



Enrollment HUB

How to Complete an MAPD Application

Summary

This job aid explains the steps to complete an MA/MAPD enrollment application.

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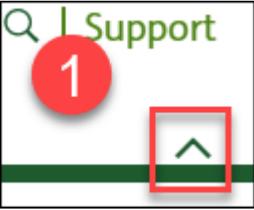
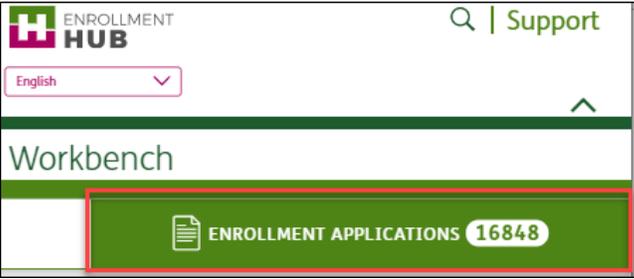
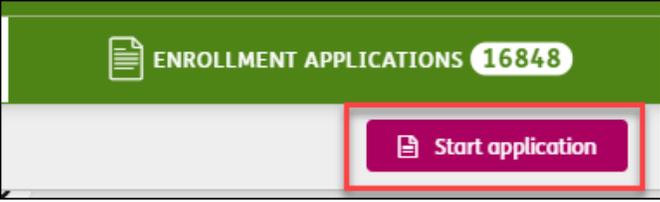
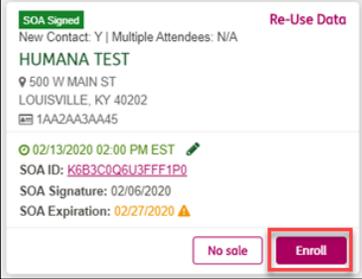
Process

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Revised 02-16-24 | TRN-REF-927en / IMO number if applicable



How to Complete an MAPD Application

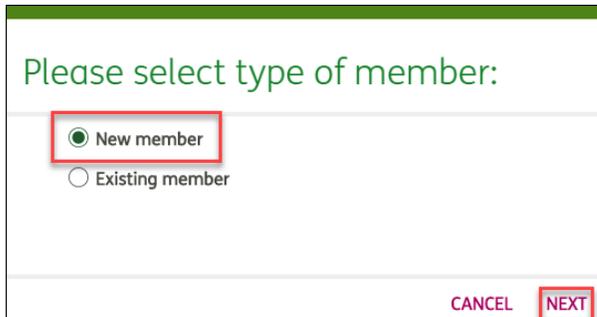
| | |
|--|---|
| <p>First, click the header toggle to reveal the language selection drop-down box. If you need to complete the application in Spanish, select Spanish from the list.</p> |   |
| <p>Click the ENROLLMENT APPLICATIONS tab.</p> |  |
| <p>From the Workbench, click on the ENROLLMENT APPLICATIONS tab. Then click on START APPLICATION.</p> <p>If you secured an SOA for your applicant in Enrollment HUB, locate the SOA card on the APPOINTMENTS tab and click ENROLL.</p> |   |

Continue on next page

How to Complete an MAPD Application

Select **NEW MEMBER** to fill-out an application for a new member.

Select **EXISTING MEMBER** to fill-out an abbreviated enrollment form for a plan-to-plan change or to add an Optional Supplemental Benefit (OSB) to a member's existing plan.



Please select type of member:

New member

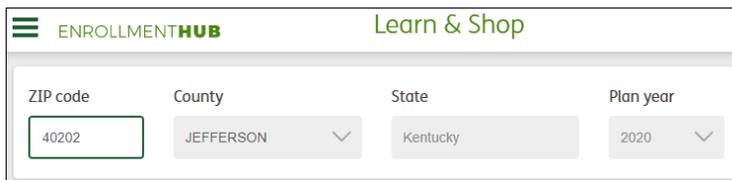
Existing member

CANCEL NEXT

Enter the applicant's zip code in the **ZIP CODE** field. The **COUNTY, STATE** and **PLAN YEAR** fields will auto-populate.



The Plan Year drop-down menu will require you to select the appropriate year during AEP.



ENROLLMENT HUB Learn & Shop

ZIP code County State Plan year

40202 JEFFERSON Kentucky 2020

The **AGENT TOOLBOX** section will give you access to the Pharmacy Calculator, Provider Locator and Digital Marketing Materials. The links are only active in Connected mode.



Agent Toolbox

PHARMACY CALCULATOR PROVIDER LOCATOR Digital Marketing Materials

Continue on next page

In the Enrollment Type section select the **INDIVIDUAL MEDICARE – (MA, MAPD, PDP)** option.



Enrollment type

Individual Medicare (MA/MAPD/PDP)

OSB Add-On

Medicare Supplement (English Only)

Medicare Supplement

Individual Dental & Vision (English Only)

Dental and Vision (IDV)

Group Individual Medicare

Group Individual Medicare

How to Complete an MAPD Application

The Pharmacy pop-up box will display. If you would like to create a drug list for your customer, click on the **GO TO PHARMACYCALCULATOR** link.

If you do not want to create a drug list for your customer, click the drop-down arrow and select a reason:

- Medications already priced
- Educated - Not Interested No Rx

Then click on **DONE**.



The pop-up will not display if you have already created a drug list by accessing the pharmacy calculator in Enrollment Hub.

Would you like to create a drug list for this customer?

[Go to PharmacyCalculator](#)

No, thanks. (Please select reason)

-- Please Select --

-- Please Select --

Medications already priced

Educated - Not Interested No Rx

DONE

Continue on next page

Select **YES** to confirm that you have completed a compliant sales presentation.

You must complete the presentation to proceed with the enrollment process. Have you completed the presentation?

Yes No

In the Eligibility Determination and Additional Information section enter:

- First Name
- Last Name
- Medicare Number
- Part A and Part B effective dates

Eligibility & Medicare Card Information

(Please enter the Medicare Card Information exactly as it appears on the Medicare Card.)

| | | |
|-----------------------------|----------------------------|----------------------|
| First Name | Middle Initial (optional) | Last Name |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Medicare Number | Re-enter Medicare Number | (Sample Card) |
| <input type="text"/> | <input type="text"/> | |
| Hospital Insurance (Part A) | Medical Insurance (Part B) | |
| <input type="text"/> | <input type="text"/> | |

How to Complete an MAPD Application

| | |
|--|---|
| <ul style="list-style-type: none">• Gender• Date of birth | <div><p>Additional Information</p><p>Gender</p><p><input type="radio"/> Male</p><p><input checked="" type="radio"/> Female</p><p>Date of birth</p><p>MM/DD/YYYY </p></div> |
|--|---|

Continue on next page

Individual Medicare Plan Listing

The Plan Listing section shows all the information about the plans that are available for the beneficiary to enroll in. The plans will display on the screen per applicant's zip code and the agent's licenses and certifications.

The Individual Medicare Plan Listing includes the following information about the plans:

1. Plan Name & Rating

- **Benefit Summary:** This section includes the name of the plan and includes a detailed summary of the plan benefits. By clicking on the plan name, a PDF of the plan's Summary of Benefits (SB) will display with additional information.
- **5-Star Rating:** The Star Rating measures the quality and performance of the plan. The plan's Star Rating helps applicants compare plans based on quality and performance. This will only display if there is a 5-Star plan(s) in the applicant's service area.

2. **Coverage and Benefits:** Each plan includes coverage benefits and detailed plan information. This section of the screen will allow you to see certain details of the plan, which you can share with your applicant.

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Learn & Shop

2024 - Individual Medicare Plan Listing
 All (23) MAPD (17) MA (3) PDP (3)

Indicates a 5 Star plan. Medicare evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change.
 All product names, logos, brands and trademarks are the property of their respective owners, and any use does not imply endorsement.

| Benefit Summary | Monthly Premium | Rx | Office PCP/ Specialist Co-pays | Max Medical Out-of-Pocket | Hospital you pay: | OSB plans | |
|---|-----------------|-----|--------------------------------|---------------------------|-------------------------|-----------|---|
| HMO Plans | | | | | | | |
| <input type="radio"/> Humana Community H1036-236 | \$0.00 | Yes | \$0 / \$15 | \$3,400.00 | Details | No | + |
| <input type="radio"/> Humana Community HMO C-SNP Diabetes and Heart H1036-234 | \$0.00 | Yes | \$0 / \$5 | \$3,100.00 | Details | No | + |

[Enroll](#)

Continue on next page

| <p>From the BENEFIT SUMMARY column, select the desired plan and click the radio button next to the plan name. You can only select one plan for each applicant.</p> | <div style="border: 1px solid black; padding: 5px;"> <p>2020 - Individual Medicare Plan Listing <input checked="" type="checkbox"/> All (14) <input checked="" type="checkbox"/> MAPD (9) <input checked="" type="checkbox"/> MA (2) <input checked="" type="checkbox"/> PDP (3) </p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Benefit Summary</th> <th style="width: 10%;">Monthly Premium</th> <th style="width: 5%;">Rx</th> <th style="width: 15%;">Office PCP/ Specialist Co-pays</th> <th style="width: 15%;">MMOOP</th> <th style="width: 10%;">Hospital you pay:</th> <th style="width: 5%;">OSB plans</th> <th></th> </tr> </thead> <tbody> <tr style="background-color: #e8f5e9;"> <td colspan="8">HMO Plans</td> </tr> <tr> <td> <input checked="" type="radio"/> Humana Community H1036-236 </td> <td>\$0.00</td> <td>Yes</td> <td>\$0 / \$30</td> <td>\$3,900.00</td> <td>Details</td> <td>Yes</td> <td style="text-align: right;">+</td> </tr> <tr> <td> <input type="radio"/> Humana Community HMO Diabetes and Heart H1036-234 </td> <td>\$0.00</td> <td>Yes</td> <td>\$0 / \$35</td> <td>\$6,700.00</td> <td>Details</td> <td>Yes</td> <td style="text-align: right;">+</td> </tr> </tbody> </table> </div> | Benefit Summary | Monthly Premium | Rx | Office PCP/ Specialist Co-pays | MMOOP | Hospital you pay: | OSB plans | | HMO Plans | | | | | | | | <input checked="" type="radio"/> Humana Community H1036-236 | \$0.00 | Yes | \$0 / \$30 | \$3,900.00 | Details | Yes | + | <input type="radio"/> Humana Community HMO Diabetes and Heart H1036-234 | \$0.00 | Yes | \$0 / \$35 | \$6,700.00 | Details | Yes | + |
|---|--|-----------------|--------------------------------|------------|--------------------------------|-----------|-------------------|-----------|--|------------------|--|--|--|--|--|--|--|---|--------|-----|------------|------------|-------------------------|-----|---|---|--------|-----|------------|------------|-------------------------|-----|---|
| Benefit Summary | Monthly Premium | Rx | Office PCP/ Specialist Co-pays | MMOOP | Hospital you pay: | OSB plans | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HMO Plans | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input checked="" type="radio"/> Humana Community H1036-236 | \$0.00 | Yes | \$0 / \$30 | \$3,900.00 | Details | Yes | + | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> Humana Community HMO Diabetes and Heart H1036-234 | \$0.00 | Yes | \$0 / \$35 | \$6,700.00 | Details | Yes | + | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Upon plan selection, the BEQ (Beneficiary Eligibility Query) service request and disclaimer will display.</p> <p>Agree = service will attempt to synchronize with CMS and verify that the information entered is correct. There are three messages that may display</p> <p>Disagree = user will continue to click “ENROLL” to move into the enrollment application form</p> | <div style="border: 1px solid black; padding: 10px;"> <p style="color: #990000; font-size: small;">It is important that the information provided is correct to the best of your knowledge. In an attempt to avoid delays of your enrollment application being processed, we would like to verify your information with CMS prior to enrollment submission.</p> <p style="color: #990000; font-size: small;">Do we have your consent to complete this verification?</p> <p style="color: #990000; font-size: small;">Please note that during this validation, CMS may provide additional details regarding your eligibility, which could assist your licensed sales agent with choosing the plan that best fits your needs.</p> <p style="text-align: right; margin-top: 10px;"> Disagree Agree </p> </div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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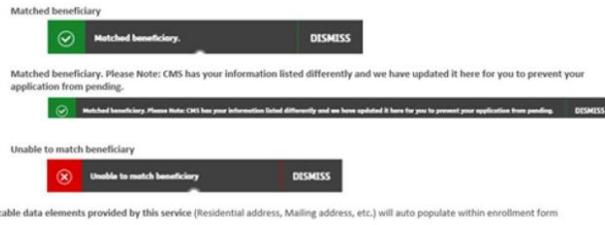
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If the information is retrieved successfully from BEQ you will receive a successful alert that will indicate if the data you provided has been updated by the service or was correctly entered. With either response, you will need to validate the beneficiary's Date of Birth, Name, Part A and Part B dates, and Medicare number to ensure it is still accurate.

After the service is ran there will be 3 possible message/results;



This service will **NOT** populate or change ANY address or demographic information. You must ensure that the residential and mailing addresses that you ket into the application are accurate

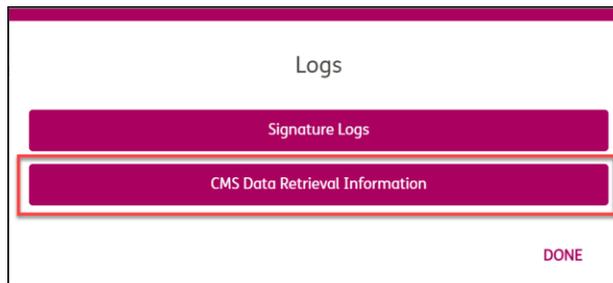
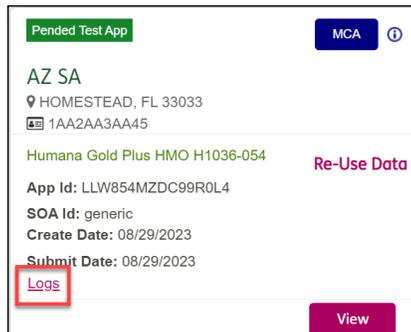
Continue on next page

If the CMS retrieval doesn't work you can still continue with the application.

If the BEQ successfully retrieves the beneficiary's information you will be able to see the information retrieved from the Logs link on the enrollees card on the Workbench.

To view that information:

1. Continue to the enrollment form
2. Click **SAVE** then click **WORKBENCH** from the menu
3. Look for the enrollee's card on your workbench
4. Click on **CMS Data Retrieval Information**



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The log will display relevant information including, but not limited to, the following:

- Low-income Subsidy start date (if applicable)
- Part D Premium Subsidy (if applicable)
- Medicaid Status (if applicable)

Example: LIS Information

| |
|---|
| DEEMED/LOW INCOME SUBSIDY START DATE (OCCURRENCE 1) |
| DEEMED/LOW INCOME SUBSIDY END DATE (OCCURRENCE 1) |
| PRTD PREMIUM SUBSIDY PERCENT (OCCURRENCE 1) |

Example: Medicaid Information

| |
|---------------------|
| MEDICAID STATUS |
| MEDICAID START DATE |
| MEDICAID END DATE |



Make sure to verify that the applicant had Medicaid or Low Income Subsidy (LIS/Extra Help) before using the Medicaid or LIS election period. If the information does not display or Medicaid/LIS has not become effective do NOT proceed with the enrollment

Continue on next page

Next, click the **ENROLL** button to move forward to the enrollment application form.

2020 - Individual Medicare Plan Listing
 All (14)
 MAPD (9)
 MA (2)
 PDP (3)

| Benefit Summary | Monthly Premium | Rx | Office PCP/ Specialist Co-pays | MMOOP | Hospital you pay: | OSB plans |
|---|-----------------|-----|--------------------------------|------------|-------------------|-----------|
| HMO Plans | | | | | | |
| <input checked="" type="radio"/> Humana Community H1036-236 | \$0.00 | Yes | \$0 / \$30 | \$3,900.00 | Details | Yes |
| <input type="radio"/> Humana Community HMO Diabetes and Heart H1036-234 | \$0.00 | Yes | \$0 / \$35 | \$6,700.00 | Details | Yes |
| <input type="radio"/> Humana Community HMO SNP DE | \$0.00 | Yes | \$0 / \$0 | \$0.00 | Details | Yes |

Enroll

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Read the **DISCLOSURE STATEMENT** to the applicant before moving forward. At the top of the form, you see the name of the plan the applicant is enrolling in. In this case the applicant is enrolling in the **MAPD HumanaChoice PPO H5216-018** plan.

Disclosure Statement

Read this information verbatim to the applicant:

The licensed sales agent that is discussing plan options with you is either employed by or contracted with Humana. This licensed sales agent may be compensated based on your enrollment in this plan.

Answering non-required fields is your choice. You can't be denied coverage if you don't complete them.

Continue on next page

In the **ACKNOWLEDGEMENT** section select either:

- **YES**, to move forward
- **NO**, if the applicant does not understand or agree with the statements

Acknowledgement

Based on what we have discussed, do you understand that this plan has coverage for medical and prescription drugs?

Yes No

Based on the plan you selected are you aware that this is NOT a Medicare Supplement Plan?

Yes No

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| | |
|---|--|
| <p>In the DECISION MAKER section specify who is completing the application.</p> | <p>Decision maker</p> <p>Please tell us who is completing your enrollment form.</p> <p><input type="radio"/> I'm completing my enrollment form on my own.</p> <p><input type="radio"/> I have Power of Attorney (POA) or other authorization under state law and am applying on someone's behalf.</p> |
| <p>Complete the following fields in the MEDICARE INFORMATION section:</p> <ul style="list-style-type: none">• Last Name• Middle Initial (optional)• First Name• Gender <p>The Medicare Number, Hospital Insurance Part A and Part B, and Date of Birth fields will auto-populate.</p> | <p>Medicare Information</p> <p>Please take out your Medicare card, your Railroad Retirement (RRB) letter, or your Social Security letter to complete this section. Please fill in these blanks so they match your red, white and blue Medicare card or your letter from Social Security/RRB.</p> <p>Please Note: You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p> <p>Hospital Insurance (Part A) 11/01/2019 </p> <p>Medical Insurance (Part B) 11/01/2019 </p> <p> You can always edit the fields by selecting the Edit pencil and updating them on the Learn & Shop page.</p> |

Continue on next page

| | |
|---|--|
| <p>Select the appropriate ELECTION PERIOD type. Your options are:</p> <ul style="list-style-type: none">• AEP• IEP• ICEP• OEP• OEP New• OEP-I• SEP | <p>Read this information verbatim to the applicant:</p> <p>Typically, you may enroll in a Medicare Advantage or prescription drug plan during the Annual Election Period (AEP) between October 15 and December 7 of each year. In addition, you can choose to change your Medicare Advantage plan once during the annual Open Enrollment Period (OEP) between January 1 and March 31 of each year, or immediately after enrolling in a plan during your IEP/ICEP (OEP NEW). Limitations on allowed plan changes during OEP apply. There are exceptions that may allow you to enroll outside of these periods. Please read the following statements carefully and select the oval to the left of any statement that applies to you. By selecting any of the below ovals you are certifying that, to the best of your knowledge, the text is a true statement about you. If we later determine that this information is incorrect, you may be disenrolled.</p> |
|---|--|

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| | |
|--|---|
| <p>Then select the Proposed Effective Date from the drop-down menu.</p> | <div data-bbox="678 222 1052 361"><p>Proposed effective date</p><input type="text"/></div> <div data-bbox="685 415 792 508"></div> <p data-bbox="818 403 1409 562"><i>All election periods will display in the application. However, based on the current date or plan type, not all election types will be available to choose.</i></p> |
| <p>In the APPLICANT ADDRESS section, complete the following sections:</p> <ul style="list-style-type: none">• Street Address 1• Street Address 2 (optional)• City <p>The County, State and Zip Code fields will auto-populate with the information entered on the LEARN & SHOP page.</p> | <div data-bbox="678 634 1412 865"><p>Applicant Address (PO Box not allowed except if experiencing homelessness) ⓘ</p><p><input type="checkbox"/> By checking this box, you, the agent, are attesting that the applicant is homeless, only has a PO Box, and lives in the county for the zip code provided.</p><p>Street Address 1</p><input type="text"/></div> <div data-bbox="691 907 805 999"></div> <p data-bbox="831 915 1409 1033"><i>Check the box if the applicant is homeless, only has a PO Box, and lives in the county for the zip code provided.</i></p> |

Continue on next page

| | |
|--|--|
| <p>If the applicant's mailing address is different from their physical address, check the box and enter the following information:</p> <ul style="list-style-type: none">• Street Address 1• Street Address 2 (optional)• City• County• State• Zip Code | <div data-bbox="678 1268 1412 1579"><p>Applicant Mailing Address (If different from physical address)</p><p><input checked="" type="checkbox"/> Check if your mailing address is different from your physical address</p><p>Street Address 1</p><input type="text"/></div> |
|--|--|

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In the **CONTACT INFORMATION** section, complete the Applicant Phone Number field (optional) and select the corresponding phone type.

If the applicant provides a cell phone number read the disclosure in the green box

If the applicant has an Email address that they would like to provide enter it in the Applicant Email field (optional).

If the applicant is a current Humana member enter their Member ID (optional).

Contact Information

Applicant Phone Number Would you like to provide your phone number? (optional)

502-502-1511

Phone Type

Cell Phone Home (land line)

READ TO APPLICANT: "There may be times when we will use an automated system to call or text you. When that happens, we will use the telephone number you provided."

Applicant Email Would you like to provide your email address? (optional)

I prefer not to provide

I prefer not to provide

Is it OK to Email?
(Note: eSignature is not allowed if this response is No.)

Yes No

Member ID Number (optional) ⓘ

Continue on next page

The Gender and Date of Birth fields in the **ADDITIONAL APPLICANT INFORMATION** section will be completed already with the data entered on the Learn & Shop page.

Next, ask the applicant the following demographic questions and check the boxes that apply. If the applicant does not wish to answer please select the **I CHOOSE NOT TO ANSWER** checkbox.

Additional Applicant Information

Gender

Male Female

Date of Birth

10/03/1954 

How to Complete an MAPD Application

| | | | | | | | | | | | | | | | | | |
|---|---|---|--|---------------------------------------|--------------------------------------|--|---|----------------------------------|---------------------------------|-----------------------------------|-------------------------------------|--|--------------------------------|-----------------------------------|---|---------------------------------|--|
| | <p>Are you of Hispanic, Latino/a, or Spanish Origin. Select all that apply.</p> <p><input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish Origin</p> <p><input type="checkbox"/> Yes, Mexican, Mexican American, or Chicano/a</p> <p><input type="checkbox"/> Yes, Puerto Rican</p> <p><input type="checkbox"/> Yes, Cuban</p> <p><input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin</p> <p><input type="checkbox"/> I choose not to answer</p> | | | | | | | | | | | | | | | | |
| | <p>What's your race? Select all that apply.</p> <table border="0"><tr><td><input type="checkbox"/> American Indian or Alaska Native</td><td><input type="checkbox"/> Native Hawaiian</td></tr><tr><td><input type="checkbox"/> Asian Indian</td><td><input type="checkbox"/> Other Asian</td></tr><tr><td><input type="checkbox"/> Black or African American</td><td><input type="checkbox"/> Other Pacific Islander</td></tr><tr><td><input type="checkbox"/> Chinese</td><td><input type="checkbox"/> Samoan</td></tr><tr><td><input type="checkbox"/> Filipino</td><td><input type="checkbox"/> Vietnamese</td></tr><tr><td><input type="checkbox"/> Guamanian or Chamorro</td><td><input type="checkbox"/> White</td></tr><tr><td><input type="checkbox"/> Japanese</td><td><input type="checkbox"/> I choose not to answer</td></tr><tr><td><input type="checkbox"/> Korean</td><td></td></tr></table> | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Other Asian | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> Chinese | <input type="checkbox"/> Samoan | <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> White | <input type="checkbox"/> Japanese | <input type="checkbox"/> I choose not to answer | <input type="checkbox"/> Korean | |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Other Asian | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other Pacific Islander | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Samoan | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> White | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> I choose not to answer | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Korean | | | | | | | | | | | | | | | | | |

Continue on next page

| | |
|--|--|
| <p>If the applicant would like to provide EMERGENCY CONTACT information check the box and enter:</p> <ul style="list-style-type: none">• Last Name• Middle Initial (optional)• First Name | <p>Emergency Contact Information (optional)</p> <p><input type="checkbox"/> I wish to provide an Emergency Contact</p> |
|--|--|

How to Complete an MAPD Application

- Relationship to applicant
- Phone Number

In the **SPOKEN LANGUAGE** and **WRITTEN LANGUAGE** section, click the drop-down menus and select the applicable languages (Optional).

If the applicant has a visual or auditory impairment and would prefer to receive information in an alternative format, click the **ALTERNATIVE FORMAT** drop-down menu and select one of the options.

Preferred Language

Spoken Language (optional)

Written Language (optional)

If you prefer us to send you information in another format, please select one of the accessible options below.

Accessible Format (optional)

Please contact our Member Services Department at 1-800-457-4708 (TTY users should call 711) if you need information in another format or language other than what is listed above. Hours are from 8 a.m. to 8 p.m. local time, Monday through Friday.

Continue on next page

In the **DIGITAL ON-BOARDING** review the statement then ask the applicant, **“Would you like to receive these communications online?”** If the applicant would like to receive communications online click on **YES** and review the information in the green box.

If the applicant would not like to learn about receiving materials electronically, select **NO** and continue to the next section of the application.



If the applicant wants to receive materials electronically, the Email

Digital on-Boarding

You can reduce the amount of mail you get by choosing to receive some communications by email. If you choose this option, we'll send you an email to help activate your secure MyHumana account so you are able to receive communications.

Would you like to receive these communications online?

- Yes No

Communications that you can receive electronically include:

- Plan Coverage Package (Evidence of Coverage, Summary of Benefits, Plan Stars Rating, and Value-Added Services)
- Annual Notice of Change
- Smart Summary[®] - Explanation of Benefits (EOB)
- Plan Messages and Notifications (Verification of Enrollment, Confirmation of Enrollment)
- Medicine Information and Resources
- Health and Wellness Information

Note to agent: if asked, the member can elect to receive certain documents by changing their preferences online at MyHumana or by calling Customer Service.

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field in the Contact Information section must be complete.

Continue on next page

In the **PRIMARY CARE PHYSICIAN** section:

- Read the disclosure statement to the applicant
- Complete the **NAME OF PRIMARY CARE PHYSICIAN (PCP)** field
- Complete the **PCP ID NUMBER** field
- Read the “*Are you an established patient of the physician you selected?*” question and select the corresponding answer.



You can use the Search For My Doctor link and use Physician Finder to locate the PCP information

PCP

Note to agent: The plan selected requires identification of a Primary Care Physician (PCP) in order to process the enrollment. If connected, you can use the “Search for my doctor” button below to locate the appropriate PCP and then enter the information requested for the Primary Care Physician for the plan that the applicant is enrolling.

Search for my doctor



Name of Primary Care Physician (PCP)

PCP ID Number

Are you an established patient of the physician you selected?

Yes

No

Continue on next page

How to Complete an MAPD Application

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| <p>In the OTHER COVERAGE section, read each question to the applicant and select the appropriate answer. Applicants can answer YES or NO to each question.</p> <p>If the applicant will have other medical health coverage and/or other prescription drug coverage in addition to the plan for which they are applying for, additional fields will display where you can enter information about the other coverage.</p> | <div data-bbox="678 537 1419 894" style="border: 1px solid black; padding: 5px;"><p>Other Coverage</p><p>Once enrolled, will you or your spouse work?</p><p><input type="radio"/> Yes <input type="radio"/> No</p><p>Will you have other prescription drug coverage (like VA, TRICARE) in addition to this plan for which you are applying?</p><p><input type="radio"/> Yes <input type="radio"/> No</p></div> |
| <p>Next, read the question “<i>Are you enrolled in your state’s Medicaid coverage?</i>” to the applicant and select YES or NO.</p> <p>If the answer is YES, complete the Applicant Medicaid Number (optional) and Effective Date (optional) fields.</p> | <div data-bbox="678 1251 1390 1486" style="border: 1px solid black; padding: 5px;"><p>Medicaid</p><p>Are you enrolled in your state’s Medicaid coverage?</p><p><input type="radio"/> Yes <input type="radio"/> No</p></div> |

How to Complete an MAPD Application

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| | <p>Applicant Medicaid Number (optional)</p> <p><i>Please make sure the correct Medicaid ID number is provided</i></p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div> <p>Effective Date (optional)</p> <div style="border: 1px solid black; padding: 2px;"> MM/DD/YYYY </div> |
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| <p>In the OPTIONAL SUPPLEMENTAL BENEFIT (OSB) QUESTIONS section, the applicant has the chance to add an OSB to their MA/MAPD plan.</p> <p>Read the “Are you interested in a supplemental benefit plan?” question, and select YES or NO. If the answer is YES, you will be required to select the OSB plan(s) that the applicant wants to add.</p> <div style="border: 1px solid purple; padding: 5px; width: fit-content; margin-top: 10px;"> <p><i>Optional Supplemental Benefits (OSB) are NOT available on every MA/MAPD plan.</i></p> </div> | <div style="border: 1px solid black; padding: 5px;"> <p>Optional Supplemental Benefits (OSB) questions</p> <p>Are you interested in a supplemental benefit plan (Dental, Vision, etc.)?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Optional Supplemental Benefits for this plan:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;"><input type="checkbox"/> MyOption Enhanced Dental HMO</td> <td style="text-align: right; padding: 2px;">\$19.50</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> MYOPTION TOTAL DENTAL HMO</td> <td style="text-align: right; padding: 2px;">\$23.30</td> </tr> <tr> <td colspan="2" style="border-top: 1px solid black; padding: 2px;">Total estimated monthly OSB fee</td> </tr> <tr> <td></td> <td style="text-align: right; padding: 2px;">\$0.00</td> </tr> </table> </div> | <input type="checkbox"/> MyOption Enhanced Dental HMO | \$19.50 | <input type="checkbox"/> MYOPTION TOTAL DENTAL HMO | \$23.30 | Total estimated monthly OSB fee | | | \$0.00 |
| <input type="checkbox"/> MyOption Enhanced Dental HMO | \$19.50 | | | | | | | | |
| <input type="checkbox"/> MYOPTION TOTAL DENTAL HMO | \$23.30 | | | | | | | | |
| Total estimated monthly OSB fee | | | | | | | | | |
| | \$0.00 | | | | | | | | |
| <p>In the PAYMENT AMOUNT section select the corresponding Payment Option:</p> <ul style="list-style-type: none"> • Automatic Checking or Savings Account Deduction | | | | | | | | | |

How to Complete an MAPD Application

- Social Security Benefit Check Deduction
- Railroad Retirement Board Benefit check Deduction
- Automatic Credit Card Deduction
- Pay Directly

Payment

Monthly premium for base plan

\$0.00

Please select a payment method to pay your monthly plan premium and/or late enrollment penalties.

Humana has an automated option to help you pay your monthly premiums. You may pay your monthly plan premium and/or late enrollment penalty via automatic deduction from your bank account (ACH), Social Security (SSA) or Railroad Retirement Board (RRB) benefit check, or credit or debit card (CC/DC). You may also choose to pay by mail using a coupon book. For your convenience, would you like to be set up on Social Security (or Railroad Retirement Board) deductions?

Payment Options

- Automatic Bank Account Deduction
- Social Security Benefit Check Deduction
- Railroad Retirement Board Benefit check deduction
- Automatic Credit or Debit Card Deduction
- Pay Directly

The next section is the **LICENSED SALES AGENT DATA**. Most of the fields in this section will auto-populate. Make sure to review the information to verify that it is correct.

Make sure to complete:

- Agency name (optional)
- Agency SAN (optional)
- MGA (optional)
- Licensed Sales Agent email address
- External Partner Alignment – Only for Partner Agents

Licensed Sales Agent data

Licensed Sales Writing Agent Name

SMART TEST AGENT

Location

KY

Licensed Sales Writing Agent SAN

1129696

Licensed Sales Writing Agent SSN

****1234

Licensed Sales Broker/Referral Agent Name

Referral Broker Test Agent

Licensed Sales Broker Referral Agent SAN

1129696

Licensed Sales Broker/Referral Agent SSN

****1234

Licensed Agent of Record (AOR) Name

SMART TEST AGENT

Licensed Agent of Record (AOR) SAN

1129696

How to Complete an MAPD Application

| | |
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| | <div style="border: 1px solid black; padding: 5px;"><p>Agency name (optional) <input type="text"/></p><p>Agency SAN (optional) <input type="text"/></p><p>MGA (optional) <input type="text"/></p><p>Licensed Sales Agent email address <input type="text" value="agent@humana.com"/></p><p>Please select an External Partner Alignment if applicable ⓘ <input type="text" value="State Farm"/></p></div> |
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Continue on next page

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| <p>The SALE DATE section is next. You will find that the GR number and BN number fields are pre-populated.</p> <p>In the VETERAN STATUS drop-down menu, select the corresponding status of the applicant:</p> <ul style="list-style-type: none">• Self• Spouse• Dependent• I am not a Veteran• Prefers not to answer <p>In the SOURCE OF LEAD drop-down menu, select the corresponding source (optional):</p> <ul style="list-style-type: none">• Generated by Agent• Business Marketing Materials• Agent Campaign• Humana Company Campaign | <div style="border: 1px solid black; padding: 5px;"><p>Sale Data</p><p>Campaign Key Code <input type="text" value="0305046921"/></p><p>GR number <input type="text" value="301813"/></p><p>BN number <input type="text" value="001"/></p></div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"><p>Veteran's Status (Would you like to provide your Veteran Status?) <input type="text"/></p></div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"><p>Source of Lead (optional) <input type="text" value="None"/></p></div> |
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Revised 02-16-24 | TRN-REF-927en / IMO number if applicable



How to Complete an MAPD Application

- Other
- None

Continue on next page

Complete the **TIER 1, TIER 2** and **TIER 3** drop-down fields.

The **PRIMARY REASON SOLD** field will be auto-populated based on the plan selected. From the **PLEASE SELECT THE REASON SOLD** drop-down select the applicable reason. The choices are:

- Good Network
- Good Service
- SNP
- Rates Competitive
- Silver Sneakers / Value Added Services
- Strong Benefit Package / Rx Coverage

Business segment (Tier 1)

Marketing source (Tier 2) Where did you hear about us?

Sale Location (Tier 3) Where did this enrollment form happen?

Primary Reason Sold

Sold - MAPD

Please Select the Reason Sold

Please Select the Reason Sold

Good Service

Brand Recognition

Continue on next page

How to Complete an MAPD Application

In the **SOA SOURCE** section specify the method you used to complete the SOA. If SOA ID is selected you will need to enter the SOA ID in the **SOA ID** field.

In the **PRODUCTS DISCUSSED** section, select the product(s) that you discussed during your presentation.

SOA Source

SOA ID

Generic (non-Humana)

SOA ID

Products discussed

ALL MA MAPD MA/MAPD

PDP Med Supp Dental Other

Vision Hospital Indemnity

There are **FOUR** signature types available in Enrollment HUB:

- **Electronic Signature** - An email will be sent to the applicant with a link that can be accessed to sign the application electronically.
- **Digital Signature** - Captures a digital signature using a touchscreen, mouse, mouse pen or signature pad

Select signature type

Choose the preferred signature method for this enrollment

- Electronic Signature Digital Signature ⓘ Telephonic Signature ⓘ
- SMS Text Signature ⓘ



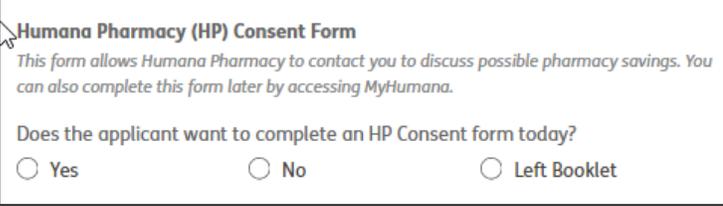
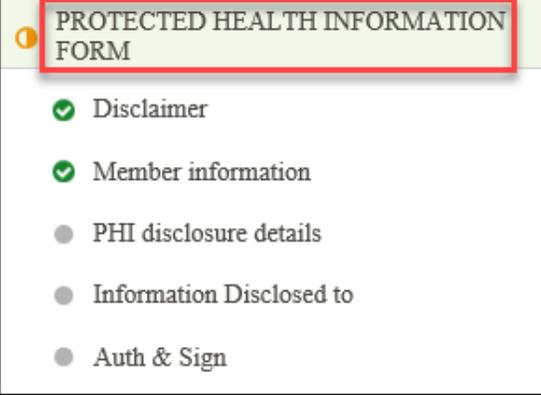
This job aid will explain the steps to capture a digital signature. For instructions on how to complete an Electronic or Telephonic signature, please review the following job aids found on the Enrollment HUB Training Toolkit:

- **[How to Complete an Electronic Signature](#)**
- **[How to Complete an Telephonic Signature](#)**
- **[How to Complete an SMS Text Signature](#)**

How to Complete an MAPD Application

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| <ul style="list-style-type: none">• Telephonic Signature – A verbal signature that is taken through an agent-assisted voice recording with a client• SMS Text Signature – An SMS text message will be sent to the user’s mobile device with a link that can be accessed to sign the application electronically |  <p>Call Center Sales Agents should NEVER use the Digital Signature option.</p> |
| <p>Next, is the DIGITAL SIGNATURE section. You must review all of the information in this section with the applicant before capturing the applicant’s signature.</p> | <p>Digital Signature</p> <p>All required information must be completed before you can select a signature method.</p> <p>*Please inform the applicant of the following: Your coverage will begin on the first day of the next month as long as CarePlus has your completed and signed enrollment form no later than the last day of the this month. If CarePlus receives your completed enrollment form after the last day of this month, your coverage will not begin until the first day of the following month.</p> <p>Once you have completed the enrollment form, please make sure you do the following before you sign it.</p> <ol style="list-style-type: none">1. Review it for accuracy2. Read the important information at the bottom of the enrollment form carefully. This information outlines how enrolling in our plan may affect other coverage you may have, the terms and conditions of the plan you are enrolling in, and what your responsibilities are as member of our plan. |
| <p>Once you have reviewed all of the required information, allow the applicant to sign the application using your touchscreen, mouse, mouse pen, or signature pad.</p> <p>Click on CAPTURE SIGNATURE.</p>  <p><i>The signature pad that is compatible with Enrollment HUB is the Topaz model T-LBK460-HSB-R</i></p> | <p>Please inform the applicant of the following: Signature of applicant or authorized legal representative (as indicated in the Decision maker section above)</p>  <p>Clear signature Capture signature</p> |
| <p>A message will display informing you that the signature was captured successfully. Click on DISMISS.</p> |  <p>You've captured the signature successfully! DISMISS</p> |

How to Complete an MAPD Application

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| <p>Click on CONTINUE.</p> |  |
| <p>Next, you will be able to fill-out the POST ENROLLMENT forms before submitting the application for processing.</p> <p>Once in the Post Enrollment Form screen, read each consent form description to the applicant and ask if they would like to complete the form(s). Select YES or NO.</p> <p> <i>Post Enrollment Forms are only available when Digital Signature is selected.</i></p> |  |
| <p>The form(s) that the applicant would like to fill-out will display on the navigation pane on the left side of the screen. Click on the Post Enrollment form name to open the form(s) and complete.</p> |  |
| <p>Once you have completed the post-enrollment forms, click on CONTINUE.</p> |  |

How to Complete an MAPD Application

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| <p>On the ENROLLMENT SUMMARY page you will be able to review and/or print the Enrollment Application and the Post-Enrollment forms.</p> | <div data-bbox="690 220 1247 451"><ul style="list-style-type: none">✔ POST ENROLLMENT FORMS✔ ENROLLMENT SUMMARY✔ MEMBER AUTHORIZATION SUMMARY✔ PROTECTED HEALTH INFORMATION SUMMARY</div> <div data-bbox="690 489 841 646"></div> |
| <p>Click on ENROLL NOW.</p> | <div data-bbox="690 709 911 793"></div> |
| <p>Click on ENROLL NOW.</p> | <div data-bbox="690 850 1414 1108"><p>You are about to submit this enrollment application with the following post enrollment forms: PHI Form, MAF Form.</p><p>Would you like to proceed?</p><p>CANCEL ENROLL NOW</p></div> |
| <p>Click on CONTINUE TO WORKBENCH.</p> | <div data-bbox="690 1211 1403 1465"><p>Thank you. Your enrollment application has been successfully submitted. Your App ID is KOHG1RKNBMO1NGU1 and MAF Form ID is KOHG6WGOB7PEMEF9. You can check the updated status in Workbench.</p><p>CONTINUE TO WORKBENCH</p></div> |

How to Complete an MAPD Application

The completed application will be displayed on the Workbench.

Click on the **HRA** link to complete the Health Risk Assessment.

| | |
|--------------------------------|-------------|
| Submitted | HRA ⓘ |
| BENCOMOTEST TESTBENCOMO | |
| 📍 LOUISVILLE, KY 40202 | |
| 🏠 1AA2AA3AA45 | |
| Humana Gold Plus HMO H5619-071 | Re-Use Data |
| App Id: LSP06096I0LDTDWW | |
| SOA Id: 54654564654645 | |
| Create Date: 02/16/2024 | |
| Submit Date: 02/16/2024 | |
| Logs | |
| | View |

Process complete