b>(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)</b>	
(a) If yes, will Medicaid pay your premiums for this Medicare Supplement policy?	<input type="radio"/> Yes <input type="radio"/> No
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward Your Medicare Part B premium?	<input type="radio"/> Yes <input type="radio"/> No
If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.	<input type="radio"/> Yes <input type="radio"/> No
START	<input type="text" value="/01/"/>
END	<input type="text" value="/01/"/>
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	<input type="radio"/> Yes <input type="radio"/> No
(b) Was this your first time in this type of Medicare plan?	<input type="radio"/> Yes <input type="radio"/> No
(c) Did you drop a Medicare Supplement policy to enroll in the Medicare plan?	<input type="radio"/> Yes <input type="radio"/> No
Do you have another Medicare Supplement policy in force?	<input type="radio"/> Yes <input type="radio"/> No
(a) If so, with what company and what plan do you have?	<input type="text"/>
(b) If so, do you intend to replace your current Medicare Supplement policy with this policy?	<input type="radio"/> Yes <input type="radio"/> No
Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.)	<input type="radio"/> Yes <input type="radio"/> No
(a) If so, with what company and what kind of policy?	<input type="text"/>
(b) What are your dates of coverage under this policy? (If you are still covered under this policy, leave "END" blank.)	
START	<input type="text" value="/01/"/>
END	<input type="text" value="/01/"/>

A yes answer to this question will open this field



# Medicare Supplement application

Questioner completed : Click Calculate

This system will let you know if the **member is eligible or not**

The screenshot shows a web-based application form for Medicare Supplement. A blue modal window titled 'MAPA' is centered on the screen, displaying the message 'Sorry, You are not Eligible' in blue text. Below the message is an 'OK' button. The background form is partially visible, showing various medical conditions with 'Yes' and 'No' radio button options. Some of the visible conditions include Alzheimer's Disease, senile dementia, organic brain disorders, senility disorder, schizophrenia; other major depressive disorders; mental or nervous disorders; cirrhosis, alcoholism or drug abuse?; Acquired AIDS Related exposure (HIV) infection; Kidney disease requiring dialysis or diabetes requiring more than 50 units of insulin daily; Internal cancer, leukemia or melanoma?; Amputation caused by disease or trauma or neuralgic or poor circulation that has caused an ulcer on the skin? Do you have any paralytic conditions?; Rheumatoid arthritis, Paget's Disease; degenerative bone disease, crippling arthritis, vertebral or hip fractures/dislocations; spinal cord disorders/injuries?; and Organ transplantation?.

**Not Eligible** click OK and start over

**Eligible** to enroll – the system will give you the plan cost

**Cost to much** – go back to the top and select a new plan – calculate again

Once plan selected – click **Enroll**

The screenshot shows the same Medicare Supplement application form, but now it is displaying a list of medical conditions with 'Yes' and 'No' radio button options. The conditions are: Heart, Coronary or Carotid Artery Disease (not including high blood pressure); Peripheral Vascular Disease; Congestive Heart Failure or any other type of Heart Failure; Enlarged Heart; Stroke; Transient Ischemic Attacks (TIA); or Heart Rhythm Disorders?; Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other Chronic Pulmonary disorders? Have you used supplementary oxygen in the last year?; Parkinson's Disease; Multiple or Lateral Sclerosis; Huntington's Disease; Muscular Dystrophy; Lupus; Hepatitis; or Lou Gehrig Disease?; Alzheimer's Disease, senile dementia, organic brain disorders, senility disorder, schizophrenia; other major depressive disorders; mental or nervous disorders; cirrhosis, alcoholism or drug abuse?; Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection?; Kidney disease requiring dialysis or diabetes requiring more than 50 units of insulin daily?; Internal cancer, leukemia or melanoma?; Amputation caused by disease or trauma or neuralgic or poor circulation that has caused an ulcer on the skin? Do you have any paralytic conditions?; Rheumatoid arthritis, Paget's Disease; degenerative bone disease, crippling arthritis, vertebral or hip fractures/dislocations; spinal cord disorders/injuries?; and Organ transplantation?. Below the list of conditions, a red box highlights a message that says 'You are Eligible. Please click ENROLL to continue...'. Below this message, there is a field for 'Rate : Preferred' with the value '199.00'. At the bottom of the red box are three buttons: 'Cancel', 'Calculate', and 'Enroll'.

# Medicare Supplement Application

## Demographics

Demographics	Medicare Card	Other Coverage	Medical Questions	Payment	Agent Only	
<b>Client Information</b>						
Proposed Effective Date		Effective date pre-fills to change the data return to the Rate Calculator				
10/01/2007						
Last Name		MI	Name must appear as it is on Medicare Card			
Leaves		<input type="checkbox"/>				
First Name		Social Security Number		Re-enter SSN		
Autumn		101-11-1010 (Optional)		101-11-1010		
<b>Permanent Address</b>						
Address1		For validation purposes it is required to correctly enter the <b>Social Security Number</b> twice if the member provides you with it.				
1515 Leafy Lane						
Address2						City
						Louisville
State	Zip	County				
IN	47150	CLARK				
<b>Mailing Address (If different from Permanent Address)</b>						
Address1		If the same as permanent address leave blank – do not us N/A				
Address2		City				
State	Zip					
<b>Email Address (Optional)</b>						
		Never use your email address				
E-mail address, if available, will be used as a means to communicate only Humana information.						
Person to notify in case of emergency (nearest relative or friend)						
Last Name		Relationship to Applicant				
First Name		Phone				
		( ) _-_-				
<div>Close Save Next</div>						

When demographic info is completed click **NEXT**

# Medicare Supplement Application – Medicare Card

This section is requesting the client's **Medicare** information. Complete the individual's Medicare information for this section of the application as it appears on their card.

Demographics

Medicare Card

Other Coverage

Medical Questions

Payment

Agent Only

Medical Health Insurance

Last Name

Banks

First Name

George

MI

Gender

☒ Male ☐ Female

D.O.B

02/18/1921

Please complete the information below as it appears on your Medicare card

Medicare Claim Number

123456789a

Re-enter Medicare Card Number

123456789a

Phone

( ) - -

Hospital Insurance (Part A)

02/01/1997

Medical Insurance (Part B)

01/01/1998

Take number from ID card

For validation purposes it is required to correctly enter the **Medicare number twice.**

Back

Close

Save

Next

When completed click Next

# Medicare Supplement Application – Other coverage

This information pre-fills from the RX calculator questioner.

You will only see this tab if you had to answer questions on the rate calculator –  
If your answer to “Are you enrolling during Open Enrollment” was **YES**  
you **will not get this page**.

**Note:** It is necessary to review this information with the member.

Demographics	Medicare Card	Other Coverage	Medical Questions	Payment	Agent Only
--------------	---------------	----------------	-------------------	---------	------------

**GUARANTEED ACCEPTANCE DETERMINATION**

Please answer the following questions to determine if you are eligible for guaranteed acceptance, to the best of your knowledge

Are you applying for coverage during your Medicare Open Enrollment period? If yes, you qualify for the Preferred rates. ☐ Yes ☒ No

Have you lost other health coverage which would qualify you for guaranteed acceptance? (NOTE: To be considered for guaranteed acceptance, Humana must receive your application, along with a copy of the termination notice you received from your prior insurer, within 63 days of termination of your prior coverage.) If yes, you qualify for the Preferred rates. ☐ Yes ☒ No

**OTHER COVERAGE INFORMATION**

**\*You do not need more than one Medicare Supplement policy.**

**\*If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.**

**\*You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.**

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.\* If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if required within 90 days of losing your employer or union-based group health plan.\*

**\*If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.**

**\*Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB).**

Back	Close	Save	Next
------	-------	------	------

# Medicare Supplement Application – Medical Questions

**This information pre-fills from the rate calculator questioner**

You will only see this tab if you had to answer questions on the rate calculator –  
If your answer to “Are you enrolling during Open Enrollment” was **YES**  
you **will not get this page**.

**Note:** It is necessary to review the medical questions with the member.

Demographics	Medicare Card	Other Coverage	Medical Questions	Payment	Agent Only
<p><b>YES OR NO ANSWERS WILL BE REQUIRED TO THE FOLLOWING QUESTIONS, TO THE BEST OF YOUR KNOWLEDGE unless you indicated that you are applying for coverage during your Medicare Open Enrollment period or qualify for guaranteed acceptance.</b></p>					
<p>In the last year, have you been hospitalized, confined to a nursing facility; or are you bedridden or confined to a wheelchair? <input type="radio"/> Yes <input checked="" type="radio"/> No</p>					
<p>In the past 90 days have you received Home Health care? <input type="radio"/> Yes <input checked="" type="radio"/> No</p>					
<p><b>Do you now have or within the last two years have you had or been advised by a physician that you need treatment or surgery for:</b></p>					
<p>Heart, Coronary or Carotid Artery Disease (not including high blood pressure); Peripheral Vascular Disease; Congestive Heart Failure or any other type of Heart Failure; Enlarged Heart; Stroke; Transient Ischemic Attacks (TIA); or Heart Rhythm Disorders? <input type="radio"/> Yes <input checked="" type="radio"/> No</p>					
<p>Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other Chronic Pulmonary disorders? Have you used supplementary oxygen in the last year? <input type="radio"/> Yes <input checked="" type="radio"/> No</p>					
<p>Parkinson's Disease; Multiple or Lateral Sclerosis; Huntington's Disease; Muscular Dystrophy; Lupus; Hepatitis; or Lou Gehrig Disease? <input type="radio"/> Yes <input checked="" type="radio"/> No</p>					
<p>Alzheimer's Disease, senile dementia, organic brain disorders, senility disorder, schizophrenia; other major depressive disorders; mental or nervous disorders; cirrhosis, alcoholism or drug abuse? <input type="radio"/> Yes <input checked="" type="radio"/> No</p>					
<p>Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection? <input type="radio"/> Yes <input checked="" type="radio"/> No</p>					
<p>Kidney disease requiring dialysis or diabetes requiring more than 50 units of insulin daily? <input type="radio"/> Yes <input checked="" type="radio"/> No</p>					
<p>Internal cancer, leukemia or melanoma? <input type="radio"/> Yes <input checked="" type="radio"/> No</p>					
<p>Amputation caused by disease or trauma or neuralgic or poor circulation that has caused an ulcer on the skin? Do you have any paralytic conditions? <input type="radio"/> Yes <input checked="" type="radio"/> No</p>					
<p>Rheumatoid arthritis, Paget's Disease; degenerative bone disease, crippling arthritis, vertebral or hip fractures/dislocations; spinal cord disorders/injuries? <input type="radio"/> Yes <input checked="" type="radio"/> No</p>					
<div><div>Back</div><div>Close</div><div>Save</div><div>Next</div></div>					

# Medicare Supplement Application – Payment

Your payment amount will pre-fill from the Rx Calculator –this rate can not be changed here.

Select how you would like to make the **initial payment** – complete any boxes that come up with that selection.

Select how you want to make the **future payments** – this may be different than the initial.

The screenshot shows the 'Payment' tab of a Medicare Supplement Application form. The form is divided into two main sections: 'Initial Payment' and 'Future Payment Options'.

**Initial Payment Section:**

- At the top, there is a tab bar with 'Demographics', 'Medicare Card', 'Other Coverage', 'Medical Questions', 'Payment', and 'Agent Only'. The 'Payment' tab is selected.
- Below the tabs, there is a yellow header 'Initial Payment'.
- A text box contains the number '139' and the instruction: 'In order for us to process your application you must submit your first month's premium.'
- Below this, a section titled 'Initial Payment' asks: 'Enter Initial Payment only if you are submitting more than your first month's premium.'
- A label 'Initial Payment \$' is followed by a text input box. A red arrow points to this box with a yellow callout: 'Do not enter a dollar amount in the initial payment Box unless paying over the monthly premium amount'.
- Below the input box are four radio button options: 'Visa', 'MasterCard', 'Discover', and 'Automatic Withdrawal'. Each option is accompanied by its respective logo. A red bracket groups these options.
- Below the radio buttons are two text input boxes labeled 'Card Number' and 'Expiration Date'. A red double-headed arrow points between these boxes, and a yellow callout says 'Fill in these boxes'.

**Future Payment Options Section:**

- A yellow header 'Future Payment Options' is at the top of this section.
- Below the header, a paragraph explains: 'You can pay your premium monthly by automatic bank withdrawal, credit card charge or coupon book. Choosing automatic bank withdrawal or credit card charge provides a \$2 discount on your monthly premium. Generally, automatic bank withdrawals and credit card charges are made the first week of each month.'
- Below this paragraph are four radio button options: 'Visa', 'MasterCard', 'Discover', and 'Automatic Withdrawal'. Each option is accompanied by its respective logo. A red bracket groups these options.
- Below the radio buttons are two radio button options: 'Checking' and 'Savings'. The 'Checking' option is selected.
- Below the radio buttons are three text input boxes: 'Depository Bank Name', 'Routing Number', and 'Account Number'. A red arrow points to the 'Routing Number' box with a yellow callout: 'The future payment option can be different than the initial'.
- Below the input boxes is a 'Clear Payment' button.
- At the bottom of the form, there is a blue bar with four buttons: 'Back', 'Save', 'Close', and 'Next'.

**ACH R/T Number Example:**

A yellow callout points to a sample ACH R/T number: '123456789'. The callout says: 'If your bank has a specific ACH R/T number, in addition to the check routing number, example shown below, please enter the ACH R/T number instead.'

The sample ACH R/T number is shown in a green box. Below it, the components are labeled: 'ABA Check Routing Number' (123456789), 'Account Number' (000123456789), 'Check Number' (1001), and 'ACH Routing/Transit Number' (123456789).

# Medicare Supplement Application – Agent Only

**Affinity Partner** – use the drop down arrow to select.

**Affinity partner Location** – only used if partner is Wal-Mart – would be store number.

**Referring Agent** – only used if this was a broker referral, must be added before app is signed.

**Source and Sub Source** – for CDS refers to where the lead came from.

**House Member** – use to determine head of house or spouse - for CDS use.

**Type and Sub Type** – use client and A.

**Campaign** – refers to the Affinity partner key code – this is located on your calendar activity if you down load this will pre fill – if using blank app you will need to take out the default and add the correct code.

**Company** – enter the name of an policies that will remain active once this plan becomes effective. If there is not one enter None.

**Type** – enter the type of plan that will remain in effect once this plan becomes effective

**Disposition** - the 3 tiered disposition resembles the new CDS version. In disposition 1 select the correct sold product . Then select reasons for enrolling under disposition 2 and 3.

**Products discussed** – Mark all products you talked about during your visit. This should match your Scope of Appointment.

Demographics	Medicare Card	Other Coverage	Medical Questions	Payment	Agent Only
<b>Office Use Only</b>					
Plan Representative Boston, Rebecca	REP # 1407608	Affinity Partner Benefit Protect	GR 231319		
Date 07/28/2009	Agency Market Point	Agency ID 611343508	Affinity Partner Location 	BN 044	
Agent Code A002	MGA Code 054	Referring Broker Name 	Referring Broker SAN 		
Campaign 0305046921					
All health insurance policies sold to the applicant which are still in force (if none, write NONE):					
Company 	Type 				
All health insurance policies sold to the applicant with in the past five years which are no longer in force (if none, write NONE)					
Company 	Type 				
Source 	Sub Source 	House Member 			
Type 	Sub Type 				
Disposition Sold - MedSupp	Disposition 2 Good Service	Disposition 3 Humana Reputation			
Products Discussed (Please select ALL that apply)					
<input checked="" type="checkbox"/> All <input type="checkbox"/> PDP <input type="checkbox"/> MA/MAPD <input type="checkbox"/> MedSupp <input type="checkbox"/> Other					

# Affinity Partners:

Office Use Only

Plan Representative:  Location:  REP #:

Date:

Referring Agent:  Agent #:  Affinity TID:

Attachments: ☐ AM001 ☐ AM002 ☐ AM006

Affinity Partner:

Use the drop down arrow to select the correct Partner – if no affinity partner, select None

Health Plan One  
Health Plan Services  
Healthy American  
Hershend Fam Entertainment  
Humana Guidance Center  
Indiana Farm Bureau  
Inspire  
Kelsey

Affinity Partner:

Affinity Partner Location:

[Search StoreID](#)

If the affinity partner is Wal mart the store number must be listed

If you don't know the Store ID:

- Click on the Search Store ID button
- Leave ID blank and click Search
- Enter State and City of the store

Was this Sale originated from a WalMart Store?

Store ID:

[Leave Store ID Blank](#)

Was this Sale originated from a WalMart Store?

State:

City:

If the affinity partner is a Humana Guidance Center the location must be entered

Affinity Partner:

Health Plan One  
Health Plan Services  
Healthy American  
Hershend Fam Entertainment  
Humana Guidance Center  
Indiana Farm Bureau  
Inspire

Affinity Partner:

Affinity Partner Location:

STOREID	ADDR1	CITY	STATE
10613	8648 Skillman Street	Dallas	TX
10615	2257 S 108th Street	West Allis	WI
10616	227 Willow Bend	Crystal	MN
10617	11316 Montgomery Road	Cincinnati	OH
10618	7666 Nob Hill Road	Tamarac	FL
10619	12100 E Colonial Dr	Orlando	FL
10620	215 Englewood Road, Suite A	Kansas City	MO
10621	3189 W Vine Street	Kissimmee	FL
10622	7945 S Harlem	Burbank	IL
10623	5943 E McKellips Rd Ste 106	Mesa	AZ
10624	8975 W Charleston Blvd	Las Vegas	NV
10626	7915 N Hale Ave	Peoria	IL
10627	7400 Gall Blvd	Zephyrhills	FL
17673	1000 N Green Valley Parkway, Suite 720	Las Vegas	NV
17674	2025 W. Henderson	Columbus	OH
17693	1915 SNOW ROAD	PARMA	OH
17694	4438 Western Avenue	Knoxville	TN
10614	711 W. Wheatland Road	Duncanville	TX
10625	1000 N Green Valley Parkway, Suite 720	Henderson	NV



# Medicare Supplement Application – Agent Only

Once the Agent only tab is completed click **Save** then **Review and Sign**.


Demographics	Medicare Card	Other Coverage	Medical Questions	Payment	Agent Only
<b>Office Use Only</b>					
Plan Representative		REP #	Affinity Partner		GR
Boston, Rebecca		1407608	NONE		231319
Date	Agency	Agency ID	Affinity Partner Location		BN
07/28/2009	Market Point	611343508			044
Agent Code	MGA Code	Referring Broker Name	Referring Broker SAN		
A002	054				
Campaign					
0305046921					
All health insurance policies sold to the applicant which are still in force (if none, write NONE):					
Company		Type			
none					
All health insurance policies sold to the applicant with in the past five years which are no longer in force (if none, write NONE)					
Company		Type			
none					
Source	Sub Source	House Member			
Referral - General	Client Referral	Head			
Type	Sub Type				
Client	A				
Disposition	Disposition 2	Disposition 3			
Sold - MedSupp	Good Service	Humana Reputation			
<div>BackCloseSaveReview and Sign</div>					

If there are any errors in the application you will receive the error page showing the mistakes marked in **red** to be fixed.

# Medicare Supplement Application- Review

Review the application for accuracy. If there is something wrong on the application click **Return to Application** – this will take you back to the tabbed section to make Changes.

No problems with the application click **Next**.

 **Review**

[Return to Application](#) [Next](#)

Client Information

Proposed Effective Date

10/01/2007

Last Name

Leaves

MI

First Name

Autumn

Social Security Number

101-11-1010 (Optional)

Re-enter SSN

101-11-1010

Permanent Address

Address1

1515 Leafy Lane

Address2

City

Louisville

State

IN

Zip

47150

County

CLARK

Mailing Address (If different from Permanent Address)

Address1

Address2

City

State

Zip

I understand that if my application is not submitted during an Open Enrollment or guaranteed issue period, Humana has the right to reject my application and any premiums paid will be refunded. I also understand that this policy will not pay benefits for stays beginning or medical expenses incurred during the first three months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within six months prior to the insurance effective date. Coverage is not limited if you enroll during an Open Enrollment or guaranteed issue period or satisfy the credible coverage requirements.


Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement may be subject to prosecution for fraud.

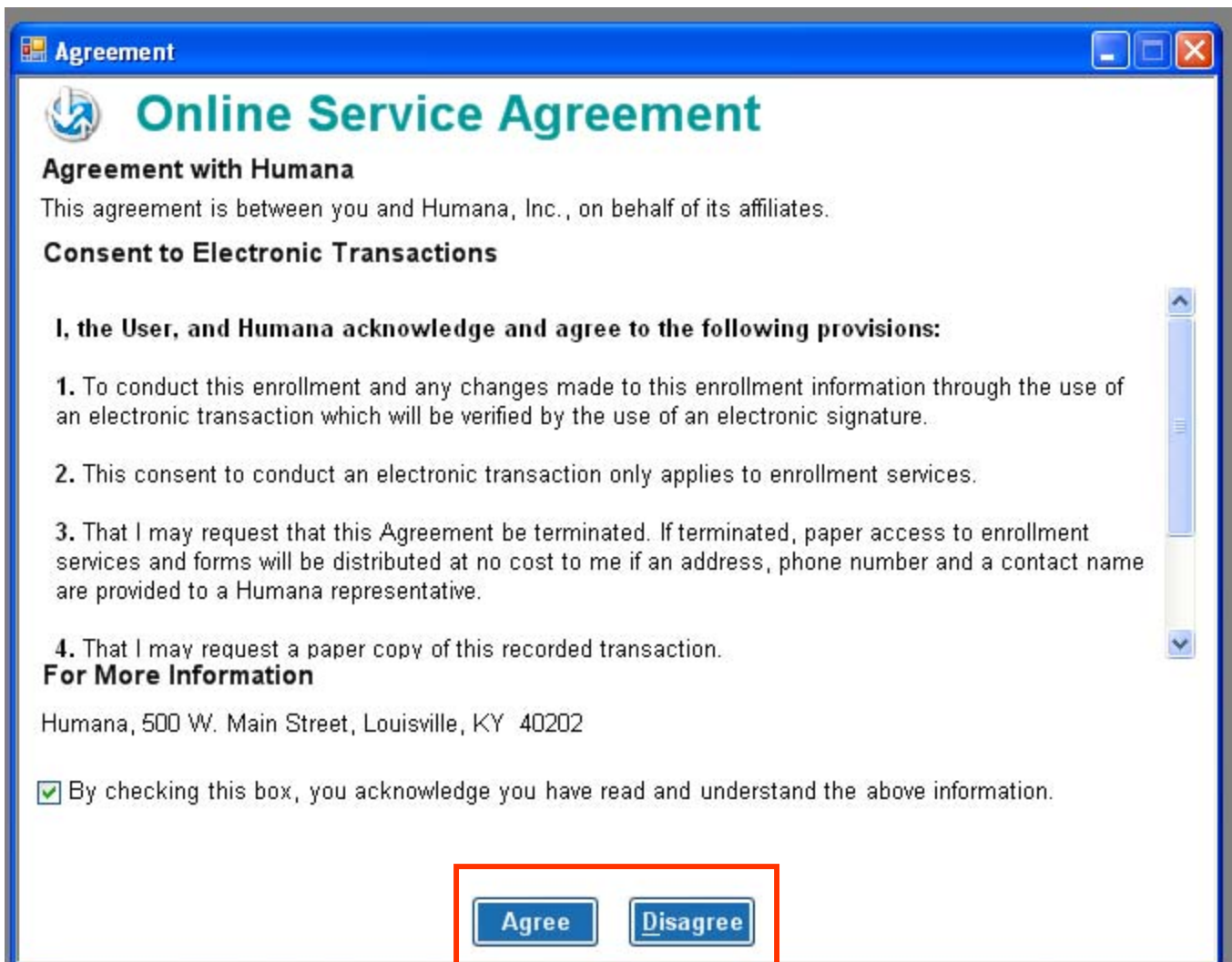
The undersigned applicant certifies that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy. The applicant further acknowledges receipt of the currently available Outline of Coverage and the "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" publication.

I have read and understand the statements above.

[Return to Application](#) [Next](#)

# Medicare Supplement Application Service Agreement

You must read the agreement to the member and have them  
Place a  in the box - then click **Next**



The screenshot shows a web browser window titled "Agreement". The main heading is "Online Service Agreement" in green. Below it is "Agreement with Humana". The text states: "This agreement is between you and Humana, Inc., on behalf of its affiliates." followed by "Consent to Electronic Transactions". A list of four provisions follows, starting with "I, the User, and Humana acknowledge and agree to the following provisions:". The provisions cover electronic transactions, consent scope, termination, and paper copy requests. Below the list is "For More Information" with Humana's address. A checkbox is checked, with the text "By checking this box, you acknowledge you have read and understand the above information." At the bottom, two buttons "Agree" and "Disagree" are highlighted with a red rectangle.

**Online Service Agreement**

**Agreement with Humana**

This agreement is between you and Humana, Inc., on behalf of its affiliates.

**Consent to Electronic Transactions**

**I, the User, and Humana acknowledge and agree to the following provisions:**

1. To conduct this enrollment and any changes made to this enrollment information through the use of an electronic transaction which will be verified by the use of an electronic signature.
2. This consent to conduct an electronic transaction only applies to enrollment services.
3. That I may request that this Agreement be terminated. If terminated, paper access to enrollment services and forms will be distributed at no cost to me if an address, phone number and a contact name are provided to a Humana representative.
4. That I may request a paper copy of this recorded transaction.

**For More Information**

Humana, 500 W. Main Street, Louisville, KY 40202

☒ By checking this box, you acknowledge you have read and understand the above information.

**Agree** **Disagree**

Ask the member if they **Agree** or **Disagree** to the service agreement  
Click the appropriate box

**Note:** if the member disagrees you will need to start over with a paper application

# Capturing Signatures: Client

After your client, or someone acting as the Power Of Attorney (POA) for the client, has read and understood the summary of the selected plan, obtain a signature

**Click in the circle next to Client Sign to activate the signature pad**

**You have completed and reviewed the following applications and/or forms:**

- Reviewed and acknowledged
- Notice of Replacement Form - **Not Applicable**
- Total Monthly Medicare Supplement Premium - **\$231**

Click here to activate the signature pad

Once you click OK on capture client signature the signature date will populate

Signature  
Signature of applicant or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc)

☒ Client Sign

☐ Witness Sign

Signature Date  
10/01/2008

Capture Signature

Signature Date

Clear Signature

Signature of Witness/Translator or person assisting in completion of application

Witness/Translator Last Name:

Relation:

Client Signature Captured

OK

**Note:** If the digital signature pad fails to capture the signature, complete a paper application and contact CSS for a replacement Signature pad.

Put the signature tablet in a position where the **client** can comfortably sign on the tablet screen. The tablet screen will light-up and your client can sign on the tablet using the attached stylus.

CLEAR OK

X \_ \_ \_ \_ \_

# Capturing Signatures: Client

As your client signs on the dotted line, his/her signature will appear in the **Signature** window on the laptop screen.

If the client does not like the appearance of their signature, they can try again after the signature on the tablet screen is cleared.

The signature can be cleared in one of two ways:

Clear Signature

- ☐ The client can tap on **CLEAR** on the tablet, or
- The agent can click on the **Clear Client Signature** button on the laptop

When the client is satisfied with their signature, the signature can be captured in one of two ways:

Capture Signature

- ☐ The client can tap on **OK** on the tablet, or
- ☐ The agent can click on the **Capture Client Signature** button on the laptop screen.

Once the signature is captured, a **Client Signature Captured** message will appear and the client's **Signature Date** will automatically be entered into the field. Click on the **OK** button to go to the next step.

The screenshot displays a software interface for capturing a signature. At the top, a label 'Signature' is followed by the instruction 'Signature of applicant or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc)'. Below this, a 'Client Sign' icon is positioned next to a rectangular box containing a handwritten signature. To the right of the signature box, there is a 'Signature Date' field with the date '10/01/2008' entered. A 'Capture Signature' button is located to the right of the date field. Below these elements, a large rectangular box contains the text 'Client Signature Captured' in blue. At the bottom of this box is an 'OK' button.

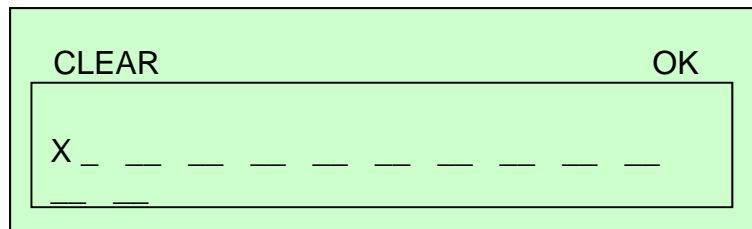
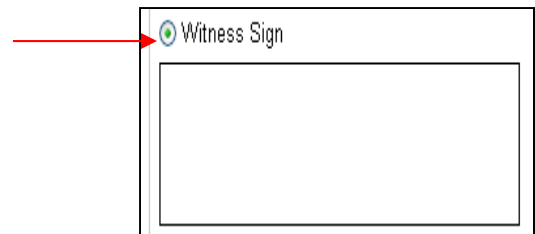
**Sales agents are not permitted to sign the enrollee's name for them!! This is the equivalent to forging their signature.**

# Capturing Signatures: Witness

Usually, a witness signature will not be necessary for the application. Some situations where a witness signature would be captured are when:

- The applicant wishes for someone else (family member, friend) to sign the application as a witness
- The applicant cannot physically completely sign their name (i.e., they sign an 'X' on the tablet)

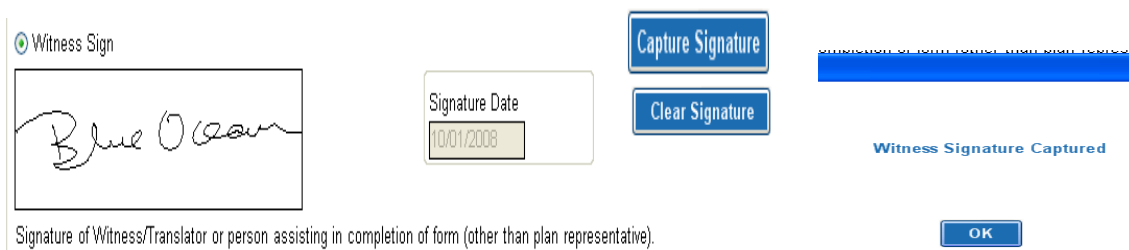
By clicking the **Witness/Translator Sign** radio button the Capture Client Signature and Clear Client Signature buttons change to **Capture Witness Signature** and **Clear Witness Signature**, respectively. The signature tablet is ready for the witness' signature.



If the witness does not like the appearance of their signature, they can try again after the signature on the tablet screen is cleared. The signature can be cleared in one of two ways:

- Tab clear on the signature pad
- The agent can click the clear witness signature button

Once the witness signature is captured, a **Witness Signature Captured** message will appear and the witness' **Signature Date** will automatically be entered into the field. Click on the **OK** button to close the message box.



# Capturing Signatures: Witness

You will now be prompted to enter the **Witness First Name**, **Witness Last Name** and **Relation to Applicant** in the fields under the witness' signature.

Witness/Translator Last Name:	Witness/Translator First Name:
<input type="text"/>	<input type="text"/>
Relation:	
<input type="text"/>	

If someone is acting as the **POA**, that person will sign in place of the member and their personal information will need to be entered in the fields at the bottom of the application.

## You as the agent are not the authorized representative

If you are the authorized legal representative, you must sign above and provide the following information.

Last Name:	First Name:	MI:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address1:	Address2:	
<input type="text"/>	<input type="text"/>	
City:	State:	Zip:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone:	Relation to Applicant:	
<input type="text"/>	<input type="text"/>	
GR:	BN:	
<input type="text"/>	<input type="text"/>	
Verifier	Verification #	<input type="radio"/> O/B <input type="radio"/> I/B <input type="radio"/> M/O
<input type="text"/>	<input type="text"/>	
Reason for not verifying	<input type="text"/>	
<input type="text"/>		

# New Member Orientation

New member orientation will go into more detail about "how" to use your plan and give valuable info on different programs that we have.

Select **Yes** or **No**. If no you must use the drop down and select a reason why.

This will write to the Smart Pad in CDS.

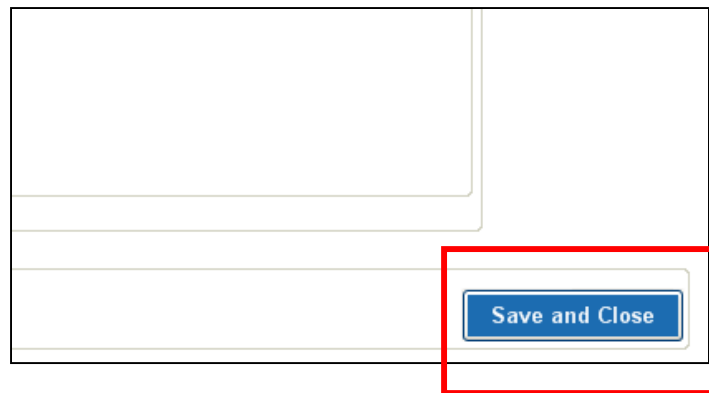
NMO (New Member Orientation) Would you like to attend NMO?	Reason for not attending NMO:
<input type="radio"/> Yes <input type="radio"/> No	--Select Reason-- --Select Reason-- Not Interested No Seminars Available for Location Selected Member has already attended. Member Undecided Other

# Saving the Application

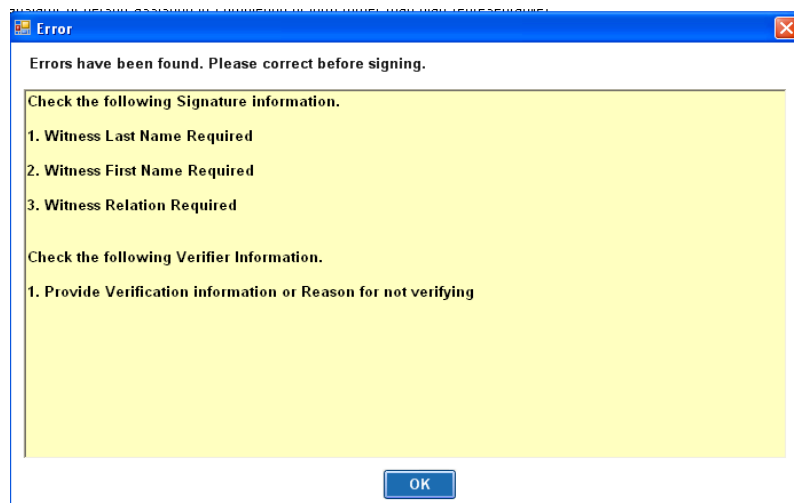
To ensure your application signature is **Saved**, you must hit the **Save and Close** button located at the bottom of the application.

If you click the **X** in the upper corner, the signature will not save.

Click on the **Save and Close** button to save the application.



If you make a mistake or forget something on the review and sign page you will see the error box showing what corrections need to be made.



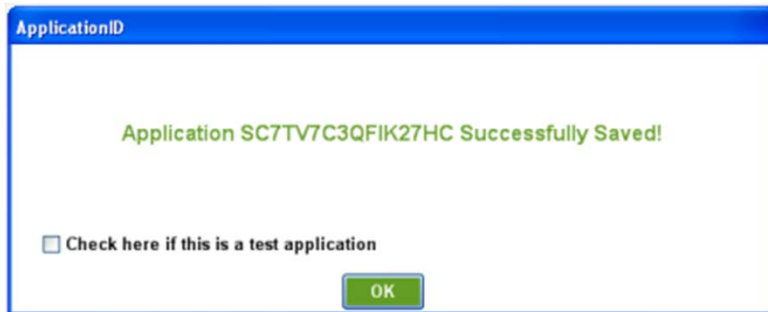
A message box will indicate the application has been saved.

Your application is now completed.  
Once you click **OK**, you will return to the MAPA Workbench.



# Saving the Application

A Test application box has been added to all applications.



Check marking this box will keep the application from fully uploading

The Test application will appear in your application list until you complete an upload process at which time it will be removed

Type	Last Name	First Name	Address	City	State	Zip	Phone	Status
SOA	craker	cheese	1515 willow rd	louisville	KY	40299	(502) 266-6666	Complete
FSB	fields	william	1514 warlock street	louisville	KY	40299	(502) 225-3321	Complete
SOA	candy	hard	1515 west main	louisville	KY	40299	(502) 666-6696	Test
FSB	Spitman	Rugger	1515 dog lane	louisville	KY	40299	(502) 666-6666	Complete
FSB	Spitman	Rugger	1515 dog lane	louisville	KY	40299	(502) 666-6666	Complete

# Group Application - Demographic Tab

Complete the client's **Demographic** information for this section of the application. Some fields will not allow data entry; the data is tied to choices made during the process and can not be changed.

Enter the **Zip Code** – this will activate the County field.

Using the drop down, select the **County** – this will activate the Available Plans.

Using the drop down in **Available Plans** – this will activate the category Enrollee

Use the drop down to select the correct enrollee

**Preferred method of Communications** - This is how the member prefers the **agent** to **contact** them. This will write to the **Keywords** box in **CDS**

The screenshot shows the 'MAPA Group Application' interface with the 'Demographics' tab selected. The form is divided into several sections: 'Client Information', 'Preferred Method of Communication', and 'Person to notify in case of emergency'. Annotations in yellow boxes provide specific instructions: 'You will need to select the group and the category of Enrollee' points to the 'Available Plans' and 'Category of Enrollee' dropdowns; 'The residential address must be a physical address NO PO BOX' points to the 'Address 1' field; 'Do not use N/A or see above in mailing address – leave blank if the same as street address' points to the 'Address 2 / APT #' field. The form includes fields for Zip Code, County, Employer or Union Name, Available Plans, Last Name, First Name, Address 1, Address 2 / APT #, City, State, Zip, Email Address (Optional), and Preferred Method of Communication (Telephone, Email, Mail). There are also fields for emergency contact information.

**MAPA Group Application**

**Demographics** Medicare Card Plan Specific Payment Agent Only

**Client Information**

Zip Code: 40291 County: BULLITT, KY DOB: 01/01/1921

Employer or Union Name: COPPERWELD VEBA

Available Plans: Copperweld Veba GPFFS 078/065

Last Name: McPhearson

Address 1: 1212 Green GOD Way

State: KY Zip: 40291

Category of Enrollee: Medicare Eligible Retiree

First Name: Flubber MI

Address 2 / APT #:

City: State: Zip:

Email Address (Optional):

Email Address, If available, will be used as a means to communicate various Hum

**Preferred Method of Communication**

☐ Telephone ☐ Email ☒ Mail

Person to notify in case of emergency (nearest relative or friend) - (Optional)

Last Name: First Name: MI

Relationship To Applicant: Phone: (###) ###-####

**Annotations:**

- You will need to select the group and the category of Enrollee
- The residential address must be a physical address NO PO BOX
- Do not use N/A or see above in mailing address – leave blank if the same as street address

**Buttons:** Back Close Save Next

# Medicare Card Tab: Group Application

This section requires the client's **Medicare** information. Complete the individual's Medicare information as it appears on the Medicare card. Some fields will not allow data entry unless their section requires information.

If the client does not have Medicaid, you would leave the choice as 'No'. You would not be able to enter information into the Medicaid # box unless you selected 'Yes' as the answer to the Medicaid question.

**Note:** For nursing home, if yes, **Date** refers to the date the client entered the facility.

**Demographics** **Medicare Card** Plan Specific Payment Agent Only

**Medicare Health Insurance**

Last Name:  First Name:  M.I.:

Please complete the information to the right exactly as it appears on your Medicare card.

Please contact Humana at 1-800-833-2367 (TDD 1-877-833-4486) if you need information in another format or language than what is listed below. Our office hours are 8a.m. to 8p.m. local time, seven days a week.

Medicare Claim Number:  Re-Enter Medicare Claim:

Sex: ☐ Male ☐ Female

Effective Date:  Hospital Insurance (Part A)  Medical Insurance (Part B)

**The name must match the Medicare card exactly**

**Medicare Claim Number is required. It is entered twice for validation.**

Iowa State University GPDP 037/104- not OE

Contract Number:  PBP:  E:

Language Preferences:

Are you currently enrolled in your state Medicaid program? ☐ Yes ☐ No

If Yes, Medicaid #:

Medicaid Effective Date:

Are you currently a resident in a nursing home or other long-term care facility? ☐ Yes ☐ No

If Yes, complete the following:

Date Entered:  Name of Facility:

Address 1:  Address 2:

City:  State:  Zip:  Phone ###-###-####:

**If you answer yes to any question you must provide any information requested in order to complete the Application.**

**Back** **Close** **Save** **Next**

Note – the language preference will write to the Smart Pad in CDS.

- the part A and B dates, Medicare effective date will write to the Benefits tab under policies.

# Plan Specific Tab: Group Application

This section is requesting information for the particular **plan** the client has selected.

With the numerous plans, the specific options for each will look different on the screen.

For example, the **PDP** form to the right asks if the client has prescription drug coverage. You would not be able to enter Carrier information unless you selected 'Yes' as the answer to the question.

The **PPO** plan to the left will ask about group health coverage, end-stage renal disease and additional prescription drug coverage.

Again, changes to future plans will cause this section to change as needed.

If you say **YES** to any question you must provide the additional information

# Payment Tab – Group Application

*If the plan you selected does not have a premium amount the tab will not open.*

This section is requesting information on how plan **payments** will be handled. Select the appropriate **Payment Option** and continue to the next section.

Medicare Card  Plan Specific **Payment** Agent Only

Monthly Premium  
Your Monthly Payment for your Humana Plan will be no more than:

This amount will NOT reflect any penalty or assistance the member may receive.

**Please select a premium payment option.** You can pay your monthly plan premium and/or late enrollment penalty by mail using a Coupon Book, Electronic Funds Transfer, or Automatic Credit Card Charge. You can also choose to pay your premium and/or late enrollment penalty by automatic deduction from your Social Security Check each month. If you qualify for extra help with your Medicare prescription plan coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

**Payment Options**

☐ SSA

☐ Coupon Book

Credit Card Name

☐ Visa ☐ MasterCard ☐ Discover

Card Number  Expiration Date

☐ Automatic Withdrawal

Bank Name  Routing Number  Account Number

**Account Type**

☐ Checking ☐ Savings

**Social Security**

Automatic deduction from your monthly Social Security benefit deduction may take two or more months to begin. In most cases Social Security benefit check will include all premiums from your to the point withholding begins.)

**Example Check:**

Your Name  
1234 Oak  
Anytown, USA

1001

20

PAY TO THE ORDER OF \$

DOLLARS

ACH R/T 123456789

FOR

123456789 000123456789 1001

ABA Check Routing Number 123456789 Account Number 000123456789 Check Number 1001 ACH Routing/Transit Number 123456789

**Buttons:** Back Close Save Next

# Agent Only Tab: Group Application

**Affinity Partner** – always select None.

**Affinity Partner Location** – not used for a group application.

**Referring Agent** – not used for group applications

**Source and Sub Source** – for CDS refers to where the lead came from.

**House Member** – use to determine head of house or spouse - for CDS use.

**Type and Sub Type** – use client and A.

**Disposition** - the 3 tiered disposition resembles the new CDS version. In disposition 1 select the correct sold product . Then select reasons for enrolling under disposition 2 and 3.

**Enrollment reason** – defaults to SEP – reason Group

**Campaign** – refers to the Affinity partner key code – this is located on your calendar activity if you down load this will pre fill – if using blank app you will need to take out the default and add the correct code.

**Proposed effective date** – defaults to the first of the following month you are in. You can change the date to reflect no more then 3 moths out.

**Presenter** – who was at the appointment with you

Demographics	Medicare Card	Plan Specific	Payment	Agent Only
Office Use Only				
Plan Representative Boston, Rebecca	Location	REP # 1407608	Affinity Partner NONE	
Date 07/28/2009		Affinity TID -	Affinity Affinity partner should always be none	
Referring Agent	Agent #	Campaign 0305046921		
Attachments <input type="checkbox"/> AM001 <input type="checkbox"/> AM002 <input type="checkbox"/> AM006				
GR 237927	BN 001			
Presenter				
<input checked="" type="radio"/> No Presenter Means only Humana agent present				
<input type="radio"/> Humana Presenter Means agent and a Humana Plan Representative were present				
<input type="radio"/> Non-Humana Presenter Means a non Humana presented product with agent present				
Source	Sub Source	House Member		
Type	Sub Type	2 dispositions are required – not all will use The 3rd one		
Disposition --Select A Disposition--	Disposition 2 Disposition not available	Disposition 3 Disposition not available		
<input type="radio"/> ICEP <input type="radio"/> IEP <input checked="" type="radio"/> SEP <input type="radio"/> AEP <input type="radio"/> OEPI SEP REASON CODE: GRP				Proposed Effective Date 11/01/2010

# Affinity Partners:

Office Use Only

Plan Representative:  Location:  REP #:

Date:

Referring Agent:  Agent #:  Affinity TID:

Attachments: ☐ AM001 ☐ AM002 ☐ AM006

Affinity Partner:

Use the drop down arrow to select the correct Partner – if no affinity partner, select None

Health Plan One  
Health Plan Services  
Healthy American  
Hershend Fam Entertainment  
Humana Guidance Center  
Indiana Farm Bureau  
Inspire  
Kelsey

Affinity Partner:

Affinity Partner Location:

[Search StoreID](#)

If the affinity partner is Wal mart the store number must be listed

If you don't know the Store ID:

- Click on the Search Store ID button
- Leave ID blank and click Search
- Enter State and City of the store

Was this Sale originated from a WalMart Store?

Store ID:

[Leave Store ID Blank](#)

Was this Sale originated from a WalMart Store?

State:

City:

If the affinity partner is a Humana Guidance Center the location must be entered

Affinity Partner:

Health Plan One  
Health Plan Services  
Healthy American  
Hershend Fam Entertainment  
Humana Guidance Center  
Indiana Farm Bureau  
Inspire

Affinity Partner:

Affinity Partner Location:

STOREID	ADDR1	CITY	STATE
10613	8648 Skillman Street	Dallas	TX
10615	2257 S 108th Street	West Allis	WI
10616	227 Willow Bend	Crystal	MN
10617	11316 Montgomery Road	Cincinnati	OH
10618	7666 Nob Hill Road	Tamarac	FL
10619	12100 E Colonial Dr	Orlando	FL
10620	215 Englewood Road, Suite A	Kansas City	MO
10621	3189 W Vine Street	Kissimmee	FL
10622	7945 S Harlem	Burbank	IL
10623	5943 E McKellips Rd Ste 106	Mesa	AZ
10624	8975 W Charleston Blvd	Las Vegas	NV
10626	7915 N Hale Ave	Peoria	IL
10627	7400 Gall Blvd	Zephyrhills	FL
17673	1000 N Green Valley Parkway, Suite 720	Las Vegas	NV
17674	2025 W. Henderson	Columbus	OH
17693	1915 SNOW ROAD	PARMA	OH
17694	4438 Western Avenue	Knoxville	TN
10614	711 W. Wheatland Road	Duncanville	TX
10625	1000 N Green Valley Parkway, Suite 720	Henderson	NV

# Service Agreement – Group Application

- The online service agreement must be read by or read to the member.
- This states they understand everything is being completed electronically. They agree to the terms and conditions.

**If the member does not agree to the Service Agreement you must complete a paper application.**

The screenshot shows a web browser window titled "Agreement". The main heading is "Online Service Agreement" in green. Below it, the subheading is "Agreement with Humana". The text states: "This agreement is between you and Humana, Inc., on behalf of its affiliates." followed by "Consent to Electronic Transactions". A list of six provisions follows, detailing the user's consent to electronic transactions and the ability to request a paper copy or termination. Below the provisions, under "For More Information", is the address: "Humana, 500 W. Main Street, Louisville, KY 40201". At the bottom, there is a checkbox with the text "By checking this box, you acknowledge you have read and understand the above information." and two buttons: "Agree" and "Disagree". A yellow callout box with a red border contains the text "Have the member put a check in the box and Then click AGREE". Red arrows point from this callout box to the checkbox and the "Agree" button.

**Online Service Agreement**

**Agreement with Humana**

This agreement is between you and Humana, Inc., on behalf of its affiliates.

**Consent to Electronic Transactions**

I, the User, and Humana acknowledge and agree to the following provisions:

1. To conduct this enrollment and any changes made to this enrollment information through the use of an electronic transaction which will be verified by the use of an electronic signature.
2. This consent to conduct an electronic transaction only applies to enrollment services.
3. That I may request that this Agreement be terminated. If terminated, paper access to enrollment services and forms will be distributed at no cost to me if an address, phone number and a contact name are provided to a Humana representative.
4. That I may request a paper copy of this recorded transaction.
5. To be bound by this agreement as stated by law throughout the term of this Agreement.
6. This agreement may be modified at any time if Humana provides notice.

**For More Information**  
Humana, 500 W. Main Street, Louisville, KY 40201

☐ By checking this box, you acknowledge you have read and understand the above information.

**Agree** **Disagree**

Have the member put a check in the box and Then click AGREE

Once the agreement is completed, you will be taken to the **Review and Sign** page.



# Application Review: Group Application

When the program recognizes that the pad is connected to the laptop, the program will then display a **Summary** page listing all the information that has been entered on the application. Scroll through the application and review the accuracy of the information with the client.

**You are reviewing the application for spelling errors and incorrect information**

**If an error is found, click return to application to correct**

## Group Application Review and Sign

<b>Client Information</b>		<b>Date Of Birth</b>	
Zip Code	County	01/01/1923	
40299	BULLITT,KY		
<b>Available Plans</b>		<b>Category of Enrollee</b>	
HumanaChoicePPO R5826-008		Medicare Eligible Retiree	
<b>Last Name</b>		<b>First Name</b>	<b>MI</b>
McPherson		Flubber	
<b>Address 1</b> <b>NO PO Box in the address</b>			
1515 SlimeWay			
<b>City</b>	<b>State</b>	<b>Zip</b>	<b>County</b>
Louisville	KY	40299	BULLITT,KY
<b>Mailing Address (if different from Street Address)</b>		<b>Phone</b>	
<b>Address 1</b>		(656) 555-5555 (###) ###-####	
<b>City</b>		<b>Address 2 APT #</b>	
<b>State</b>		<b>Zip</b>	
<b>Email Address, If available, will be used as a means to communicate various Humana related information (Optional)</b>			
<b>Email Address (Optional)</b>			
<b>Preferred Method of Communication</b>			
<input type="radio"/> Telephone <input type="radio"/> Email <input checked="" type="radio"/> Mail			
<b>Person to notify in case of emergency (nearest relative or friend) - (Optional)</b>			
<b>Last Name</b>		<b>First Name</b>	<b>MI</b>
MCMiller		Budha	
<b>Relationship To Applicant</b>		<b>Phone</b>	
daughter		(502) 888-8888 (###) ###-####	

Application Review continued on next page...

# Application Review – Group Application

The system has already scanned the application to ensure it was complete.

Medicare Health Insurance		
Last Name <input type="text" value="McPherson"/>	First Name <input type="text" value="Flubber"/>	M.I. <input type="text" value=""/>
<div>Please complete the information to the right exactly as it appears on your Medicare card.</div> <div>Please contact Humana at 1-800-833-2367 (TDD 1-877-833-4486) if you need information in another format or language than what is listed below. Our office hours are 8a.m. to 8p.m. local time, seven days a week.</div>	Medicare Claim Number <input type="text" value="123456789a"/>	Re-Enter Medicare Claim <a href="#">Check Medicare number</a> <input type="text" value="123456789a"/>
	Sex: <input checked="" type="radio"/> Male <input type="radio"/> Female	Effective Date: Hospital Insurance (Part A) <input type="text" value="01/01/1998"/>
		Medical Insurance (Part B) <input type="text" value="01/01/1998"/>
HumanaChoicePPO R5826-008		
Contract Number <input type="text" value="R5826"/>	PBP <input type="text" value="008"/>	Language Preferences <input type="text" value="English"/>
Are you currently enrolled in your state Medicaid program? <input type="radio"/> Yes <input checked="" type="radio"/> No		
If Yes, Medicaid # <input type="text" value=""/>		
Medicaid Effective Date <input type="text" value=""/>		
Are you currently a resident in a nursing home or other long-term care facility? <input type="radio"/> Yes <input checked="" type="radio"/> No		
If Yes, complete the following:		
Date Entered <input type="text" value=""/>	Name of Facility <input type="text" value=""/>	
Address 1 <input type="text" value=""/>		Address 2 <input type="text" value=""/>
City <input type="text" value=""/>	State <input type="text" value=""/>	Zip <input type="text" value=""/>
Phone ###.###.#### <input type="text" value=""/>		
<div><b>PLEASE READ THIS IMPORTANT INFORMATION</b></div> <div><b>You must read this to the member</b></div> <p>on health care benefits. If you have health coverage from an employer or union, joining you. If you have questions, visit their website, or contact their office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.</p> <p><b>By completing this enrollment form, I agree to the following:</b></p> <p><u>Humana ChoicePPO or Humana MyCare is</u> a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform Humana of any <u>prescription drug coverage that I have or may not in the future. I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may</u></p> <p><b>Release of Information:</b></p> <p>By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Humana will release my information (including prescription drug event data) to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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.</p> <p>I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), the signature certifies that <b>1)</b> this person is authorized under State law to complete this enrollment and <b>2)</b> documentation of this authority is available upon request by Humana or Medicare.</p> <p><b>I have Read and Understand the Statements Above.</b></p>		

# Capturing Signatures: Client

After your client, or someone acting as the Power Of Attorney (POA) for the client, has read and understood the summary of the selected plan, obtain a signature

**Click in the circle next to Client Sign to activate the signature pad**

The screenshot shows a web-based signature capture interface. At the top, it says "Signature" and "Signature of applicant or authorized legal representative (including valid Power of Attorney)". There are two radio buttons: "Client Sign" (selected) and "Witness Sign". A red arrow points to the "Client Sign" radio button with a yellow box containing the text "Click here to activate the signature pad". Below the radio buttons are two signature pads. The top pad shows a handwritten signature "Stanley Euer". To the right of the top pad is a "Signature Date" field showing "10/01/2008" and a "Capture Signature" button. Below the top pad is a "Signature Date" field with a date picker and a "Clear Signature" button. Below the bottom pad are fields for "Witness/Translator Last Name:" and "Relation:". A red arrow points from the "Capture Signature" button to a modal window titled "Signature" which displays "Client Signature Captured" and an "OK" button. A yellow box at the top right contains the text "Once you click OK on capture client signature the signature date will populate".

**Note:** If the digital signature pad fails to capture the signature, complete a paper application and contact CSS for a replacement Signature pad.

Put the signature tablet in a position where the **client** can comfortably sign on the tablet screen. The tablet screen will light-up and your client can sign on the tablet using the attached stylus.

The diagram shows a green rectangular signature tablet. At the top left is a "CLEAR" button and at the top right is an "OK" button. In the center is a large rectangular area with a dashed line and an "X" at the top left corner, indicating where the client should sign.

# Capturing Signatures: Client

As your client signs on the dotted line, his/her signature will appear in the **Signature** window on the laptop screen.

If the client does not like the appearance of their signature, they can try again after the signature on the tablet screen is cleared.

The signature can be cleared in one of two ways:

Clear Signature

- ☐ The client can tap on **CLEAR** on the tablet, or
- The agent can click on the **Clear Client Signature** button on the laptop

When the client is satisfied with their signature, the signature can be captured in one of two ways:

Capture Signature

- ☐ The client can tap on **OK** on the tablet, or
- ☐ The agent can click on the **Capture Client Signature** button on the laptop screen.

Once the signature is captured, a **Client Signature Captured** message will appear and the client's **Signature Date** will automatically be entered into the field. Click on the **OK** button to go to the next step.

The screenshot displays a software interface for capturing a signature. At the top, a label 'Signature' is followed by a descriptive text: 'Signature of applicant or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc)'. Below this, there is a 'Client Sign' button and a rectangular box containing a handwritten signature that reads 'Stanley River'. To the right of the signature box, there is a 'Signature Date' field with the date '10/01/2008' entered. A 'Capture Signature' button is positioned to the right of the date field. Below these elements, a separate window or modal is shown with a blue header bar. Inside this window, the text 'Client Signature Captured' is displayed in blue, and an 'OK' button is located at the bottom center.

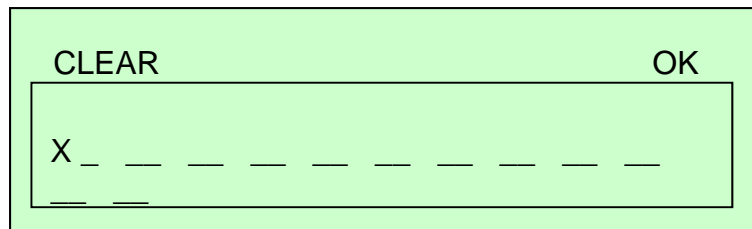
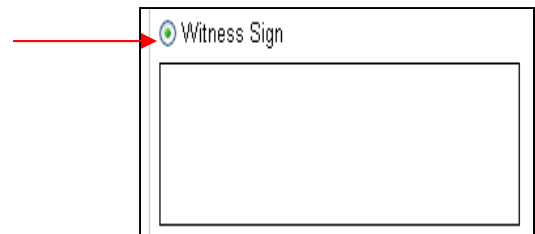
**Sales agents are not permitted to sign the enrollee's name for them!! This is the equivalent to forging their signature.**

# Capturing Signatures: Witness

Usually, a witness signature will not be necessary for the application. Some situations where a witness signature would be captured are when:

- The applicant wishes for someone else (family member, friend) to sign the application as a witness
- The applicant cannot physically completely sign their name (i.e., they sign an 'X' on the tablet)

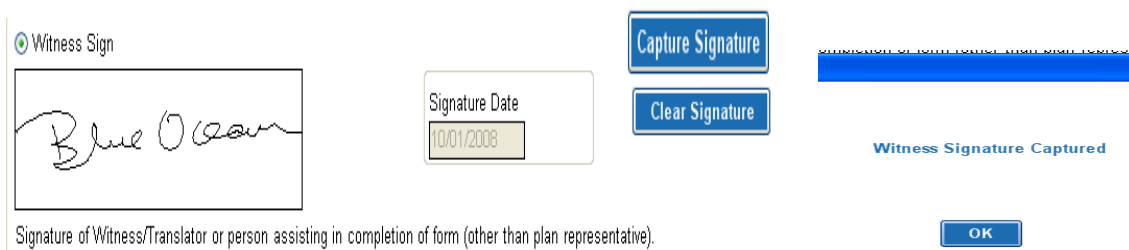
By clicking the **Witness/Translator Sign** radio button the Capture Client Signature and Clear Client Signature buttons change to **Capture Witness Signature** and **Clear Witness Signature**, respectively. The signature tablet is ready for the witness' signature.



If the witness does not like the appearance of their signature, they can try again after the signature on the tablet screen is cleared. The signature can be cleared in one of two ways:

- Tab clear on the signature pad
- The agent can click the clear witness signature button

Once the witness signature is captured, a **Witness Signature Captured** message will appear and the witness' **Signature Date** will automatically be entered into the field. Click on the **OK** button to close the message box.



You will now be prompted to enter the **Witness First Name**, **Witness Last Name** and **Relation to Applicant** in the fields under the witness' signature.

Witness/Translator Last Name: <input type="text"/>	Witness/Translator First Name: <input type="text"/>
Relation: <input type="text"/>	

If someone is acting as the **POA**, that person will sign in place of the member and their personal information will need to be entered in the fields at the bottom of the application.

### You as the agent are not the authorized representative

If you are the authorized legal representative, you must sign above and provide the following information.

Last Name: <input type="text"/>	First Name: <input type="text"/>	MI: <input type="text"/>
Address1: <input type="text"/>	Address2: <input type="text"/>	
City: <input type="text"/>	State: <input type="text"/>	Zip: <input type="text"/>
Phone: <input type="text"/>	Relation to Applicant: <input type="text"/>	
GR: <input type="text"/>	BN: <input type="text"/>	
Verifier <input type="text"/>	Verification # <input type="text"/>	<input checked="" type="radio"/> O/B <input type="radio"/> I/B <input type="radio"/> M/O
Reason for not verifying <input type="text"/>		

When both signatures have been captured and the witness' information has been entered in the appropriate fields, you are ready to call for verification.

## Verification

It is Humana policy to **complete a verification on all applications**.

Verification for a group application is done by mail the **M/O** option is automatically selected

<input type="radio"/> O/B	<input type="radio"/> I/B	<input checked="" type="radio"/> M/O
---------------------------	---------------------------	--------------------------------------

# New Member Orientation

New member orientation will go into more detail about "how" to use your plan and give valuable info on different programs that we have.

Select **Yes** or **No**. If no you must use the drop down and select a reason why. This will write to the Smart Pad in CDS.

NMO (New Member Orientation)  
Would you like to attend NMO?

☐ Yes ☐ No

Reason for not attending NMO:

--Select Reason--  
--Select Reason--  
Not Interested  
No Seminars Available for Location Selected  
Member has already attended.  
Member Undecided  
Other

Selecting **Yes will not enroll the member** in an orientation class.

## Materials Used

Select all the materials that you used during your Appointment. This information will write to the Smart Pad in CDS

Materials Used

☒ MAPD Power Point Presentation  
☐ MA Power Point Presentation  
☐ PDP Power Point Presentation  
☒ Summary of Benefits  
☐ Value Added Services  
☐ Benefit and Provider Leaflet  
☐ Compensation sheet  
☒ Right Source

# Saving the Application

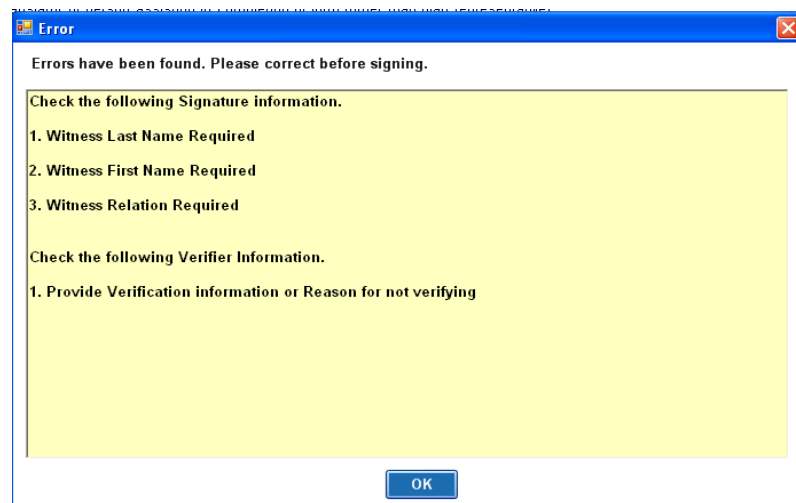
To ensure your application signature is **Saved**, you must hit the **Save and Close** button located at the bottom of the application.

If you click the **X** in the upper corner, the signature will not save.

Click on the **Save and Close** button to save the application.



If you make a mistake or forget something on the review and sign page you will see the error box showing what corrections need to be made.




A message box will indicate the application has been saved.

Your application is now completed.  
Once you click **OK**, you will return to the MAPA Workbench.



# Eligibility Determination – AEF



## Eligibility Determination

Please select a plan type

☐ MAPD      ☐ MA      ☐ PDP

Select the plan type the member wants to enroll in. The plan you select here will determine plans that you receive on the application.

Are you enrolling using a SEP?

☐ Yes      ☐ No

Note: Click Yes to select SEP reason

The zip code and County are only needed if YES is selected for the SEP  
The option will remain Gray if the selection is NO

Zip Code  County

[SEP Reason Codes](#)

SEP Reason Code

Date of SEP event:

SEP Other:

### Part A and Part B dates

Hospital Insurance Part A

Date Of Birth

Medical Insurance Part B

These dates are taken from the Medicare card. The dates and DOB will help determine the election period options you receive.

Select a plan year

☐ 2011      From Jan 1<sup>st</sup> thru Oct 15<sup>th</sup> the plan year will be greyed out      ☐ 2012      The plan year only needs to be selected from Oct 15<sup>th</sup> thru the end of Nov.

Determine Eligibility

[Click here to get election period options](#) [Determine Eligibility](#)

Select an Election Period if not enrolling using a SEP

☐ ICEP    ☐ IEP    ☐ SEP    ☐ AEP    ☐ OEPI

Proposed Effective Date

Once you have the information completed click Determine Eligibility and the system will activate the election codes that are available.

Select the correct election period and click continue. [Close](#) [Continue](#)

# Eligibility Determination – AEF

**Eligibility Determination**

Please select a plan type

☒ MAPD    ☐ MA    ☐ PDP

Are you enrolling using a SEP? Selecting YES requires the county Zip code and Sep reason code

☒ Yes    ☐ No    Note: Click Yes to select SEP reason

Zip Code: 40299    County: BULLITT, KY    **SEP Reason Codes**

SEP Reason Code:    Date of SEP event:    SEP Other: This is only used if you select other as the SEP code

Some SEP reason will require a date

If **SEP** is the election period you must select The reason for the SEP

Note: Only use other as a last resort option for the SEP selection

**Select SEP Reason Code**

ReasonCode	Description	Select a Reason
CHR	One-time SEP for Initial Enrollment into a Chronic Care SNP plan	<input type="checkbox"/>
COS	SEP for individuals enrolled in cost plans that are nonrenewing their contracts	<input type="checkbox"/>
CRE	SEP for individuals who are not adequately informed of a loss of creditable coverage or never had creditable coverage	<input type="checkbox"/>
ERR	SEP for individuals whose enrollment or non enrollment in a Part D plan is erroneous due to an action, inaction or error by a federal employee	<input type="checkbox"/>
ESR	SEP for individuals with ESRD whose entitlement determination was made retroactively	<input type="checkbox"/>
GEP	SEP for individuals who enroll in Part B during the Part B General Enrollment Period	<input checked="" type="checkbox"/>
LEC	I am either losing coverage I had from an employer or union or leaving employer or union coverage	<input type="checkbox"/>
LIS	I receive extra help paying for Medicare prescription drug coverage	<input type="checkbox"/>
LLS	I am no longer eligible for extra help paying for my Medicare prescription drugs	<input type="checkbox"/>

OK Cancel


If you select a reason code that is not available for this time period the system will tell you the SEP is not available and to select about election period


**MAPA**

This SEP is not available at this time. Please select another one or select a different election period.

OK

# Abbreviated Enrollment Form - AEF

**MAPA Abbreviated Enrollment Form**

**HUMANA**  
Guidance when you need it most

If you are changing plans within the same Humana Medicare Advantage Organization you should use this form. This form may not be used to enroll in any Humana Medicare Advantage Plan for the first time.

Note: If plan is open, your coverage will be effective the first day of the next month following the date Humana receives this completed form and any required attachments.

Please fill out the following:

Current Zip Code :  Current County :  I am currently a member of the Humana Plan

My current monthly premium is (if applicable):  **Old Rate**

☐ New zip and county as same as current zip and county

New Zip Code  New county  I would like to change to the Humana Plan

I understand that this plan may have different health and/or prescription drug benefits and has a monthly premium (if applicable) of:  **New Rate**

**Riders**

☐ MYOPTION ENHANCED DENTAL

☐ MYOPTION VISION

Name of Plan you are Enrolling in:

If they want to add a rider put a check next to it - Remember if they already have one you need to mark it

Last Name  First Name  M.I.

Permanent Address 1  Permanent Address 2

City  State  Zip  County  Phone

DOB

Member ID Number ( As listed on your Humana Identification card ) :

Medicare Claim Number  Re-enter Medicare  **Enter members current Humana ID number**

Email addresses, if available, will be used as a means to communicate various Humana related information (Optional)

Mailing Address 1 : (If different from permanent address)

Mailing Address 1  Mailing Address 2

City  State  Zip Code

Hospital Insurance Part A

**Only enter a mailing address if it is different  
Then the residential address**

Confidential and Proprietary to Humana Inc.  
Humana Internal Use only

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For Training Purposes Only. Not CMS Approved  
07/23/2012

# Abbreviated Enrollment Form - AEF

**Monthly Premium**  
Your Monthly Payment for your Humana Plan will be no more than:

**A payment option must always be selected even if the premium is Zero**

**Please select a premium payment option.** You can pay your monthly plan premium or late enrollment penalty by mail using a Coupon Book, Electronic Funds Transfer, or Automatic Credit Card Charge. You can also choose to pay your premium or late enrollment penalty by automatic deduction from your Social Security Check each month. If you qualify for extra help with your Medicare prescription plan coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

**Payment Options**

☐ Social Security Benefit Check Deduction

☐ Railroad Retirement Board Benefit Check Deduction (You must currently be receiving a Railroad Retirement Board benefit check in order to qualify for this payment option.)

☐ Coupon Book

**Credit Card Name**

☐ Visa 

☐ MasterCard 

☐ Discover 

**Card Number**

**Expiration Date**

☐ Electronic Funds Transfer

**Bank Name**

**Routing Number**

**Account Number**

**For**

**ABA or bank routing number** **bank account number**

**Select how they want to pay for the plan**

**Account Type**

☐ Checking ☐ Savings

**Office Use Only**

**Old Plan GR/BN:**

GR

BN

**Plan Representative**

**REP #**

**Date**

**Location**

**Campaign**

**Referring Agent**

**Agent #**

**Current Plan GR/BN:**

GR

BN

**Affinity Partner**

**Affinity Partner Location**

**2 dispositions are required – not all will have 3 dispositions  
This information will update in CDS when you upload**

**Source**

**Type**

**Sub Type**

**Disposition**

**Disposition 2**

**Disposition 3**

☒ ICEP ☒ IEP ☐ SEP ☐ AEP ☐ OEPI

**Proposed Effective Date**

**Products Discussed (Please select ALL that apply)**

☒ All ☐ Other

☐ MA/MAPD ☐ PDP

☐ MedSupp

**Disposition** - the 3 tiered disposition resembles the new CDS version. In disposition 1 select the correct sold product . Then select reasons for enrolling under disposition 2 and 3.

# Abbreviated Enrollment Form

## Source Information

### Tier 1:

What was the original source of the lead ( how did the client learn about Humana)

- Medicare campaign/seminar/ad
- TIPS campaign/seminar/ad
- Veterans campaign/seminar/ad, etc.

### Tier 2:

Where they heard about the plan DMS call, HGC, WLMT, Veteran Referral, Self-Referral, etc.

### Location:

- where the application was completed.
- may not be where the lead was sent which would be Tier 2
- In home appt was scheduled but directed to WLMT for convenience, etc.



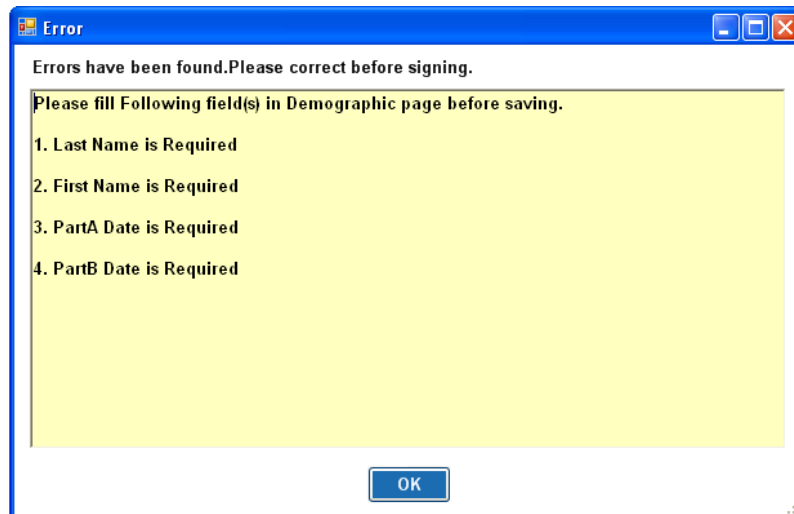
The screenshot shows a web form titled "Source Information". It contains three questions with corresponding dropdown menus:

- Question: "What was the source for this sale?"  
Tier 1: [--Select Source--] (dropdown)  
Tier 2: [--Select Source--] (dropdown)
- Question: "What was the location for this sale?"  
[--Select Location--] (dropdown)

# Abbreviated Enrollment Form - AEF

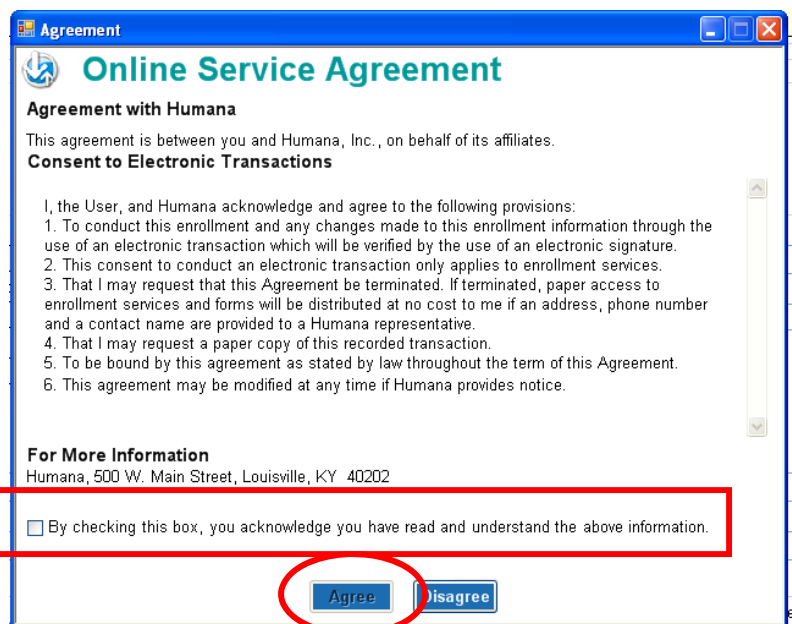


When you click **Review and Sign** the system will review the application looking for errors – if found you will get the error page and need to correct them before you can move on



Once the **errors** are **corrected** – **save** again then click **review and sign** again

Now you have the online service agreement read this to the member and have them Check the box and click **Agree**



# Abbreviated Enrollment Form - AEF

Now review the application with the member before signing

**Abbreviated Enrollment Form Summary**

If you are changing plans within the same Humana Medicare Advantage Organization you should use this form. This form may not be used to enroll in any Humana Medicare Advantage Plan for the first time.

Sections of this form may have been pre-filled for your convenience. If any of this pre-filled information is incorrect, please make the necessary corrections.

**Note: If plan is open, your coverage will be effective the first day of the next month following the date Humana receives this completed form and any required attachments.**

Please fill out the following:

Current Zip Code: 40291 Current County: BULLITT, KY I am currently a member of the Humana Plan: HumanaChoice PPO SNP-OA R5626-065

My current monthly premium is (if applicable): \$9.00

☐ New zip and county as same as current zip and county

New Zip Code: 40299 New county: JEFFERSON, KY I would like to change to the Humana Plan: HumanaChoicePPO R5626-008

I understand that this plan may have different health and/or prescription drug benefits and has a monthly premium (if applicable) of: \$9.00

Last Name: Ring First Name: Diamond M.I.: M.L.

Permanent Address 1: 1515 Willy street Permanent Address 2:

City: Louisville State: KY Zip: 40299 County: JEFFERSON, KY Phone: ( ) -

**Release of Information:**

By joining this Medicare health plan, I acknowledge that Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Humana will release my information (including prescription drug event data) to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country.

[Humana ChoicePPO or Humana M... employed by or contracted with Hu...]

I understand that beginning with the completed enrollment form if I have than using services out-of-network, benefits, even if received out of net...

I attest that I am not receiving any services or medical coverage, pres...

I understand that my signature on this application form means that I have read and understand the contents of this applic... what rules I must follow in order to receive coverage with this Humana plan.

Signature of applicant or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.)

☒ Client Sign

☐ Witness Sign

Signature of Witness/Translator or person assisting in completion of form (other than plan representative).

Witness/Translator Last Name: Relation: Witness/Translator First Name:

If you are the authorized legal representative, you must sign above and provide the following information.

Last Name: First Name: M.I.: Address1: Address2: City: Zip: State: Relation to Applicant: Phone: BN: GR: 235464 010

**Remember to read this important Information section**

**The member will sign the signature pad and Click OK – you will need to click OK on the Client signature captured screen – this will add The signature date**

**Enter POA information here**

**Save and Close**

**Sales agents are not permitted to sign the enrollee's name for them!! This is the equivalent to forging their signature.**

# Capturing Signatures: Client

As your client signs on the dotted line, his/her signature will appear in the **Signature** window on the laptop screen.

If the client does not like the appearance of their signature, they can try again after the signature on the tablet screen is cleared.

The signature can be cleared in one of two ways:

Clear Signature

- ☐ The client can tap on **CLEAR** on the tablet, or
- The agent can click on the **Clear Client Signature** button on the laptop

When the client is satisfied with their signature, the signature can be captured in one of two ways:

Capture Signature

- ☐ The client can tap on **OK** on the tablet, or
- ☐ The agent can click on the **Capture Client Signature** button on the laptop screen.

Once the signature is captured, a **Client Signature Captured** message will appear and the client's **Signature Date** will automatically be entered into the field. Click on the **OK** button to go to the next step.

The screenshot displays a software interface for capturing a signature. At the top, a label 'Signature' is followed by a descriptive text: 'Signature of applicant or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc)'. Below this, there is a 'Client Sign' button and a rectangular box containing a handwritten signature that reads 'Stanley River'. To the right of the signature box is a 'Signature Date' field with the date '10/01/2008' entered. A 'Capture Signature' button is positioned to the right of the date field. Below these elements is a large rectangular box with a blue header bar. Inside this box, the text 'Client Signature Captured' is displayed in blue. At the bottom of this box is an 'OK' button.

**Sales agents are not permitted to sign the enrollee's name for them!! This is the equivalent to forging their signature.**



You will now be prompted to enter the **Witness First Name**, **Witness Last Name** and **Relation to Applicant** in the fields under the witness' signature.

Witness/Translator Last Name: <input type="text"/>	Witness/Translator First Name: <input type="text"/>
Relation: <input type="text"/>	

If someone is acting as the **POA**, that person will sign in place of the member and their personal information will need to be entered in the fields at the bottom of the application.

### You as the agent are not the authorized representative

If you are the authorized legal representative, you must sign above and provide the following information.

Last Name: <input type="text"/>	First Name: <input type="text"/>	MI: <input type="text"/>
Address1: <input type="text"/>	Address2: <input type="text"/>	
City: <input type="text"/>	State: <input type="text"/>	Zip: <input type="text"/>
Phone: <input type="text"/>	Relation to Applicant: <input type="text"/>	
GR: <input type="text"/>	BN: <input type="text"/>	
Verifier <input type="text"/>	Verification # <input type="text"/>	<input checked="" type="radio"/> O/B <input type="radio"/> I/B <input type="radio"/> M/O
Reason for not verifying <input type="text"/>		

When both signatures have been captured and the witness' information has been entered in the appropriate fields, you are ready to call for verification.

## Verification

It is Humana policy to **complete a verification on all applications**.

Verification for an AEF application is the **O/B** option and it is automatically selected



A screenshot of the verification options. The 'O/B' option is selected and highlighted with a red rectangular box. Below the options, there are several small, faint icons.

# New Member Orientation

New member orientation will go into more detail about "how" to use your plan and give valuable info on different programs that we have.

Select **Yes** or **No**. If no you must use the drop down and select a reason why. This will write to the Smart Pad in CDS.

NMO (New Member Orientation)  
Would you like to attend NMO?

☐ Yes ☐ No

Reason for not attending NMO:

--Select Reason--  
--Select Reason--  
Not Interested  
No Seminars Available for Location Selected  
Member has already attended.  
Member Undecided  
Other

Selecting **Yes will not enroll the member** in an orientation class.

## Materials Used

Select all the materials that you used during your Appointment. This information will write to the Smart Pad in CDS

Materials Used

☒ MAPD Power Point Presentation  
☐ MA Power Point Presentation  
☐ PDP Power Point Presentation  
☒ Summary of Benefits  
☐ Value Added Services  
☐ Benefit and Provider Leaflet  
☐ Compensation sheet  
☒ Right Source

# Optional Supplemental Benefit Enrollment

General information on what form to use and when

1. If the agent is enrolling the member in both the **MA plan plus OSB** at the same time and this is the **member's first enrollment**, **Individual form** is used
2. If agent is enrolling the member in both the **MA plan plus OSB** at the same time and this member is **changing from one contract to another**, the **Individual form** is used
3. If the agent is enrolling the member in a **new MA plan under the same contract number**, **with or without OSB**, the **AEF is used**
4. If the agent is enrolling the member in a **MA plan only** and it's the member's **first enrollment** or **changing from contract to contract**, **individual form** is used
5. If the **member already has an OSB** plan and **wants** to purchase **another** the **stand alone form** should be used. **Agent must mark both OSB products (old and new) to ensure the member is not termed out of the original one.**
6. If the member wants to **DROP** an **OSB** and remain on the same base plan - the member **must call Customer Service**. **No agent is allowed to do this via an application and may not be paid for it.**

The Stand-Alone OSB form displays available OSB's for current plan and calculates effective date based on current plan.

Note: Renewing members adding OSB's during AEP will only get 1/1 effective date and AEP as the only option for Election Period.

# Optional Supplemental Benefit Enrollment Form

Select plan type and then application type

**Application Type**

**Language**

☒ English ☐ Spanish

**Plan Type**

☒ Humana ☐ Care Plus

☐ AEF ☐ Group ☐ Individual

☒ OSB ☐ Member Authorization

☐ SOA ☐ FSB ☐ REAL For Me

☐ Medicare Supplement

☐ Single ☐ Husband and Wife

## Client Information

Enrollment in a Medicare Advantage Plan is required for Enrollment in a Humana Optional Supplemental Benefit

Zip Code

40299

County

BULLITT, KY

Current Humana Medicare Advantage Plan:

HumanaChoicePPO R5826-008

My Current monthly premium is (if applicable)

73.00

Humana Medicare Advantage Effective Date:

10/01/2010

Optional Supplemental Proposed Effective Date:

11/01/2010

Effective date is calculated based on 30-days from current plan.

This must be the same election period used on the original application

Name of Optional Supplemental Benefit you are enrolling in\*:

\*If you're currently enrolled in an OSB, you must select it on this form to continue receiving this benefit. Select OSB offerings may not be available in all areas.

## OSB Riders

Riders

☐ MYOPTION VISION

Available OSB's are displayed based on current plan selected

Name of Plan you are Enrolling in:

HumanaChoicePPO R5826-008

# Optional Supplemental Benefit Enrollment Form

Never use a PO Box in the address. The address must be a street address

Address		First Name	MI
Last Name		Green	<input type="checkbox"/>
Residential Address 1:		Address 2/Apt. #	
1212 Slim lane			
City	State	Zip Code	County
Louisville	KY	40299	BULLITT, KY
Phone			
(502) 888-8888			
Member ID Number ( As listed on your Humana Identification card )		This number will come from the Members Humana card . This is not a required field	
<input type="text"/>			
Medicare Claim Number		Re-enter Medicare Number	
<input type="text"/>		<input type="text"/>	
		This number must match the Medicare Card. Enter it twice for validation	

Preferred Method of Communication:		How the members wants the agent to contact them
<input type="radio"/> Telephone	<input type="radio"/> Email	<input checked="" type="radio"/> Mail
(Optional) Email addresses:		
By providing this address, you are giving Humana permission to send non-enrollment materials via email.		
<input type="text"/>		
Mailing Address :		
<input type="checkbox"/> Check here if the Mailing Address is the same as the Residential Address		
Mailing Address 1		Mailing Address 2
<input type="text"/>		<input type="text"/>
City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Hospital Insurance Part A		Medical Insurance Part B
<input type="text"/>		<input type="text"/>

# Optional Supplemental Benefit Enrollment Form

## Monthly Premium

Your Monthly Payment for your Humana Plan will be no more than:

Your Optional Supplemental Premium:

Your total monthly payment will be no more than:

The system will calculate both the Humana plan rate and the OSB rate together for one deduction

**Please select a premium payment option.** You can pay your monthly plan premium by mail using a Coupon Book, Electronic Funds Transfer, or Automatic Credit Card Charge. You can also choose to pay your premium by automatic deduction from your Social Security Check each month. Your Optional Supplemental Benefit Premium will be added to your Humana Medicare Advantage plan premium as one combined Premium, therefore you may only select one Premium Payment Option. If you choose a Premium Payment Option that is different from what was previously selected for your Humana Medicare Advantage plan this will replace the previously selected Premium Payment Option. If no Premium Payment Option is selected below, your previously selected Premium Payment Option will be applied. If no

## Payment Options

☐ Social Security Benefit Check Deduction

☐ Railroad Retirement Board Benefit Check Deduction (You must currently be receiving a Railroad Retirement Board benefit check in order to qualify for this payment option.)

☐ Coupon Book

Credit Card Name

☐ Visa

Credit Card Number

☐ Electronic Funds Transfer

Depository Bank Name:

☐ [No Title] Card

Credit Card Expiration Date:

Routing Number

Account #

For 123456789 123456789101 3026

ABA or bank routing number

bank account number

☐ Electronic Funds Transfer (EFT) Please Provide the following:

☐ Checking

☐ Savings

## Office Use Only

Current Plan GR/BN

GR

BN

Plan Representative

REP #

Affinity Partner

Date

Location

Campaign

Affinit TaxId

Affinity Partner Location

Referring Agent

Agent #

Package Id

Source

Sub Source

House Member

Type

Disposition 1 should be Sold OSB

Disposition

Disposition 2

Disposition 3

Products Discussed (Please select ALL that apply)

☐ All

☐ MA/MAPD

☐ MedSupp

☐ Other

☐ PDP

Select other and then add OSB - dental or vision

You must add at least 2 levels of disposition

Other Product Description

Close

Save

Review and Sign

Click save then review and sign when the application is completed

# Affinity Partners:

Office Use Only

Plan Representative: Boston, Rebecca Location: REP #: Affinity Partner: **Use the drop down arrow to select the correct Partner – if no affinity partner, select None**

Date: 07/01/2009

Referring Agent: Agent #: Affinity TID:

Attachments: ☐ AM001 ☐ AM002 ☐ AM006

Affinity Partner dropdown list:

- Select A Partner-
- Health Plan One
- Health Plan Services
- Healthy American
- Hershend Fam Entertainment
- Humana Guidance Center
- Indiana Farm Bureau
- Insphere
- Kelsey

Affinity Partner: WalMart

Affinity Partner Location:  [Search StoreID](#)

If the affinity partner is Wal mart the store number must be listed

If you don't know the Store ID:

- Click on the Search Store ID button
- Leave ID blank and click Search
- Enter State and City of the store

WalMart

Was this Sale originated from a WalMart Store?

Store ID:  Leave Store ID Blank

No Search

WalMart

Was this Sale originated from a WalMart Store?

State:  City:

No Search

If the affinity partner is a Humana Guidance Center the location must be entered

Affinity Partner: Health Compare

Affinity Partner dropdown list:

- Health Plan One
- Health Plan Services
- Healthy American
- Hershend Fam Entertainment
- Humana Guidance Center
- Indiana Farm Bureau
- Insphere

Affinity Partner: Humana Guidance Center

Affinity Partner Location:

STOREID	ADDR1	CITY	STATE
10613	8648 Skillman Street	Dallas	TX
10615	2257 S 108th Street	West Allis	WI
10616	227 Willow Bend	Crystal	MN
10617	11316 Montgomery Road	Cincinnati	OH
10618	7666 Nob Hill Road	Tamarac	FL
10619	12100 E Colonial Dr	Orlando	FL
10620	215 Englewood Road, Suite A	Kansas City	MO
10621	3189 W Vine Street	Kissimmee	FL
10622	7945 S Harlem	Burbank	IL
10623	5943 E McKellips Rd Ste 106	Mesa	AZ
10624	8975 W Charleston Blvd	Las Vegas	NV
10626	7915 N Hale Ave	Peoria	IL
10627	7400 Gall Blvd	Zephyrhills	FL
17673	1000 N Green Valley Parkway, Suite 720	Las Vegas	NV
17674	2025 W. Henderson	Columbus	OH
17693	1915 SNOW ROAD	PARMA	OH
17694	4438 Western Avenue	Knoxville	TN
10614	711 W. Wheatland Road	Duncanville	TX
10625	1000 N Green Valley Parkway, Suite 720	Henderson	NV

# Optional Supplemental Benefits

## Source Information

### Tier 1:

What was the original source of the lead ( how did the client learn about Humana)

- Medicare campaign/seminar/ad
- TIPS campaign/seminar/ad
- Veterans campaign/seminar/ad, etc.

### Tier 2:

Where they heard about the plan DMS call, HGC, WLMT, Veteran Referral, Self-Referral, etc.

### Location:

- where the application was completed.
- may not be where the lead was sent which would be Tier 2
- In home appt was scheduled but directed to WLMT for convenience, etc.

Source Information

What was the source for this sale?

Tier 1: --Select Source--

Tier 2: --Select Source--

What was the location for this sale?

--Select Location--



# Optional Supplemental Benefit Enrollment Form

Products Discussed (Please select ALL that apply)

<input type="checkbox"/> All	<input type="checkbox"/> Other
<input checked="" type="checkbox"/> MA/MAPD	<input type="checkbox"/> PDP
<input type="checkbox"/> MedSupp	

This selection is used as a reminder for you. It will **write to the keywords section**. The products discussed should match your SCOPE.

Once you have completed all the fields, **click Save**.

ApplicationID

Application **6MTRL846AI13GCI** Saved Successfully!

When saved, the **Application number** will appear

Click OK

Once you have saved the information, you are ready to Review and Sign.

Every time you click **Review and Sign** you will be asked if this sale originated from **WalMart** – If Yes enter the store ID  
If No leave ID blank and click no


WalMart

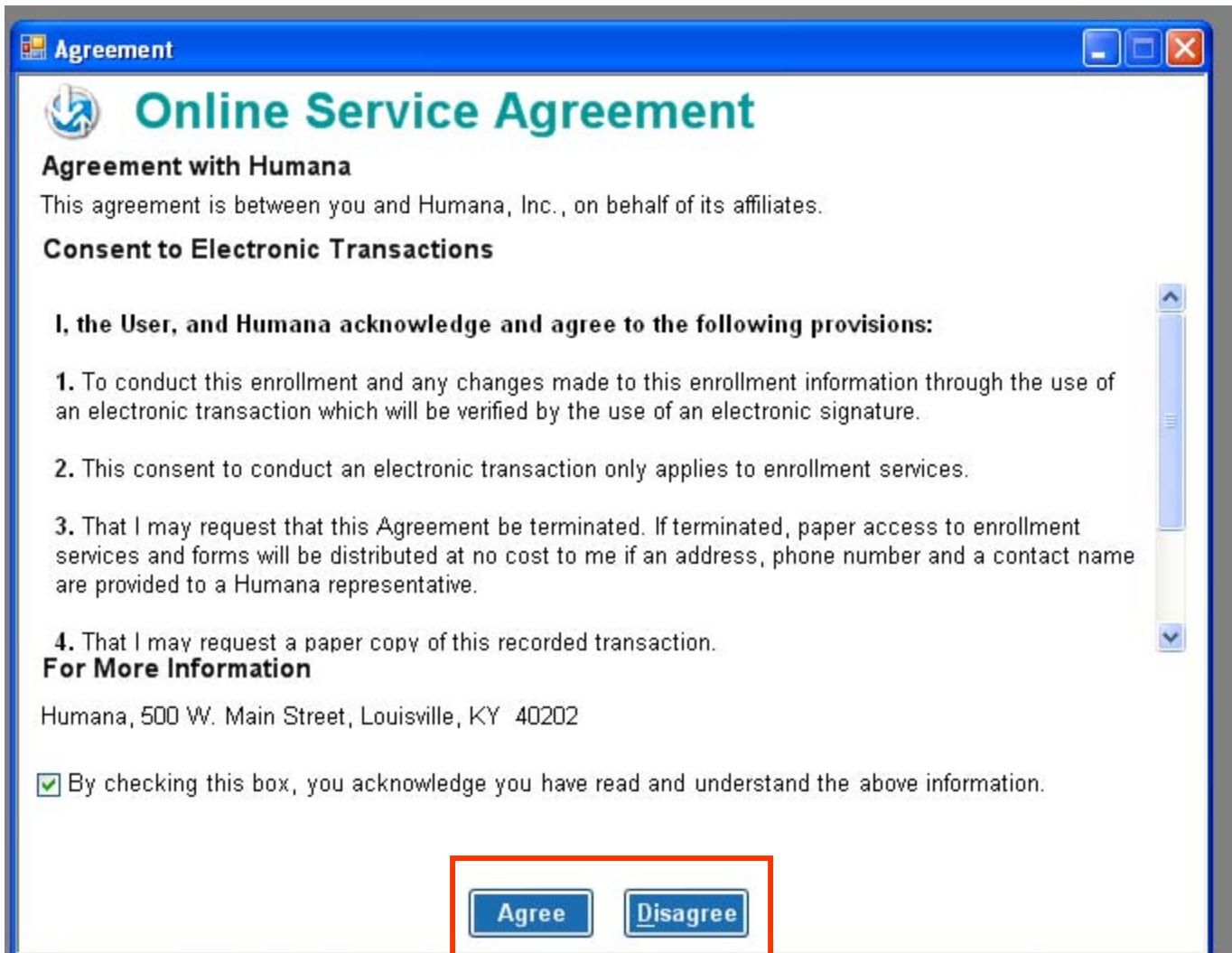
Was this Sale originated from a WalMart Store?

Store ID

# Online Service Agreement

You must read the agreement to the member and have them

Place a  in the box - then click **Next**



The screenshot shows a web browser window titled "Agreement". The main heading is "Online Service Agreement" in green. Below it is "Agreement with Humana". The text states: "This agreement is between you and Humana, Inc., on behalf of its affiliates." followed by "Consent to Electronic Transactions". A list of provisions follows, starting with "I, the User, and Humana acknowledge and agree to the following provisions:". The provisions are numbered 1 through 4. Below the list is "For More Information" with the address "Humana, 500 W. Main Street, Louisville, KY 40202". A checkbox is checked, with the text "By checking this box, you acknowledge you have read and understand the above information." At the bottom, there are two buttons: "Agree" and "Disagree", which are highlighted by a red rectangular box.

**Online Service Agreement**

**Agreement with Humana**

This agreement is between you and Humana, Inc., on behalf of its affiliates.

**Consent to Electronic Transactions**

**I, the User, and Humana acknowledge and agree to the following provisions:**

1. To conduct this enrollment and any changes made to this enrollment information through the use of an electronic transaction which will be verified by the use of an electronic signature.
2. This consent to conduct an electronic transaction only applies to enrollment services.
3. That I may request that this Agreement be terminated. If terminated, paper access to enrollment services and forms will be distributed at no cost to me if an address, phone number and a contact name are provided to a Humana representative.
4. That I may request a paper copy of this recorded transaction.

**For More Information**

Humana, 500 W. Main Street, Louisville, KY 40202

☒ By checking this box, you acknowledge you have read and understand the above information.

**Agree** **Disagree**

Ask the member if they **Agree** or **Disagree** to the service agreement

Click the appropriate box

**Note:** if the member disagrees you will need to start over with a paper application

# Optional Supplementary Benefit Summary

## Review and Sign form

### Client Information

(Enrollment in a Medicare Advantage Plan is required for Enrollment in a Humana Optional Supplemental Benefit)

Zip Code

40299

County

BULLITT, KY

I am Currently a member of the Humana Plan

HumanaChoicePPO H1806.001

My Current monthly premium is (if applicable)

222.00

Humana Medicare Advantage Effective Date:

10/01/2009

Optional Supplemental Proposed Effective Date:

11/01/2009

Effective date is always the 1<sup>st</sup> of the following month

Name of Optional Supplemental Benefit you are enrolling in\*:

\*if you are currently enrolled in an OSB, you must select it on this form to continue receiving this benefit.

### OSB Riders

#### Riders

☒ MYOPTION ENHANCED DENTAL

☒ MYOPTION VISION

Make sure if they already have an OSB you have both selected on this form

Name of Plan you are Enrolling in:

HumanaChoicePPO H1806.001

### Address

Last Name

Grimlin

First Name

Green

MI

Residential Address 1: No PO box for the address

1212 Slim lane

Address 2/Apt. #

City

Louisville

State

KY

Zip:

40299

County

BULLITT, KY

Phone

(502) 888-8888

Member ID Number ( As listed on your Humana Identification card ) :

Medicare Claim Number

123456789a

Re-enter Medicare Number

123456789a

### Preferred Method of Communication

☐ Telephone

☐ Email

☒ Mail

# Optional Supplementary Benefit Summary

## Review and Sign form

<b>Monthly Premium</b>				
Your Monthly Payment for your Humana Plan will be no more than:	222.00			
Your monthly payment for your Optional Supplemental Benefit(s) will be:	22.00			
Your total monthly payment will be no more than:	244			
<a href="#">Review the rate for all the plans</a>				
<b>Please select a premium payment option.</b> You can pay your monthly plan premium by mail using a Coupon Book, Electronic Funds Transfer, or Automatic Credit Card Charge. You can also choose to pay your premium by automatic deduction from your Social Security Check each month. Your Optional Supplemental Benefit Premium will be added to your Humana Medicare Advantage plan premium as one combined Premium, therefore you may only select one Premium Payment Option. If you choose a Premium Payment Option that is different from what was previously selected for your Humana Medicare Advantage plan this will replace the previously selected Premium Payment Option. If no Premium Payment Option is selected below, your previously selected Premium Payment Option will be				
<b>Payment Options</b>				
<input checked="" type="radio"/> Social Security Benefit Check Deduction				
<input type="radio"/> Coupon Book				
<b>Credit Card Name</b>				
<input type="radio"/> Visa	<input type="radio"/> MasterCard			
<input type="radio"/> Discover				
<b>Card Number</b>	<b>Credit Card Expiration Date:</b>			
- - - - -	/			
<input type="radio"/> Auto Credit Card Charge Please provide the following information				
<b>Bank Name</b>	<b>Routing Number</b>	<b>Account #</b>		
<b>Electronic Funds Transfer (EFT) Please Provide the following:</b>				
<input type="radio"/> Checking	<input type="radio"/> Savings			
<b>Social Security</b>				
Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums from your enrollment effective date up to the point withholding begins.)				
<b>*Important note about Social Security Check Deduction</b>				
<b>Office Use Only</b>				
Current Plan GR/BN:				
GR	233350			
BN	009			
<b>Plan Representative</b>	<b>REP #</b>	<b>Affinity Partner</b>		
Boston, Rebecca	1407608	NONE		
<b>Date</b>	<b>Location</b>	<b>Campaign</b>	<b>Affinit TaxId</b>	<b>Affinity Partner Location</b>
09/10/2009		0305046921	00-0007	
<b>Referring Agent</b>	<b>Agent #</b>	<b>Package Id</b>		
		000007		
<b>Source</b>	<b>Sub Source</b>	<b>House Member</b>		
Referral - General		Head		
<b>Type</b>	<b>Sub Type</b>			
Client				
<b>Disposition</b>	<b>Disposition 2</b>	<b>Disposition 3</b>		
Sold - MAPD	Rates Competitive			
<b>Main plan member enrolled</b>				
Products Discussed (Please select ALL that apply)				
<input type="checkbox"/> All	<input checked="" type="checkbox"/> Other	<b>Other Product Description</b>		
<input checked="" type="checkbox"/> MA/MAPD	<input type="checkbox"/> PDP	OSB dental and vision		
<input type="checkbox"/> MedSupp				
<b>I understand that my signature (or signature of the person authorized to act on behalf of the applicant under the laws of the State where he/she resides) on this application means that I have read, understand, and agree to the contents of this application.</b>				

# Capturing Signatures: Client

After your client, or someone acting as the Power Of Attorney (POA) for the client, has read and understood the summary of the selected plan, obtain a signature

**Click in the circle next to Client Sign to activate the signature pad**

The screenshot shows a web-based signature capture interface. At the top, it says "Signature" and "Signature of applicant or authorized legal representative (including valid Power of Attorney)". Below this, there are two radio buttons: "Client Sign" (selected) and "Witness Sign". A red arrow points to the "Client Sign" radio button with a yellow box containing the text "Click here to activate the signature pad". To the right of the "Client Sign" radio button, there is a yellow box with the text "Once you click OK on capture client signature the signature date will populate". Below the "Client Sign" radio button, there is a signature pad showing a handwritten signature "Stanley Euer". To the right of the signature pad, there is a "Signature Date" field showing "10/01/2008" and a "Capture Signature" button. Below the signature pad, there is a "Witness Sign" radio button. To the right of the "Witness Sign" radio button, there is a "Signature Date" field showing "10/01/2008" and a "Clear Signature" button. Below the "Witness Sign" radio button, there is a text field for "Signature of Witness/Translator or person assisting in completion". Below this, there are two text fields: "Witness/Translator Last Name:" and "Relation:". A red arrow points from the "Capture Signature" button to a modal window titled "Signature". The modal window has a blue header and a white body. It contains the text "Client Signature Captured" and an "OK" button. A red box highlights the "OK" button.

**Note:** If the digital signature pad fails to capture the signature, complete a paper application and contact CSS for a replacement Signature pad.

Put the signature tablet in a position where the **client** can comfortably sign on the tablet screen. The tablet screen will light-up and your client can sign on the tablet using the attached stylus.

The diagram shows a green rectangular box representing the signature tablet. Inside the box, there are two buttons: "CLEAR" on the left and "OK" on the right. Below these buttons, there is a large rectangular area with a dashed line and an "X" at the top left corner, indicating the signing area.

# Capturing Signatures: Client

As your client signs on the dotted line, his/her signature will appear in the **Signature** window on the laptop screen.

If the client does not like the appearance of their signature, they can try again after the signature on the tablet screen is cleared.

The signature can be cleared in one of two ways:

Clear Signature

- ☐ The client can tap on **CLEAR** on the tablet, or
- The agent can click on the **Clear Client Signature** button on the laptop

When the client is satisfied with their signature, the signature can be captured in one of two ways:

Capture Signature

- ☐ The client can tap on **OK** on the tablet, or
- ☐ The agent can click on the **Capture Client Signature** button on the laptop screen.

Once the signature is captured, a **Client Signature Captured** message will appear and the client's **Signature Date** will automatically be entered into the field. Click on the **OK** button to go to the next step.

The screenshot displays a software interface for capturing a signature. At the top, a label 'Signature' is followed by a descriptive text: 'Signature of applicant or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc)'. Below this, there is a 'Client Sign' button and a rectangular box containing a handwritten signature that reads 'Stanley River'. To the right of the signature box is a 'Signature Date' field with the date '10/01/2008' entered. A 'Capture Signature' button is positioned to the right of the date field. Below these elements is a large rectangular box with a blue header bar. Inside this box, the text 'Client Signature Captured' is displayed in blue. At the bottom of this box is an 'OK' button.

**Sales agents are not permitted to sign the enrollee's name for them!! This is the equivalent to forging their signature.**

You will now be prompted to enter the **Witness First Name**, **Witness Last Name** and **Relation to Applicant** in the fields under the witness' signature.

Witness/Translator Last Name: <input style="width: 90%;" type="text"/>	Witness/Translator First Name: <input style="width: 90%;" type="text"/>
Relation: <input style="width: 90%;" type="text"/>	

If someone is acting as the **POA**, that person will sign in place of the member and their personal information will need to be entered in the fields at the bottom of the application.

### You as the agent are not the authorized representative

If you are the authorized legal representative, you must sign above and provide the following information.

Last Name: <input style="width: 95%;" type="text"/>	First Name: <input style="width: 95%;" type="text"/>	MI: <input style="width: 20px;" type="text"/>
Address1: <input style="width: 95%;" type="text"/>	Address2: <input style="width: 95%;" type="text"/>	
City: <input style="width: 95%;" type="text"/>	State: <input style="width: 30px;" type="text"/>	Zip: <input style="width: 40px;" type="text"/>
Phone: <input style="width: 100px;" type="text"/>	Relation to Applicant: <input style="width: 95%;" type="text"/>	
GR: <input style="width: 100px;" type="text"/>	BN: <input style="width: 100px;" type="text"/>	
Verifier <input style="width: 130px;" type="text"/>	Verification # <input style="width: 180px;" type="text"/>	
Reason for not verifying <input style="width: 180px;" type="text"/>		

☒ O/B   
 ☐ I/B   
 ☐ M/O

When both signatures have been captured and the witness' information has been entered in the appropriate fields, you are ready to call for verification.

## Verification

It is Humana policy to **complete a verification on all applications**.

Verification for an OSB application is the **O/B** option and it is automatically selected

☒ O/B

# New Member Orientation

New member orientation will go into more detail about "how" to use your plan and give valuable info on different programs that we have.

Select **Yes** or **No**. If no you must use the drop down and select a reason why. This will write to the Smart Pad in CDS.

NMO (New Member Orientation)

Would you like to attend NMO?

☐ Yes ☐ No

Reason for not attending NMO:

--Select Reason--

--Select Reason--

Not Interested

No Seminars Available for Location Selected

Member has already attended.

Member Undecided

Other

Selecting **Yes will not enroll the member** in an orientation class.

## Materials Used

Select all the materials that you used during your Appointment. This information will write to the Smart Pad in CDS

Materials Used

☒ MAPD Power Point Presentation

☐ MA Power Point Presentation

☐ PDP Power Point Presentation

☒ Summary of Benefits

☐ Value Added Services

☐ Benefit and Provider Leaflet

☐ Compensation sheet

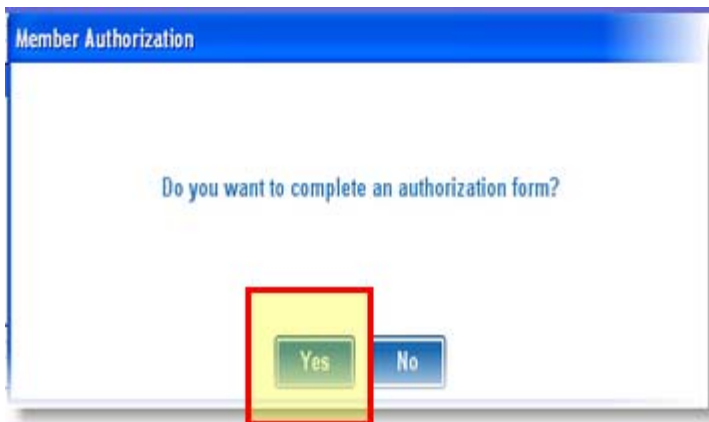
☒ Right Source



# Member Authorization Form

A Member Authorization form can be completed as the last step of the individual application or as a stand alone form.

<b>Application Type</b>		
<b>Language</b>		
<input checked="" type="radio"/> English	<input type="radio"/> Spanish	
<b>Plan Type</b>		
<input checked="" type="radio"/> Humana	<input type="radio"/> Care Plus	
<input type="radio"/> AEF	<input type="radio"/> Group	<input type="radio"/> Individual
<input type="radio"/> OSB	<input checked="" type="radio"/> Member Authorization	
<input type="radio"/> SOA	<input type="radio"/> FSB	<input type="radio"/> REAL For Me
<input type="radio"/> Medicare Supplement	<input type="radio"/> Single	<input type="radio"/> Husband and Wife



Member Authorization

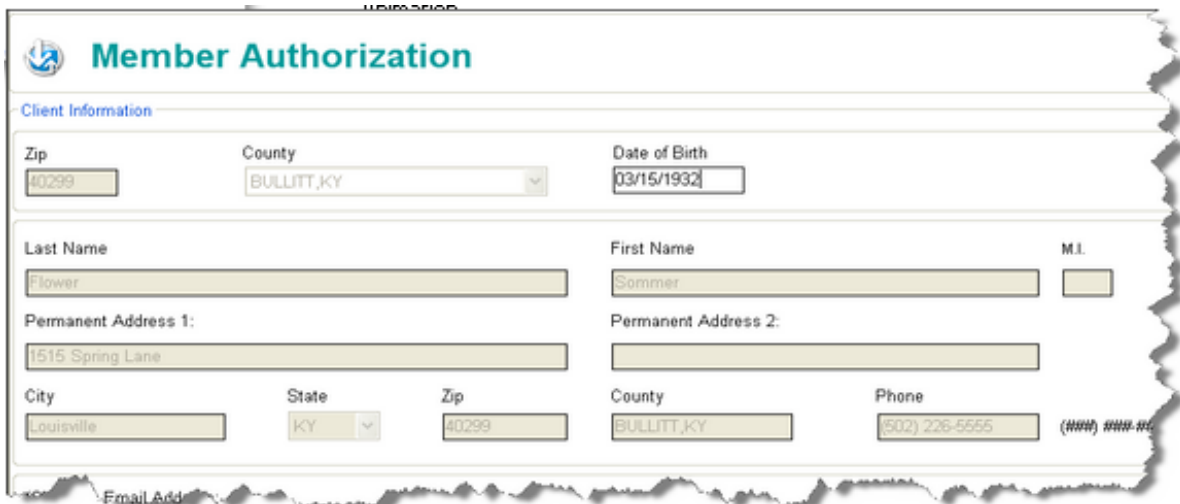
Do you want to complete an authorization form?

**Yes** No

At the end of the Individual application a pop up box will appear

Select **YES**

The Member Authorization form will open with all the member information pre filled



**Member Authorization**

**Client Information**

Zip: 40299 County: BULLITT, KY Date of Birth: 03/15/1932

Last Name: Flower First Name: Sommer M.I.:


Permanent Address 1: 1515 Spring Lane Permanent Address 2:

City: Louisville State: KY Zip: 40299 County: BULLITT, KY Phone: (502) 226-5555

Email Address:

# Member Authorization Form

- If the member is over 65 enter the name the same way it would appear on the Medicare ID card.
- The address must be a residential address not a PO box.
- The Medicare claim number field is optional. If you enter the Medicare claim number you must enter it twice for validation.
- If an e-mail address is add the member is agreeing to receive Information about other products via email.

 **Member Authorization**

[Client Information](#)

Zip

40299

County

BULLITT,KY

Date of Birth

10/15/1943

Last Name

Monster

First Name

Cookie

M.I.

Permanent Address 1:

1515 Seseame Street

Permanent Address 2:

City

Louisville

State

KY

Zip

40299

County

BULLITT,KY

Phone

(502) 999-8878

(###) ### ####

(Optional) Email Address:

(By providing your email/phone number, you consent to receiving information via email or phone).

Medicare Claim Number

Re-Enter Medicare Claim Number

Gender

☒ Male ☐ Female

Confidential and Proprietary to Humana Inc.  
Humana Internal Use only

114

For Training Purposes Only. Not CMS Approved  
07/23/2012

# Member Authorization Form

There are 3 sections that the client can request information on.


- Product Selection
- Advocacy and Volunteer
- Future Products

**Note: the client is required to select at least one, but not limited to just one. They can select as many as they like.**

## Product Selection

Yes, I'd like to receive information on the following non-health related products and services (please check all that apply):

- ☐ Life Insurance Products
- ☐ Other Insurance Products (including hospital, accident long-term care, and disability)
- ☐ Annuities
- ☐ All of the above

Put a  next to the options the member would like Information about .

## Advocacy and Volunteer

Yes, I'd like to receive information about (please check all that apply):

- ☐ Opportunities to volunteer in community activities
- ☐ Pending state or federal legislation
- ☐ Grassroots advocacy organizations including opportunities to join such organizations
- ☐ Wellness products and programs
- ☐ All of the above

Humana can only contact the client about topics selected on the form.

## Future Products

Yes, I'd like to receive information about these future product offerings when they are available (please check all that apply):

- ☐ Health insurance spending account
- ☐ Travel Insurance Products
- ☐ Pet Insurance
- ☐ All of the above

## Office Use Only

Plan Representative

Agent, Dummy

Agent #

1129696

Date

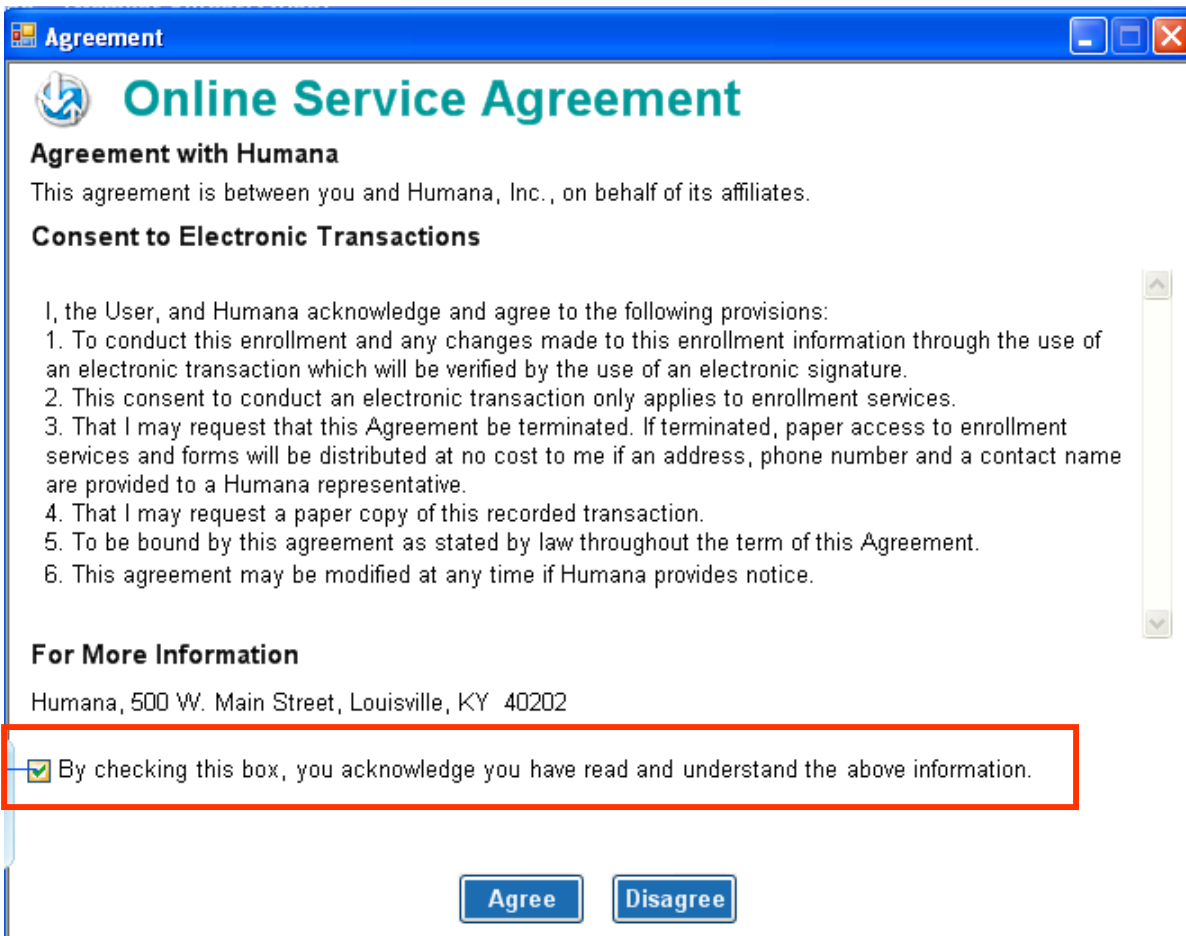
05/04/2010

The agent information will pre fill.


# Member Authorization Form

## Review and Sign

The client will be asked to acknowledge that they are in agreement to the electronic signature and submission



**Agreement**

 **Online Service Agreement**

**Agreement with Humana**

This agreement is between you and Humana, Inc., on behalf of its affiliates.

**Consent to Electronic Transactions**

I, the User, and Humana acknowledge and agree to the following provisions:

1. To conduct this enrollment and any changes made to this enrollment information through the use of an electronic transaction which will be verified by the use of an electronic signature.
2. This consent to conduct an electronic transaction only applies to enrollment services.
3. That I may request that this Agreement be terminated. If terminated, paper access to enrollment services and forms will be distributed at no cost to me if an address, phone number and a contact name are provided to a Humana representative.
4. That I may request a paper copy of this recorded transaction.
5. To be bound by this agreement as stated by law throughout the term of this Agreement.
6. This agreement may be modified at any time if Humana provides notice.

**For More Information**

Humana, 500 W. Main Street, Louisville, KY 40202

☒ By checking this box, you acknowledge you have read and understand the above information.

**Agree** **Disagree**

# Member Authorization Form

## Review and Sign

Review the demographic Information.

Make sure at least one selection is made to receive Information on.

Member Authorization Form Summary					
Client Information					
Zip	County	Date of Birth			
40299	BULLITT, KY	10/15/1943			
Last Name		First Name		M.I.	
Monster		Cookie			
Permanent Address 1:		Permanent Address 2:			
1515 Seseame Street					
City	State	Zip	County	Phone	
Louisville	KY	40299	BULLITT, KY	(502) 999-8878 (###) ###-####	
(Optional) Email Address:					
(By providing your email/phone number, you consent to receiving information via email or phone).					
Medicare Claim Number		Re-Enter Medicare Claim Number		Gender	
				<input checked="" type="radio"/> Male <input type="radio"/> Female	
Product Selection					
Yes, I'd like to receive information on the following non-health related products and services (please check all that apply):					
<input checked="" type="checkbox"/> Life Insurance Products					
<input type="checkbox"/> Other Insurance Products (including hospital, accident long-term care, and disability)					
<input type="checkbox"/> Annuities					
<input type="checkbox"/> All of the above					
Advocacy and Volunteer					
Yes, I'd like to receive information about (please check all that apply):					
<input type="checkbox"/> Opportunities to volunteer in community activities					
<input type="checkbox"/> Pending state or federal legislation					
Future Products					
Yes, I'd like to receive information about these future product offerings when they are available (please check all that apply):					
<input type="checkbox"/> Health insurance spending account					
<input type="checkbox"/> Travel Insurance Products					
<input type="checkbox"/> Pet Insurance					
<input type="checkbox"/> All of the above					

# Member Authorization Form

## Review and Sign

Read the consent statement to the member – this explains how to cancel.



Office Use Only

Plan Representative

Agent, Dummy

Agent #

1129696

Date

05/04/2010

**I have Read and Understand the Statements Above.**

Consent:

If, at any time, I choose to cancel this authorization, I understand that I must do so in writing by sending my Name, Address, Date of Birth, and Member ID to Humana MarketPOINT, P.O. Box 14706, Lexington, KY 40512-4706.

I understand that canceling my permission in writing won't apply to information already released. Unless otherwise canceled, this authorization will expire two years from the signature date.

I understand it's Humana's policy not to disclose my personal information to third parties – except as permitted under the federal privacy laws. Humana is required to let me know that should my personal information be disclosed to third parties, the information may be redisclosed and may not be protected by privacy laws.

Click the radio button to active signature pad

Signature

Signature of applicant or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.):

☒ Client Sign

Signature Date

Capture Signature

Signature of Witness/Translator or Person assisting in completion of form (other than agent)

☒ Witness/Translator signature

Signature Date

Clear Signature

Witness/Translator Last Name:

Witness/Translator First Name:

Relation:

If you are the authorized legal representative (POA), you must sign above and provide the following information.

Last Name:

First Name:

MI:

Address1:

Address 2/Apt#

City:

State:

Zip:

Phone:

Relation to Applicant:

Return To Application

Save and Close

Click return if an Error was found

Click save and close when completed

# Free Standing Benefits - FSB

A free standing benefit is a benefit that does not require enrollment to a Mediocre Advantage plan.

Select the Plan Type  
The select the FSB radio button to enroll in a free standing benefit

Application Type

Language

☒ English
 ☐ Spanish

Plan Type

☒ Humana
 ☐ Care Plus

☐ AEF
 ☐ Group
 ☐ Individual
 ☐ OSB
 ☐ Member Authorization
 ☐ SOA
 ☒ FSB
 ☐ REAL For Me
 ☐ Medicare Supplement
 ☐ Single
 ☐ Husband and Wife

Click **Create Blank Application** to enroll a new member (someone not downloaded)

Click **Enroll** next to the name of the down loaded contact to get the application to pre fill.

Contact Search

Search By: All

Find:

Go

Create Blank Application

Appt Time	Last Name	First Name	Address	City	State	Zip	Phone	
May 10 2010 2:00PM	HILL	ABBI		Palmetto	FL	34221	(941)-723-9432	Enroll
May 10 2010 9:00AM	MONSTER	HENRY	607 E 3RD ST APT ...	PELLA	IA	50219	(641)-628-3631	Enroll

# Free Standing Benefits - FSB

## Demographics

Social security is required.

The member must agree to these terms

Address: a PO Box can be used

There are phone number fields one is optional the other required.

Demographics				Dependents	Payment	Agent Only
Client Information						
Zip Code	County	Date of Birth	Social Security Number:			
40299	BULLITT, KY	06/15/1919	111-11-1111			
Available Plans			Re-enter SSN			
Prepaid Dental C550			111-11-1111			
<input type="checkbox"/> By enrolling in this plan you are agreeing to a one-year minimum contract with HumanaOne. You will not be allowed to cancel this plan until one year from your selected effective date						
Last Name		First Name		Middle Initial:		
MONSTER		HENRY				
Permanent Address 1		Permanent Address 2/Apt #				
607 E 3RD ST APT 318						
City	State	Zip	County			
PELLA	KY	40299	BULLITT, KY			
Daytime Phone: (Optional)		Home Phone (Required)		Gender		
( ) - -		(641) 628-3631		<input checked="" type="radio"/> Male <input type="radio"/> Female		
Language Preferences		Other Language				
Other						
(Optional) Humana Medicare Member ID/HICN:		Re-enter Humana Medicare Member ID/HICN:		Dental Facility Number:		
By providing this address, you are giving Humana permission to send non-enrollment materials via email.						
(Optional) Email Address:		Dental Facility Number is required for DHMO plans only				
Close		Save		Next		



# Free Standing Benefits - FSB

## Dependents

To add a dependent click the blue link [Add Dependents](#).

Demographics **Dependents** Payment Agent Only

[Add Dependents](#)

Dependent added in error: click the red [Remove](#) link

Select Type :  
spouse or child

Address same as  
primary insured  
check same as  
member box.

Gender will pre fill  
once name is added

Social Security  
number is not  
required for the  
spouse or child

Demographics **Dependents** Payment Agent Only

Type: Please select type Remove

☐ Spouse  
☐ Child

Date of Birth:  (Optional) Humana Medicare Member ID/HICN:  Re-enter Humana Medicare Member ID/HICN:

Last Name:  First Name:  Middle Initial:

☐ Same as Member Address

Permanent Address 1: (Not a PO Box)  Permanent Address 2/Apt #:

City:  State:  Zip:  Phone:

Gender: ☐ Male ☐ Female

Social Security Number:  Re-enter SSN:  Dental Facility Number:

[Add Dependents](#)

To add a new dependent click Add dependents again

# Free Standing Benefits - FSB

## Payment

### Premium

- There is a \$1 Administrative fee
- One time enrollment fee
- Single payment option

Demographics	Dependents	Payment	Agent Only
--------------	------------	---------	------------

Premium

Your Monthly Premium:  Monthly premium includes \$1 Administrative fee

One-time Enrollment Fee (non-refundable):

Total Initial Payment:

Single Payment Option:  Saves \$11/Yr

Payor: Same as insured click the box and information will pre fill

Alternate Payor – primary insured not paying for the plan  
add demographic information

Payor Information

☒ If you are the primary insured and paying for the plan then please check box

If you are paying for the plan, please provide the following information. Then tell us how you would like to pay for the plan by completing the Payment Options. If you will be paying for someone else's plan, please also complete the Alternate Payor section below.

Last Name		First Name		Middle Initial:
<input type="text" value="MONSTER"/>		<input type="text" value="HENRY"/>		<input type="text"/>
Address 1		Permanent Address 2/Apt #		
<input type="text" value="607 E 3RD ST APT 318"/>		<input type="text"/>		
City	State	Zip		
<input type="text" value="PELLA"/>	<input type="text" value="KY"/>	<input type="text" value="40299"/>		
Daytime Phone: (Optional)		Home Phone (Required)		
<input type="text" value="(333) 333-3333"/>		<input type="text" value="(641) 628-3631"/>		

Alternate Payor

If you are paying for an insurance plan for someone else, please provide the following information about the primary insured whose plan you will be paying for. Please note, if you are paying for someone else's plan, you will be responsible for signing this authorization to withdraw funds from your selected accounts; not the primary insured.

Last Name:		First Name:		Middle Initial:
<input type="text" value="MONSTER"/>		<input type="text" value="HENRY"/>		<input type="text"/>

Alternate payor will have to sign the application.

# Free Standing Benefits - FSB

## Payment



### Important things to remember

The standard enrollment fee can be waived when:

- The enrollment fee is only waived on Dental and Vision benefits
- The enrollees must live in the same state
- The payor must be the same on both applications

Payor Information

☒ If you are the primary insured and paying for the plan then please check box

**If you are paying for the plan, please provide the following information. Then tell us how you would like to pay for the plan. If you are paying for someone else's plan, please also complete the Alternate Payor section below.**

Last Name: Stanley First Name: Matt Middle Initial:

Address 1: 1515 paper lane Permanent Address 2/Apt #:

City: Louisville State: KY Zip: 40299

Home Phone (Required): (502) 222-2222 Daytime Phone: (Optional):

**Premium**

Your Monthly Premium: 15.74 Monthly premium includes \$0.75 association fee and \$1.00 Administrative

One-time Enrollment Fee (non-refundable): 0.00 **Your enrollment fee is waived**

Total Initial Payment: 15.74

Single Payment Option: 176.88 saves \$12 /yr

# Free Standing Benefits - FSB

## Payment

- Select payment option for billing cycle
- There are only 2 payment options for the initial payment
  - Credit card
  - Electronic Transfer

Note: each option requires bank information

**Payment Options**

Please select payment option for your billing cycle and payment preference for your premium payment.

☐ Annual Payment ☒ Monthly Payment

Initial Premium

☒ Visa ☐ MasterCard ☐ Discover

Credit Card Number: 4111-1111-1111-1111 CVV: @@@@ Expiration Date: 04/2013 Cardholders Name: willie ames

☐ Electronic Funds Transfer

Depository Bank Name: Routing Number: Account Number:

Account #

☐ Checking ☐ Savings

I authorize Humana to draw premium payment and charges from my credit card account until this authorization is revoked by me.

**Annotations:**

- If annual payment is selected no subsequent information will be needed. The fields will be disabled
- CW = the 3 numbers on the back of the card
- If alternate payor the card holder name will be different then the insureds.
- If your bank has a specific ACH R/T number, in addition to the check routing number, please enter the ACH R/T number instead.

- Subsequent payment can be made differently then the initial.
- Make selection and enter information required.
- If payment is the same select same box – every thing will pre fill

**Subsequent Payment**

☐ Same as Initial Payment

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Credit Card Number: CVV: Expiration Date: Cardholders Name:

☒ Electronic Funds Transfer

Depository Bank Name: bank of mom Routing Number: 112233445 Account Number: 2522111111122233

Account #

☒ Checking ☐ Savings

# Free Standing Benefits - FSB

## Agent Only

Plan Representative:

- Writing agent
- Information will pre fill

Writing Agent/Producer:

Plan Representative

Boston, Rebecca

Representative Number

1407608

- ☒ Career Agent
- ☐ Delegated Agent
- ☐ MECA Agent

- Affinity Partner, campaign and Affinity TID will pre fill if downloaded contact
- If no affinity partner select None
- Disposition 1 will be FSB
- Disposition 2 why they wanted the FSB
- Disposition 3 depends on disposition 2 and not always needed

Agent Info:

Date

05/10/2010

Location:

Affinity Partner

Benefit Protect

Campaign

0302047632

Affinity TID

20-1577297

Referring Agent

Referring Agent  
Number

Affinity Partner Location

Source

Referral - General

Sub Source

Client Referral

House Member

Head

Type

Client

Sub Type

B

Disposition1

Sold - FSB

Disposition2

Good Service

Disposition3

Disposition not available

Proposed Effective Date :

06/01/2010

Effective date will pre fill no change can be made to this date

Products Discussed (Please select ALL that apply)

- ☐ All ☒ Other
- ☐ MA/MAPD ☐ PDP
- ☐ MedSupp

Other Product Description

FSB dental

# Affinity Partners:

Office Use Only

Plan Representative: Boston, Rebecca Location: REP #: Affinity Partner: -Select A Partner--

Date: 07/01/2009 Referring Agent: Agent #: Affinity TID: Health Plan One Health Plan Services Healthy American Hershend Fam Entertainment Humana Guidance Center Indiana Farm Bureau Insphere Kelsey

Attachments: ☐ AM001 ☐ AM002 ☐ AM006

Use the drop down arrow to select the correct Partner – if no affinity partner, select None

Affinity Partner: WalMart

Affinity Partner Location: Search StoreID

If the affinity partner is Wal mart the store number must be listed

If you don't know the Store ID:

- Click on the Search Store ID button
- Leave ID blank and click Search
- Enter State and City of the store

WalMart

Was this Sale originated from a WalMart Store?

Store ID: Leave Store ID Blank

No Search

WalMart

Was this Sale originated from a WalMart Store?

State: City:

No Search

If the affinity partner is a Humana Guidance Center the location must be entered

Affinity Partner: Health Compare

Health Plan One Health Plan Services Healthy American Hershend Fam Entertainment Humana Guidance Center Indiana Farm Bureau Insphere

Affinity Partner: Humana Guidance Center

Affinity Partner Location:

STORE ID (AFFINITY PARTNER LOCATION)	ADDRESS	CITY	STATE
10613	8648 Skillman Street	Dallas	TX
10615	2257 S 108th Street	West Allis	WI
10616	227 Willow Bend	Crystal	MN
10617	11316 Montgomery Road	Cincinnati	OH
10618	7666 Nob Hill Road	Tamarac	FL
10619	12100 E Colonial Dr	Orlando	FL
10620	215 Englewood Road, Suite A	Kansas City	MO
10621	3189 W Vine Street	Kissimmee	FL
10622	7945 S Harlem	Burbank	IL
10623	5943 E McKellips Rd Ste 106	Mesa	AZ
10624	8975 W Charleston Blvd	Las Vegas	NV
10626	7915 N Hale Ave	Peoria	IL
10627	7400 Gall Blvd	Zephyrhills	FL
17673	1000 N Green Valley Parkway, Suite 720	Las Vegas	NV
17674	2025 W. Henderson	Columbus	OH
17693	1915 SNOW ROAD	PARMA	OH
17694	4438 Western Avenue	Knoxville	TN

# Free Standing Benefits

## Source Information

### Tier 1:

What was the original source of the lead ( how did the client learn about Humana)

- Medicare campaign/seminar/ad
- TIPS campaign/seminar/ad
- Veterans campaign/seminar/ad, etc.

### Tier 2:

Where they heard about the plan DMS call, HGC, WLMT, Veteran Referral, Self-Referral, etc.

### Location:

- where the application was completed.
- may not be where the lead was sent which would be Tier 2
- In home appt was scheduled but directed to WLMT for convenience, etc.



The screenshot shows a web form titled "Source Information". It contains three questions with corresponding dropdown menus:

- Question: "What was the source for this sale?"  
Tier 1: [--Select Source--] (dropdown)  
Tier 2: [--Select Source--] (dropdown)
- Question: "What was the location for this sale?"  
[--Select Location--] (dropdown)

# Free Standing Benefits - FSB



Proposed Effective Date : 06/01/2010

## Dental C550 DHMO effective dates are calculated as follows:

- If application is received between the 1st and 15th of the month, the policy effective date will be the 1st of the next month.
- If application is received between the 16th and end of the month, the policy effective date will be the 1st of the 2nd following month.

Example: App. received May 18th for processing; policy effective date will be July 1st.

The reason for the difference in effective dates is due to the member having to select a primary care dentist and being included in the monthly membership rosters sent to providers.

## Dental Preventive Plus PPO and VCP or Focus Vision plan effective dates are calculated as follows:

- Applications received between the 1st and end of any month will have a policy effective date of the 1st of the following month.
- If application is received between the 1st and 15th of the month, the policy effective date can be the 1st of the current month, **if it is requested and indicated on the application.**

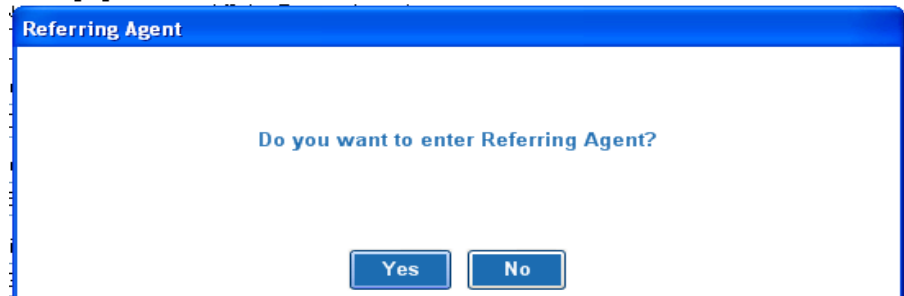
Note: if paying monthly a double deduction will be taken for the first payment



# Free Standing Benefits - FSB

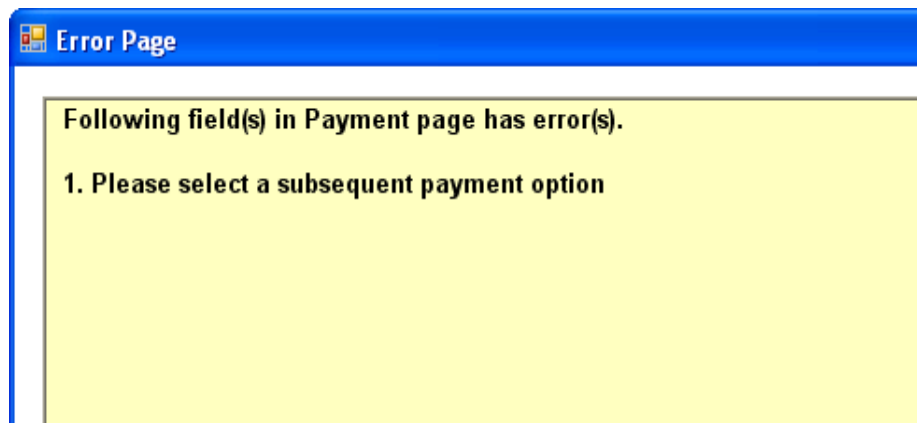
## Review and Sign

- If lead came from broker referral the agent needs to be added.



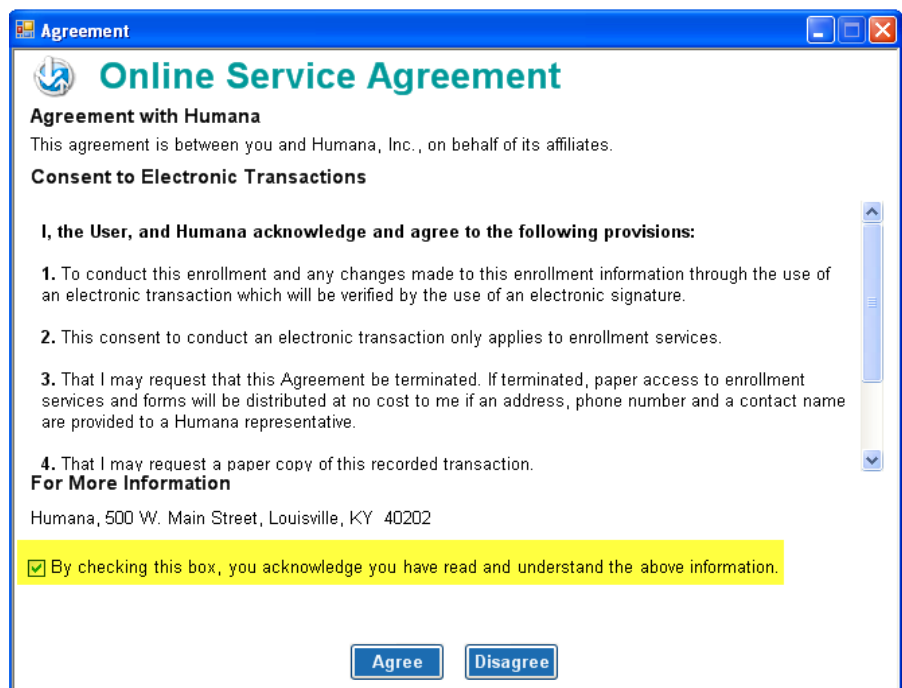
A dialog box titled "Referring Agent" with a blue header. The main area is white and contains the text "Do you want to enter Referring Agent?" in blue. At the bottom, there are two buttons: "Yes" and "No".

- The system will scan the application to look for missing information.
- If something is missing an error page will appear showing what needs to be corrected.



An error page with a blue header titled "Error Page". The main area is yellow and contains the text "Following field(s) in Payment page has error(s)." and "1. Please select a subsequent payment option".

- The Online Service Agreement states the member agrees to the only enrollment the box must be checked.



An "Agreement" window with a blue header. The title is "Online Service Agreement" in green. Below the title is "Agreement with Humana" and a paragraph: "This agreement is between you and Humana, Inc., on behalf of its affiliates." The section "Consent to Electronic Transactions" is followed by a bold statement: "I, the User, and Humana acknowledge and agree to the following provisions:". This is followed by four numbered points: 1. To conduct this enrollment and any changes made to this enrollment information through the use of an electronic transaction which will be verified by the use of an electronic signature. 2. This consent to conduct an electronic transaction only applies to enrollment services. 3. That I may request that this Agreement be terminated. If terminated, paper access to enrollment services and forms will be distributed at no cost to me if an address, phone number and a contact name are provided to a Humana representative. 4. That I may request a paper copy of this recorded transaction. Below this is "For More Information" and the address "Humana, 500 W. Main Street, Louisville, KY 40202". A yellow highlighted box contains a checked checkbox and the text "By checking this box, you acknowledge you have read and understand the above information." At the bottom are "Agree" and "Disagree" buttons.

# Free Standing Benefits - FSB

## Review and Sign

Review the entire application with the member to make sure all information is entered correctly.



### Free Standing Benefits Summary

#### Client Information

Zip Code	County	Date of Birth	Social Security Number:
40299	BULLITT, KY	06/15/1919	111-11-1111
Available Plans		Re-enter SSN	
Prepaid Dental C550		111-11-1111	
<hr/>			
Last Name	First Name	Middle Initial:	
MONSTER	HENRY		
Permanent Address 1		Permanent Address 2/Apt #	
607 E 3RD ST APT 318			
City	State	Zip	County
PELLA	KY	40299	BULLITT, KY
Daytime Phone: (Optional)	Home Phone (Required)	Gender	
(333) 333-3333	(641) 628-3631	<input checked="" type="radio"/> Male <input type="radio"/> Female	
Language Preferences	Other Language		
Other			

#### Type

Spouse

Date of Birth	(Optional) Humana Medicare Member ID/HICN:	Re-enter Humana Medicare Member ID/HICN:		
02/15/1956				
Last Name	First Name	Middle Initial:		
Monster	Martha			
<input type="checkbox"/> Same as Member Address				
Permanent Address 1: (Not a PO Box)		Permanent Address 2/Apt #		
607 E 3RD ST APT 318				
City	State	Zip	Phone:	Gender
PELLA	KY	40299	( ) -	<input type="radio"/> Male <input checked="" type="radio"/> Female
Social Security Number:	Re-enter SSN	Dental Facility Number:		
- -	- -			

#### Premium

Your Monthly Premium: 25.08 Monthly premium includes \$1 Administrative fee  
One time Enrollment Fee (non - refundable): 35.00  
Total Initial Payment: 60.08  
Single Payment Option: 323.96 Saves \$11/Yr

# Free Standing Benefits - FSB

## Review and Sign

The FSB application could require up to 5 signatures

- The Client and Agent will always sign
- Spouse will have to sign if being insured
- Payor will sign only if someone other than the primary insured is paying the premium.
- Witness/Translator will sign if the application needed to be translated or a witness was present for the signature of the client.

Signature

Signature of Applicant or Authorized Legal Representative (including valid Power of Attorney, Legal Guardian, etc)

☐ Client Sign

☐ Agent Sign

☐ Spouse Sign

☐ Payor Sign

☐ Witness Sign

Signature of Witness/Translator or Person assisting in completion of form (other than agent)

Witness/Translator Last Name:

Witness/Translator First Name:

Click the radio button next to the person signing to activate the signature pad.

Signatures must be completed in order.

Only the signatures needed will show except for the witness.

Save and Close once everything is completed.

## Review and Sign

Power Attorney signing the application :

- must provide demographic information for them
- They must send supporting documents to billing and enrollment to stay in the plan.

If you are the authorized legal representative (POA), you must sign above and provide the following information.

Last Name	First Name:	MI:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	Address 2	
<input type="text"/>	<input type="text"/>	[No Title]
City	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone	Relationship to Applicant	
<input type="text"/>	<input type="text"/>	

You will be receiving a request for supporting documentation upon your enrollment. This supporting documentation is required in order to remain on the plan.

The FSB application allows the upload to be delay  
Upload must be completed before effective date

**Optional Upload Delay**

☐ Upload Delay

EffectiveDate

Please enter date for application upload

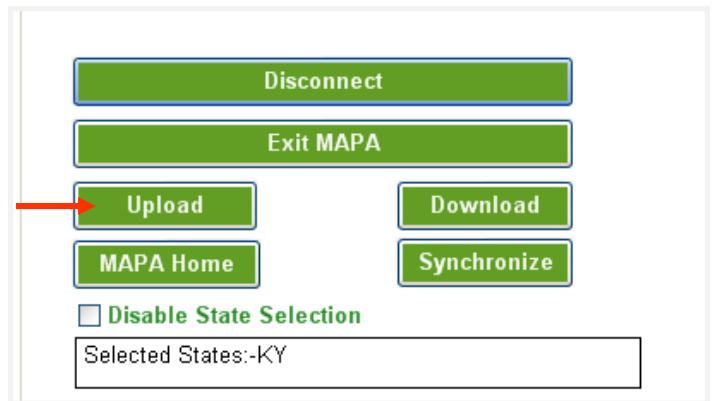
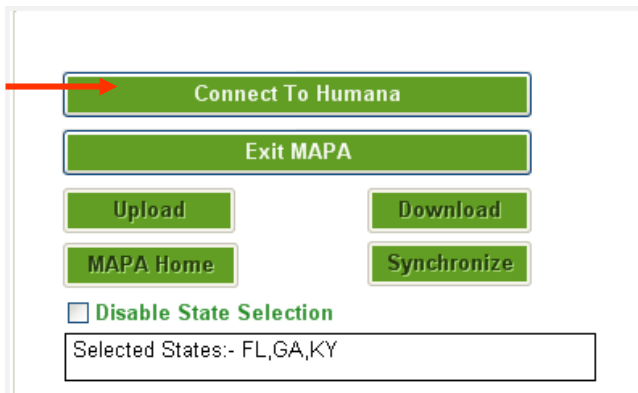
Example: application written and signed on 7/10/2011

Upload Delay set to 7/29/2011.

On 7/29/11 when an upload is completed this application will be sent

# Uploading

To upload completed applications follow the previous process **Connect to Humana** and select **Upload** from the Agent Self Service Center page.



**Applications must be uploaded at the end of everyday**



You must upload completed applications everyday.

# Uploading

An error message has been added to advise you when the lead files are running

When error received wait 30 minutes then try again

The screenshot shows the MAPA Workbench interface. At the top, it says 'Welcome Rebecca Boston! Please remember to Synchronize and DOWNLOAD!'. There are buttons for 'Disconnect', 'Upload', and 'MAPA Home'. A message box in the center states: 'The Lead file is currently processing, please wait 30 minutes before uploading.' with 'Yes' and 'No' buttons. Below the message box is a table with columns: Type, Last Name, First Name, Address, City, State, Zip, Phone, Status, and Hold Status. The table contains three rows of data.

Type	Last Name	First Name	Address	City	State	Zip	Phone	Status	Hold Status
Individual	Pet	Plewer	1515 dit lane	Louisville	KY	40299	(502) 466 5555	MAPA Cancelled	
Individual-SNP	Fish	Fred	1515 west st.	Louisville	FL	33497	(562) 333 3333	Incomplete	
CarePlus-Individual	will	robinson	950 will go	dade	FL	33012		Incomplete	

## Upload justification

Applications must be uploaded every night

A 24 hour upload justification section has been added

If an application is not uploaded 24 hours from the time signed justification must be provided

The screenshot shows a dialog box titled 'Reason For Not Uploading'. It contains a message: 'Applications taken on the following date(s) were not uploaded within 24 hours of completion. Select the reason for the delay of upload for each date. If there was a system issue, include the CSS help ticket number.' There are fields for 'Signature Date' (7/18/2011 9:53:43 PM), 'Reason' (a dropdown menu with options: --Select a Reason--, Computer Issue, Connection Issue, Forgot, MAPA Issue, Other), and 'CSS Ticket Number' (a text box with the placeholder 'enter ticket number here'). Below these fields is a table with columns: ApplicationID, Last Name, First Name, Address, City, State, Zip, Phone, Plan/Enrolled, and Signature Date. The table contains three rows of data.

ApplicationID	Last Name	First Name	Address	City	State	Zip	Phone	Plan/Enrolled	Signature Date
600KR14A5E34LT	Thane	Thane	1100A3	West	FL	33497	(562) 333 3333	Humana Gold Choice PFFS ...	7/18/2011 9:53 PM
600KR14A5E3400A	Palmer	Palmer	West	West	FL	33497	(562) 333 3333	Humana Walmart-Preferred ...	7/18/2011 11:13 PM
600KR14A5E34YYD	Deer	Deer	Cass	Cass	FL	33497	(562) 333 3333	HumanaChoicePFO R3005-0...	7/18/2011 11:20 PM

# Uploading

## Upload Completed Applications

Below is an example of a upload summary.

UPLOAD STATUS REPORT					
<a href="#">Print</a>		<a href="#">Print Preview</a>		<a href="#">Export</a>	<a href="#">Done</a>
<b>Upload Complete</b>					
Uploaded:	1 of 5	Applications			
Added:	0 of 5	Contacts			
Updated:	6 of 5	Contacts			
Disposition For:	1 of 5	Contacts (Non TM Lead)			
Disposition For:	0 of 5	Contacts (TM Leads)			
<b>CDS - Contacts Updated</b>					
ApplicationID	Last Name	First Name	Phone		
6MTRL8645XM21JC	Pot	Flower	(502)-666-5555		
S6MTRL832N182LP8	Wonka	Willie	(502)-444-5585		
C7TV7C30XB033YX	wonka		(502)-444-4444		
<b>CDS - Contacts Which Failed To Update</b>					
ApplicationID	Description	Last Name	First Name	Phone	
C7TV7C30XB033YX	A128135	wonka	willy	(502)-444-4444	
<b>Successfully Uploaded Applications</b>					
ApplicationID	Application Type	Last Name	First Name	Phone	Plan Name
C7TV7C30XB033YX	Individual	wonka	willy	(502)-444-4444	HumanaChoice PP...
<b>Applications Which Failed To Upload</b>					
ApplicationID	Application Type	Description	Last Name	First Name	Plan Name
6MTRL8645XM21JC	Individual		Pot	Flower	

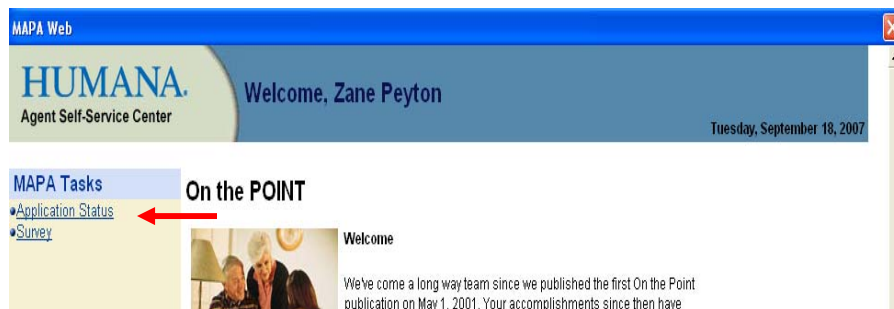
Application Failed to Upload"" or "Application Stuck on Machine" or "Application is Missing".

You should **contact CSS** – At the time of the call you must be at your computer and have internet access. CSS will take a snap shot of the application and send to IT to find out the issue.

**They will need–** Member Name  
Member Medicare ID  
Application ID  
Date application was taken

# Application Status

The application status report will allow you to keep track of all your submitted applications.



Click on  
**Application Status.**

Use the green down  
arrows and enter the  
**From Date** and  
**To Date.**

Select the **Plan Type**  
And **Report Type** you  
want to search on.

Click **SUBMIT.**

A screenshot of the MAPA Web interface showing the 'Agent Report' form. The header is the same as the previous screenshot. The form title is 'Agent Report'. Below the title, a red message states: 'Applications submitted through MAPA will display the following day. Paper applications submitted to ACS will display once the application data has been successfully transmitted to Humana.' The form has two date fields: 'From Date: 9/1/2007' and 'To Date: 9/18/2007', each with a green down arrow. A red arrow points to the 'From Date' field. Below the date fields, there are two dropdown menus: 'Report:' with 'Individual' selected, and 'Plan Type:' with 'MAPD' and 'PDP' options. A red bracket groups these two dropdowns. To the right of the 'Plan Type' dropdown is a link 'Select All'. At the bottom of the form are two buttons: 'Submit' and '<< Previous'.



## MAPA reporting now offers verification reports

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The data contained in this report is for administrative use only and may not be used for marketing purposes of any kind or to solicit disenrolled members. Failure to comply is a violation of federal privacy laws and will result in legal action and disciplinary action up to and including termination.

08/01/2009 - 09/06/2009

Source	Application ID	Last Name	First Name	Middle Initial	Plan Name	Verification Date	Verification Number	Verifier's Name	Reason for Not Verifying
Digital	600KR14XIFT3C09	Smith	Meaghan	A	HumanaChoice PPO H1806-001	08/31/2009			Verification System Down
Digital	600KR15DL559QI	Martin	Betty	A	Humana Gold Plus HMO SNP-DB H1036-117	09/03/2009	3434235334	Adrey	
Digital	600KR15DL55N9I	Brown	Bella mapa	M	HumanaChoicePPO R5826-066	09/03/2009			Seminar Enrollment

## MAPA reporting now ties OSB's and SOA's to applications

[AE Pend Code Legend](#) [Printer Friendly Version](#) [Export](#) [Previous](#) [D](#)

The data contained in this report is for administrative use only and may not be used for marketing purposes of any kind or to solicit disenrolled members. Failure to comply is a violation of federal privacy laws and will result in legal action and disciplinary action up to and including termination.

08/01/2009 - 02/01/2010

Source	Application ID	Last Name	First Name	Middle Initial	Plan Name	OSB (s)	Signature Date	Upload Date	Effective Date	Date Entered in CI	CMS Accrual Date	Scope of Appointment ID	Scope of Appointment Product	AE Pend Code	Disenrol Date
Digital	9TYQMB4W0FD33NY	Marker	Sharpie		HumanaChoicePPO R5826-008	Yes	08/21/2009	08/21/2009	09/01/2009	03/07/2008	03/07/2008	VPND4W0FD3055	MAPD		
Digital	9TYQMB4W0FD37TI	Sub	Way		Humana Gold Choice PFFS H1804-185	Yes	08/21/2009	08/21/2009	09/01/2009	02/03/2008		VPND4W0FD3055	MAPD	AE0362BQ	
Digital	9TYQMB4W0FD3HV1	Patterson	Barbara		Humana Gold Choice PFFS H1804-193	Yes	08/21/2009	08/21/2009	09/01/2009	02/03/2008					
Digital	9TYQMB4W0FD3NDE	Crane	Scott		HumanaChoicePPO H0623-001	Yes	08/24/2009	08/24/2009	09/01/2009	02/11/2008					
Digital	9TYQMB4W0FD3NS6	Amos	Tori		HumanaChoicePPO H0623-001	Yes	08/24/2009	08/24/2009	09/01/2009	02/11/2008	01/07/2009				01/07/2009
Digital	9TYQMB4W0FD3O0H	Hunter	Wayne		HumanaChoicePPO H1806-001	Yes	08/24/2009	08/24/2009	09/01/2009	02/20/2008	03/01/2008				
Digital	9TYQMB4X30931IQ	Mapatested	Gjaubhyi A		HumanaChoicePPO R5826-008	Yes	08/31/2009	08/31/2009	09/01/2009	02/20/2008	03/01/2008				
Digital	9TYQMB4XAQ13HCR	Turner	Rebecca A		HumanaChoice PPO H1806-001	Yes	08/31/2009	08/31/2009	09/01/2009	02/19/2008	03/18/2008				

# Reporting

A report retrieval option has been added to the MAPA Workbench

1. Run the report
2. Close the report
3. retrieve the report at a later date
4. Click Reports
5. Enter the date of the report needed
6. select Report TYPE
7. Click Retrieve Reports
8. Select the report file

06/01/2011 - 08/09/2011

## Application Status report

Source	Application ID	UIC	Last Name	First Name	Vehicle	County	Plan Name	CSE	Phone	Signature	Upload Date	Effective Date	Received Date	in AE	Entered	Approved	CDS
Digital Ref	071V7C020U-371N		Car	Pat		WANCERUPSH	Choice PFFS	Yes			08/09/2011	08/09/2011	07/01/2011	In Process			
Digital	4296037		Shenest Street	EROWARD		HumanaChoice PPO	H0145C01	Yes			08/08/2011	08/08/2011	07/01/2011	In Process			
Digital	4296002		Tester	Humana	BOONE	Humana Warner Preferred Rx Plan (PDP)		Yes	8888888888		08/15/2011	08/15/2011	07/01/2011	In Process			

**Upload Report**

Upload Complete

Uploaded:	1 of 3	Applications
Added:	1 of 7	Contacts
Updated:	4 of 7	Contacts
Disposition For:	5 of 7	Contacts (Ren TM Lead)
Disposition For:	6 of 7	Contacts (TM Lead)
Outcomes For:	7 of 7	Activities

CDS - Contacts Updated

ApplicationID	Last Name	First Name	Phone
0000000000	MOORE	MOORE	(502) 297-1111
0000000000	DUCK	DONALD	(802) 971-0006
0000000000	COSKIE	COSKIE	(502) 455-0055

CDS - Contacts Which Failed to Update

ApplicationID	Description	Last Name	First Name	Phone
0000000000	Update failed for Contact - Self	Self	Self	
0000000000	Update failed for Contact - Blank	Blank	Blank	(202) 202-2002

Successfully Uploaded Applications

ApplicationID	Last Name	First Name	Phone
0000000000	Ring	Diamond	

Applications Which Failed to Upload

ApplicationID	Description	Last Name	First Name	Phone
0000000000	Update failed for Application with Policy ID is 45	Self	Self	
0000000000	Update failed for Application with Policy ID is 46	Blank	Blank	(202) 202-2002

**Reports**

Please select Date range for reports

From Date: 05/13/2011 To Date: 08/10/2011

Select Report Type: Application Status Report

**Retrieve Reports**

Select a Application Status Report File: No reports available

**Open** **Cancel**

	A	B	C	D	E	F	G
1	"CDS - CONTACTS UPDATED"						
2							
3	ApplicationID	LastName	FirstName	PhoneNumber			
4	F6MTRL8A4D3V2FCZ	crunch	captin	(502)-333-3333			
5							
6							
7	"CDS - CONTACTS WHICH FAILED TO UPDATE"						
8							
9	ApplicationID	UploadContactDescription	LastName	FirstName	PhoneNumber		
10							
11							
12	"SUCCESSFULLY UPLOADED APPLICATIONS"						
13							
14	ApplicationID	ApplicationType	LastName	FirstName	PhoneNumber	PlanName	
15	F6MTRL8A4D3V2FCZ	FSB	crunch	captin	(502)-333-3333	Ind Dental Preventative Plus PPO	
16							
17	"APPLICATIONS WHICH FAILED TO UPLOAD"						
18							
19	ApplicationID	ApplicationType	UploadContactDescription	LastName	FirstName	PhoneNumber	PlanName

# Clone an Application

Sometimes, you will be working with a client and need to complete another application for a related family member. To keep from having to start with a blank application, you can create a **Clone** (a copy) of the client's application that is stored on your laptop, make the necessary changes for the client's relative, and save the new member's application. You create a clone of an application by **clicking the application record** (this will highlight the record and make the **Clone Application** button accessible) and then clicking on the **Clone Application** button.

**Application Search**

Search By: ☒ All ☐ Complete ☐ Incomplete

**Clone App** **Load App** **Cancel App**

Type	Last Name	First Name	Address	City	State	Zip	Phone	Status
Individual	Tree	Crab	9898 Willow Tree ...	Louisville	KY	40299		Incomplete
Individual	fefe	efere			KY	40220		Incomplete
Individual	River	Swanny	1212 River Rd	Louisville	KY	40299	(222)-222-2222	Complete
Group	Puff	Powder	1212 Cotton lane	louisville	KY	40299	(222)-222-2222	Incomplete
AEF	Ring	Diamond	1515 Willy street	Louisville011999	KY	40299		Complete

A copy of the application will appear containing the members demographic information just as it was stored in the original. You can now make any necessary additions/changes to the application and process it in the same way as you did for the client.

**Demographics** **Medicare Card** **Clinical Qualifying** **Plan Specific** **Payment** **Agent Only**

**Client Information**

Zip Code: 40299 County: BULLITT, KY Social Security Number(Optional): Re-enter SSN: Date Of Birth: / /

Available Plans: --Select a Plan--

Last Name: River First Name: MI:

Address 1: 1212 River Rd Address 2 / APT #:

City: Louisville State: KY Zip: 40299 County: BULLITT, KY Phone: (222) 222-2222 (###) ###-####

Mailing Address (if different from Street Address)

Address 1: Address 2 APT #:

City: State: Zip:

Email Address, If available, will be used as a means to communicate various Humana related information (Optional)

# Copy an Application

Copy Application: will allow an agent to create one application and auto fill a different application with the data

Note: The review and sign page will not copy

## Steps:

1. Select the member application to copy
2. Click on the new application type to complete
3. Click Copy App

The screenshot shows the MAPA application interface. On the left, there are buttons for 'Connect To Humana', 'Exit MAPA', 'Upload', 'Download', 'MAPA Home', and 'Synchronize'. On the right, there is a section for 'Application Type' with radio buttons for 'English' (selected), 'Spanish', 'Group', 'Individual', 'Member Authorization' (with 'FSB' selected and 'REAL For Me' as an option), and 'Are Supplement' (with 'Single' and 'Husband and Wife' as options). Below this is the 'Application Search' section with a 'Search By:' dropdown set to 'All' and a filter for 'Incomplete' (highlighted with a red box and a hand icon pointing to it, labeled '1'). Below the filter is a table with columns: Type, Last Name, First Name, Address, City, State, Zip, Phone, Status, and Hold Status. The table contains four rows of data. The first row is highlighted in blue. A red box and a hand icon pointing to the 'Copy App' button are labeled '3'. The 'Copy App' button is located at the bottom right of the table.

Type	Last Name	First Name	Address	City	State	Zip	Phone	Status	Hold Status
Individual	Pot	Flower	1515 dirt lane	louisville	KY	40299	(502)-666-5555	Complete	
FSB	Duck	Donald	1515 disney lane	louisville	KY	40299	(502)-666-6666	Incomplete	
Individual	Fish	Fred	1515 west main Street	louisville	KY	40299	(502)-333-3333	Incomplete	
FSB	Studley	Juan	125 main street	palm coast	FL	33497	(502)-222-2222	Incomplete	

# Deleting an Application

You can **delete incomplete applications** that are stored on your laptop by clicking the application record (this will highlight the record and make the **Delete Application** button accessible) and then clicking on the **Delete Application** button.

**You are never to delete a signed application!!**

Application Search

Search By: ☒ All ☐ Complete ☐ Incomplete

Type	Last Name	First Name	Address	City	State	Zip	Phone	Status
Individual	MAPATESTED	GL	622 W 300 N	DECATUR	IN	46733	(219)-724-7538	Incomplete

1) Highlight the application needed and click Delete App

MAPA

Are you sure you want to Delete this application?

2) Click yes

3 ) A message box will confirm the application has been deleted. Click OK to close the message boxes.

MAPA

Application Deleted

# Canceling an Application

The cancel App button is only used for **COMPLETED** applications.

If the member calls the agent to cancel before the agent has uploaded the application, they are to mark it **MAPA cancelled** which passes an error code to Enrollment

Click on the application you want to cancel  
Then click the Cancel APP button

Application Search

Search By: ☒ All ☐ Complete ☐ Incomplete

Type	Last Name	First Name	Address	City	State	Zip	Phone	Status
Individual	fefe	efere			KY	40220		Incomplete
Individual	River	Swanny	1212 River Rd	Louisville	KY	40299	(222)-222-2222	Complete
Group	Puff	Powder	1212 Cotton lane	Louisville	KY	40299	(222)-222-2222	Incomplete
AEF	Ring	Diamond	1515 Willy street	Louisville011999	KY	40299		Complete

You will have to select YES to Confirm you want to cancel this application

MAPA

Are you sure you want to Cancel this application?

Once you say YES the application is canceled

Application Cancelled

The status will change to MAPA cancelled  
And upload as a cancelled application

Application Search

Search By: ☒ All ☐ Complete ☐ Incomplete

Type	Last Name	First Name	Address	City	State	Zip	Phone	Status
Individual	fefe	efere			KY	40220		Incomplete
Individual	River	Swanny	1212 River Rd	Louisville	KY	40299	(222)-222-2222	MAPA Cancelled

# Member Receipt

All the information you need to complete the receipt is on the application this receipt is used when you write a MAPA or Fast APP application.

**NEVER add PHI (e.g. SSN,DOB) information to a receipt**

Temporary Proof of Membership in Humana's Medicare Plans		Humana Medicare Plans	
Application ID Number: <u>6MTRL85JDH42KRG</u>		New Member Services: 1-888-839-7316	
Member Name: <u>Bugs Bunny</u>		Monday-Friday, 8 a.m. – 6 p.m.	
Proposed Effective Date: <u>04/01/2009</u>		TDD# (for hearing impaired): 1-800-833-3301	
Plan Name: <u>Humana PPO Enhanced</u>		24-Hour Precertification: 1-800-523-0023	
Primary Care Physician (PCP): _____		Doctor and Hospital: Preadmission certification is required for all nonemergency and nonurgent services for HMO plans; however, it is requested for PPO and PFFS plans.	
PCP Phone (if applicable): _____		Providers can call Provider Relations at 1-866-291-9714 for PFFS plan terms and conditions.	
Copayment: PCP _____ Specialist _____ ER _____		Medicare Plan: GR: <u>240673</u> Rx Plan: PCN: <u>03200000</u>	
		BN: <u>001</u> BN: <u>610649</u>	
<u>Rebecca Boston</u> <u>03/02/09</u>		<u>Bugs Bunny</u> <u>03/02/09</u>	
Agent Signature	Date	Member Signature	Date
GN85023DRR 0206		Medicare approved HMO, PPO, PDP and PFFS plans.	

# Member Receipt For OSB

All the information you need to complete the receipt is on the application  
this receipt is used when you write an OSB application.

Note: At this time we do not have specialized receipts for the OSB applications, below is an example of how to modify the MA receipts for the OSB.

**NEVER add PHI (e.g. SSN,DOB) information to a receipt**

Temporary Proof of Membership in Humana's Medicare Plans		Humana Medicare Plans	
Application ID Number: <u>6MTRL85JDH42KRG</u>		New Member Services: 1-888-839-7316	
Member Name: <u>Bugs Bunny</u>		Monday-Friday, 8 a.m. – 6 p.m.	
Proposed Effective Date: <u>04/01/2009</u>		TDD# (for hearing impaired): 1-800-833-3301	
Plan Name: <u>Enter name of OSB plan</u>		24-Hour Precertification: 1-800-523-0023	
Primary Care Physician (PCP): <u>Dental HMO dentist name</u>		Doctor and Hospital: Preadmission certification is required for all nonemergency and nonurgent services for HMO plans; however, it is requested for PPO and PFFS plans.	
PCP Phone (if applicable): <u>Number of HMO dentist</u>		Providers can call Provider Relations at 1-866-291-9714 for PFFS plan terms and conditions.	
Copayment: PCP _____ Specialist _____ ER _____		Medicare Plan: GR: <u>240673</u> Rx Plan: PCN: <u>03200000</u>	
		BN: <u>001</u> BN: <u>610649</u>	
<u>Rebecca Boston</u> <u>03/02/09</u>		<u>Bugs Bunny</u> <u>03/02/09</u>	
Agent Signature _____ Date _____		Member Signature _____ Date _____	
GN85023DRR 0206		Medicare approved HMO, PPO, PDP and PFFS plans.	



# **Troubleshoot MAPA**

## **What is Troubleshoot MAPA?**

Many times agents are not able to perform various operations through MAPA: such as Upload applications, download etc.

The Troubleshoot option in MAPA will resolve all such issues. It will also fix missing database objects or issues related to troubleshoot.

Troubleshoot will not erase any data from agent's machine.

## **When to Troubleshoot MAPA?**

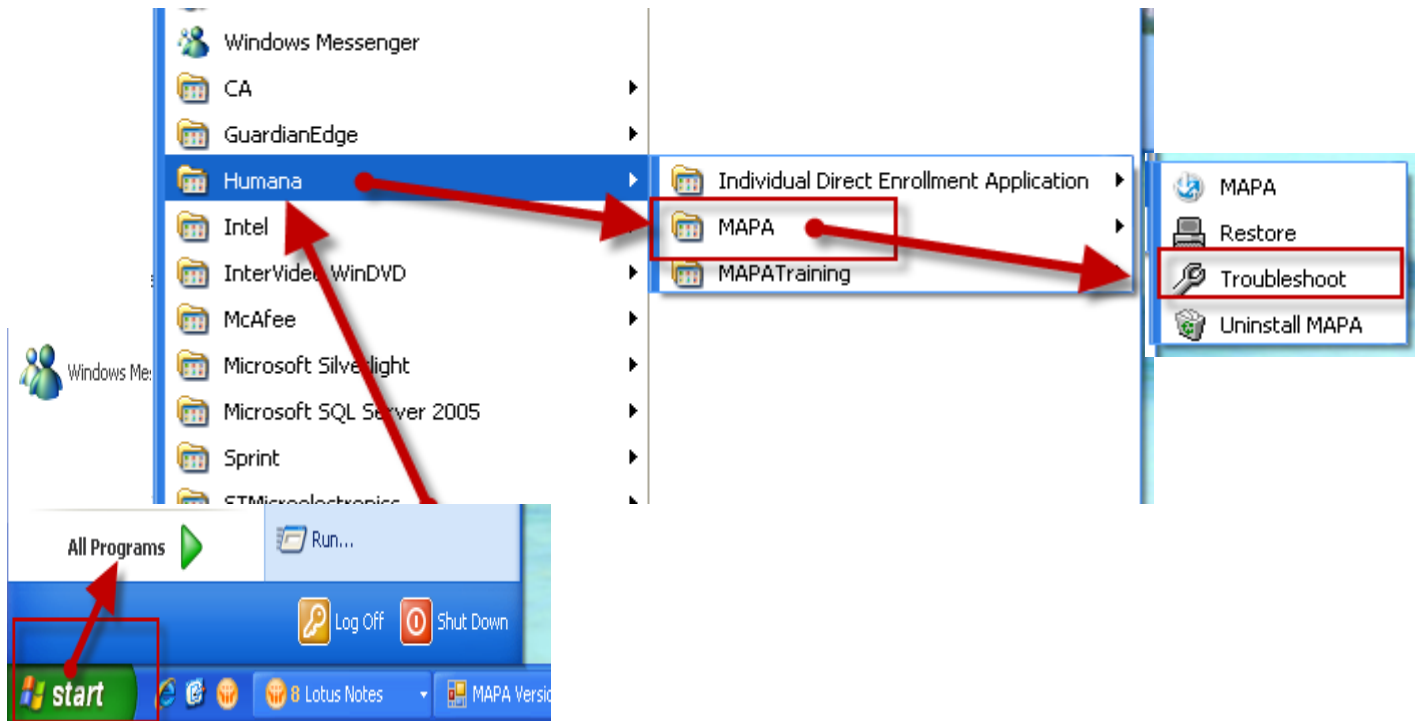
Troubleshoot option can be used while agents are facing following issues

1. Unable to Sync or Download
2. Unable to upload applications.
3. Applications upload issue
4. Agent has certification and is unable to see the plans
5. MAPA fails to load an application

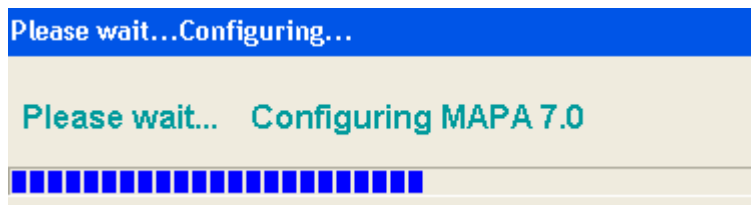


## How to Troubleshoot MAPA

Go to Start->All Programs->Humana->MAPA-> Troubleshoot



When you Click on Troubleshoot. MAPA will configure on Agent's machine.



After Troubleshooting MAPA:

Log into MAPA

Create a new UserId and Password for MAPA.

Log into MAPA again

Connect to Humana and Synchronize then Download MAPA.