

Onine Encourations



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Alignment
Health
Agent Portal Login
Agent Fortal Login
Email Address
Email Address
Password
Sign in
Forgot your password?
NEED AN ACCOUNT? Alignment agents and agencies receive access to our broker portal upon certification Contact our Partner Experience team for help

STEP 1

Go to: https://brokerportalalignmentprd.b2clogin.com/ Enter Email Address and Password

Click on the "Sign in" button

ONLINE ENROLLMENT INSTRUCTIONS

<u></u>	Ithcare				Welcome Bryan	LOG OUT
HOME	SUBMIT ENROLLMENT	MY CLIENTS	MY COMMISSIONS	FORMS & DOCUMENT	S CERTIFICATION	HELPFUL TOOLS
) Accepted Applicati	ions YTD	27 Submitted A	opplications YTD	Ŕ	O Pending Applications	
ast Update: 0 seco	ond(s) ago	Last Update	: 0 second(s) ago		Last Update:	
) Accepted Applicati	ions MTD	0 Submitted A	opplications MTD	Ŕ	NEW ENROLLMENTS YTD: () PLAN TRANSFERS YTD: ()	B
.ast Update:		Last Update	c		Last Update: 0 second(s) ago	ı
Month to Date					(PBP/market) Year to Date	one by rioduce
Month to Date					(PBP/market) Year to Date	
Month to Date					(PBP/market) Year to Date	4 1 1 1
Month to Date					(PBP/market) Year to Date	
Month to Date					(PBP/market) Year to Date	
Month to Date					(PBP/market) Year to Date	4 1 1 2 1 2 1 2 1 0 008 01

STEP 2

Welcome to the Agent Portal Home Page

To submit an enrollment, click on Submit Enrollment header



ONLINE ENROLLMENT INSTRUCTIONS

Alignment Healthca	re				Welcome Bryan	LOG OUT
HOME	SUBMIT ENROLLMENT	MY CLIENTS	MY COMMISSIONS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into a	n Alignment F	lealthcare pla	an			Review Scripts
	Are you comr	nunicating with the clie	ent in person or telephonic	ally? O In Person	By Phone	1
	Do you want	to record the conversat	tion through Broker Portal	? • Yes	O No	
	i Before gett	ing started, please enter y	our phone number as well a	the client's and any other a	pplicable parties.	
		Enter phone	e numbers to invite:			
		Agent Phone	e Number: *			
		801-123-45	567			
		Client/Other	Phone Numbers: *			
		801-123-45	567	\otimes		
			+ Add phone number			
			Start			

STEP 3

Select the appropriate enrollment type

- In Person
 - Skip to step 4
- By Phone
 - Move to step 3A

Alignment Healthca	re				Welcome Bryan	LOG OUT
НОМЕ	SUBMIT ENROLLMENT	MY CLIENTS	MY COMMISSIONS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into a	ın Alignment H	lealthcare pla	n			Review Scripts
	Are you comn Do you want 1	municating with the clien to record the conversati	nt in person or telephonica on through Broker Portal?	Illy? O In Person	By Phone No	Close >
	i Before getti	ing started, please enter yo	our phone number as well as t	the client's and any other ap	plicable parties.	2024 HMO & PPO Enrollment (ENGL
		Enter phone Agent Phone 801-123-456	numbers to invite: Number: * 67			HMO & PPO Enrollment (SPAN SNP Enrollment (ENGLISH) SNP Enrollment (SPANISH) SOA (ENGLISH)
		Client/Other F	Phone Numbers: *	\otimes		SOA (SPANISH)
			+ Add phone number			
			Start			

STEP 3A

You will notice the phone scripts will populate on the right side of the screen.

Choose the appropriate script to use during your call

Alignment Healthcar	re				Welcome Bryan	LOG OUT
НОМЕ	SUBMIT ENROLLMENT	MY CLIENTS	MY COMMISSIONS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into a	n Alignment H	lealthcare pla	n			Review Scripts
	Are you com Do you want	municating with the clie to record the conversati	nt in person or telephoni ion through Broker Porta	cally? O In Person	By Phone No	Close >
	i Before get	ting started, please enter yo	our phone number as well a	s the client's and any other a	pplicable parties.	2024
		Enter phone Agent Phone 801-123-45	numbers to invite: Number: * 67			HMO & PPO Enrollment (EN HMO & PPO Enrollment (SP SNP Enrollment (ENGLISH) SNP Enrollment (SPANISH) SOA (ENGLISH)
		Client/Other I 801-123-45	Phone Numbers: * 67	\otimes	l	SOA (SPANISH)
			+ Add phone numbe	r		
			Start			

STEP 3B

Make sure that you choose "Yes" to record the conversation through Broker Portal.

If you have your own or agency provided recording process you may choose "No". There will be a checkbox that appears when you press "No" which will have you attest that you are responsible for recording the conversation and will maintain it for a duration of 10 years.

Alignment Healthc	are				Welcome Bryan	LOG OUT
HOME	SUBMIT ENROLLMENT	MY CLIENTS	MY COMMISSIONS	FORMS & DOCUMENT	S CERTIFICATION	HELPFUL TOOLS
Enroll into a	an Alignment F	lealthcare pla	in			Review Scripts
	Are you comr Do you want	municating with the clie to record the conversati	ent in person or telephonic	cally? O In Person ?	 By Phone No 	Close > 2024 ~
	(i) Before getti	ing started, please enter yo Enter phone Agent Phone	our phone number as well as a numbers to invite: Number: *	the client's and any oth	er applicable parties.	HMO & PPO Enrollment (ENGLISH) HMO & PPO Enrollment (SPANISH) SNP Enrollment (ENGLISH) SNP Enrollment (SPANISH)
		801-123-450 Client/Other I 801-123-45	67 Phone Numbers: * 667	\otimes		SOA (ENGLISH) SOA (SPANISH)
			+ Add phone number Start			

STEP 3D

Enter your phone number in the first space provided

Then enter your client's number in the second space provided.

You may add another person to that call by pressing the "+Add phone number" button then entering their number.

When you add these numbers, the system will create a call room by calling the phone numbers and you will speak into your phone to record the call.

ONLINE ENROLLMENT INSTRUCTIONS

=== Alignment Healthca	re				Welcome Bryan	LOG OUT
НОМЕ	Alignment Healthcare HOME SUBMIT ENROLLMENT MY CLEE Inroll into an Alignment Healthcar Image: Trind a Plan (2) View, Compare, Se Image: Trind a Plan (3) Please read the script Plan Image: Trind a Plan (3) Please read the script Plan Image: Trind a Plan (3) Please Image: Trind a Plan (3) Please <	MY CLIENTS	MY COMMISSIONS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into a	n Alignment H	lealthcare pla	n	Welcome Bryan LOG OUT MY COMMISSIONS FORMS & DOCUMENTS CERTIFICATION HELPFUL TOOLS Image: Continue (a) Enroll (c) Review scripts SOA Confirmation (a) Enroll (c) Review and Submit now requires a TPMO to verbally convey the following the minute of a sales call: (c) Review and Submit e.a. Currently, I represent [number of organizations] organizations organizations or area. Please contact Medicare.gov, 1–800–MEDICARE, or your information on all of your options." est fits your client's needs. ext	Review Scripts	
1 Find a Plan	2 Vi	ew, Compare, Select	3 SOA Confirmation	4 Enroll	5 Review	and Submit
	(i) Please re standardi "I do not of which offee local State	ad the script below, as zed disclaimer within tl fer every plan available in y r [number of plans] produc Health Insurance Program	CMS now requires a TPM he first minute of a sales your area. Currently, I represe ts in your area. Please conta- to get information on all of y	O to verbally convey the f call: int [number of organizations] ct Medicare.gov, 1-800-MED your options."	organizations NCARE, or your	
	F	Find a Plan tha	at best fits your	[.] client's needs.		
		Zip	Code *			
		-	Continue			

STEP 3E

Read this disclaimer to your client Enter the beneficiary's Zip Code, and click Continue

Skip to step 5



ONLINE ENROLLMENT INSTRUCTIONS

Alignment Healthc	are				Welcome Bryan	LOG OUT
НОМЕ	SUBMIT ENROLLMENT	MY CLIENTS	MY COMMISSIONS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into a	an Alignment H	lealthcare pla	n			
1 Find a Plan	Note Not Compare, Select () Find a Plan () View, Compare, Select () Sola Confirmation () Enroll () Find a Plan () View, Compare, Select () Sola Confirmation () Enroll () Find a Plan that best fits your client's needs. 2/2 Code * () Continue	and Submit				
	F	Find a Plan tha	at best fits your	r client's needs.		

STEP 4

In Person: Enter the beneficiary's Zip Code, and click Continue

ONLINE ENROLLMENT INSTRUCTIONS

Alignment Healtho	are				Welcome Bryan	LOG OUT
HOME	SUBMIT ENROLLMENT	MY CLIENTS	MY COMMISSIONS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into	an Alignment H	ealthcare pla	ın			
1 Find a Plan	(2) Vi	ew, Compare, Select	3 SOA Confirmation	4 Enroll	5 Revie	w and Submit
	F	ind a Plan tha Zip Code * 92868 Orange County, CA	Coverage 2024 2024 Select 2023 2024 Continue	r client's needs		

STEP 5

Select Coverage Year, and click Continue

ONLINE ENROLLMENT INSTRUCTIONS

			🗎 ava-	broker-dev.azurewebs	ites.net	C		0 1
Alignment He	althcare						Welcome Scot	LOG OUT
HOME	SUBI	MIT ENROLLMENT	MY CLIENTS	FOR	MS & DOCUMENTS	CERTIFICAT	ION	HELPFUL TOOLS
Enroll into	an Alignm	nent Healtho	care plan					
0	Find a Plan	View, Compa	ire, Select	3 SOA Confirma	ation	Enroll	5 Review and S	ubmit
Available p	ans in zip co	ode 92868 (O	range County	')		Sc	Lowest Mo	onthly Premium
O Choice Pla	n (HMO) 001	Compare Plans	Platinum Plan	(HMO) 008	Compare Plans	Heart & Diabo	etes Plan (HM	IO SNP) Compare
	\$0			\$0			\$0	
	Monthly Premium			Monthly Premium			Monthly Premiu	m
\$0	\$0	\$3,200	\$0	\$0	\$1,499	\$0	\$0	\$3,400
PCP Copay In-Network	Specialist Copay In-Network	Out-Of-Pocket Max In-Network	PCP Copay In-Network	Specialist Copay In-Network	Out-Of-Pocket Max In-Network	PCP Copay In-Network	Specialist Copay In-Network	y Out-Of-Pocket Max In-Network
OTC \$10/Month 24/7 Concierge (Telehealth Member Rewards	are Ageneric Heathcar	CESS AA	OTC \$20/Month 24/7 Concierge C Telehealth Member Rewards	are	cess AA	OTC \$20/Month 24/7 Concierge Telehealth Member Reward	Care	CCESS
/iew plan details > Select primary care p Search for other prov	hysician >		View plan details > Select primary care pl Search for other provi	hysician > iders >		View plan details > Select primary care Search for other pro	physician > oviders >	
RIMARY CARE F	HYSICIAN SELECT	ΓΙΟΝ						
Ve strongly enco	urage selection of	a primary care						
ssigned automa	tically to HMO enr	ollees if one is						
ot selected here	. For PPO plans, P	CP selection is						

STEP 5

Select the Desired Plan

If enrolling into an HMO, you will need to Select Primary Care Physician

ONLINE ENROLLMENT INSTRUCTIONS

Se	earch by PCP Name or NPI	Q
	Clear Selection	
Sho code	wing Primary Care Providers within 3 e 92868	5 miles of zip
	Angel Guillen Perez, M NPI: 1477654440 PCP - Family Medicine Nearest Location: 2015 W 1st St Santa Ana, CA 92703	D 뗡
	B B 3 Groups Locations	9 3.10 miles away
C	 Joseph Rossini, DO NPI: 1689612848 PCP - Family Medicine Nearest Location: 1168 N Euclid St Anaheim, CA 92801 	5
	61GroupsLocations	5.78 5.78 5.78
	Paul R. Mercer, MD NPI: 1649224098 PCP - Family Medicine Nearest Location: 1275 N Rose Dr Placentia, CA 92870	(5)
	6 6 4 Groups Locations	7 .11 miles away
	« < 1 2 1068	> >>
		(

STEP 6

Select PCP by clicking on one of the preloaded names, or SEARCH by typing in the PCP's name

You will also notice there are ribbon ratings next to doctors' names. This is the High-Quality PCP badge it will only show on 4 or 5 star rated physicians

ONLINE ENROLLMENT INSTRUCTIONS



STEP 6 (cont)

Once you click on desired PCP a pop-up box will open for you to select a MEDICAL GROUP

Check the box if they are an existing patient with that provider

Press the "Proceed" button

Scroll to the bottom of the page and press the green "Continue" button

ONLINE ENROLLMENT INSTRUCTIONS

M Fri Oct 2	1	agents.alignmenthealthcare.com ≘		
	This optional benefit offers an enhanced provider netwo	ork. View dental provider network.		
		Enhanced Dental Option		
		\$27.00		
		Monthly Premium		
	Diagnostic 0%			
	Restorative 50-70%			
	Endodontics 70%			
	Periodontics 0-70%			
	Extractions 50-70%			
	Prosthodontics 70%			
	Calendar Year Maximum Coverage \$1,500			
	Back	No Thanks, continue without optional benefit	Yes, I want to add the optional benefit!	

STEP 6 (cont)

Optional Supplemental Buy-Up

Select whether member would like to enroll into the optional supplemental buy up

If yes, click on Yes, I want to add the optional benefit

If no, click on No Thanks, continue without optional benefit



ONLINE ENROLLMENT INSTRUCTIONS

Alignment Healtho	care				Welcome Bryan	LOG OUT
HOME	SUBMIT ENROLLMENT	MY CLIENTS	MY COMMISSIONS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into	an Alignment H	lealthcare pla	n			
(1) Find a Plan	2 Vi	ew, Compare, Select	3 SOA Confirmation	(4) Enroll	5 Review	v and Submit
• Zip code: 9 Physician Na Provider ID: 0 Medical Grou	92868 - Alignment He a me: Angel Guillen Perez, M DCNSC11477654440 ip: Optum Care Network - 3	alth Platinum + Inst a MD South Coast	acart (HMO) 008 - P	lan Year 2024 - \$0.00	1	
Who's completing	the Enrollment Applicatio	1?				
Field Agent			~			
s information bein	g provided by the beneficia	ary authorized represent	tative? * O Ye	s O No		
cope of Sale he Centers for Me hsure understand his form is confide o you have a Scop	es Appointment Cor edicare and Medicaid Serv- ing of what will be discuss ential and should be comp pe of Sales Appointment F	firmation Form ces requires agents to o ed between the agent a eted by each person wit orm to upload? *	document the scope of a ind the Medicare benefic th Medicare or his ther au	marketing appointment pr iary (or their authorized rep uthorized representative. o	ior to any face-to-face sa resentative). All informa	ales meeting to tion provided on
			oload SOA Or drop fil	es here		
I attest that this	file is an SOA *					
		Please review t	his enrollment information	on with the client.		
			Expand <			
		E	Back Contin	ue		

STEP 7

If beneficiary has an authorized representative, you will upload a copy of the Power of Attorney (POA)

If you have a physical copy of the Scope of Appointment (SOA), you will upload a copy.

If you DO NOT have a physical copy of the Scope of Appointment (SOA), click NO

Scroll to the bottom of the page and press the green "Continue" button

ONLINE ENROLLMENT INSTRUCTIONS

	5	lan		
1 Find a Plan	2 View, Compare, Select	3 SOA Confirmation	(4) Enroll	5 Review and Submit
• Zip code: 92868 - /	Alignment Health Platinum + Ir	nstacart (HMO) 008 - Plan '	Year 2024 - \$0.00 🖋	
Physician Name: Ange Provider ID: OCNSC11 Medical Group: Optum	l Guillen Perez, MD 477654440 Care Network - South Coast			
/ho's completing the Enrol	Iment Application?			
		~		
Field Agent				
Field Agent	d by the beneficiary authorized repre	sentative? * O Yes	No	
Field Agent s information being provide Scope of Sales Appo	d by the beneficiary authorized represi intment Confirmation Forn	sentative? * O Yes	No	
Field Agent s information being provide Scope of Sales Appo The Centers for Medicare ar insure understanding of which his form is confidential and	d by the beneficiary authorized repres Nintment Confirmation Forn Id Medicaid Services requires agents at will be discussed between the age should be completed by each persor	sentative? * O Yes n to document the scope of a mar nt and the Medicare beneficiary (with Medicare or his/her author	No keting appointment prior (or their authorized repre- ized representative.	to any face-to-face sales meeting to sentative). All information provided on

To be completed by applicant or authorized representative

Please initial below beside the type of product(s) you want the agent to discuss.

Medicare Advantage Plans (Part C) and Cost Plans



Medicare Health Maintenance Organization (HMO)

A Medicare Advantage Plan that Provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan

A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

STEP 7 (CONT)

If you DO NOT have a physical copy of the Scope of Appointment (SOA), click NO

You will need to complete and electronic version of the Scope of Appointment (SOA)

ONLINE ENROLLMENT INSTRUCTIONS

By signing below, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing below does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Electronic Signature Agreement

By signing below, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement.

BENEFICIARY OR AUTHORIZED REPRESENTATIVE SIGNATURE AND SIGNATURE DATE

Signature - First and Last Name *	Date *		
	11/15/2023		

To be completed by Agent

Agent Name *	Agent Phone *	Beneficiary Name		Beneficiary Phone	
BRYAN HO	443-322-2222				
Beneficiary Address		Initial Method of Contact *		Represented Plans *	
		Select	~	Alignment Health Plan	~

Electronic Signature Agreement

By signing below, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement.

AGENT SIGNATURE AND SIGNATURE DATE

Signature - First and Last Name *	Date Appointment Completed *		
	11/15/2023	F	

Scope of Appointment documentation is subject to CMS record retention requirements.

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:



Please review this enrollment information with the client.

Expand <

Back Continue

STEP 7 (CONT)

Once the Scope of Appointment (SOA), has been completed, scroll down and click CONTINUE

Please provide a brief description if the SOA is signed at the time of the appointment.

ONLINE ENROLLMENT INSTRUCTIONS

Enroll into an Align	ment Healthcare pl	an		
-				
1 Find a Plan	2 View, Compare, Select	3 SOA Confirmation	4 Enroll	6 Review and Submit
1 - Medicare Advantage Eligib	ility Verification 2 - Client I	nformation 3 - Additior	al Information	
• Zip code: 92868 - Aligi	nment Health Platinum + In	stacart (HMO) 008 - Pla	n Year 2024 - \$0.00	Ø
Physician Name: Angel Gui Provider ID: OCNSC114776 Medical Group: Optum Care	illen Perez, MD 554440 e Network - South Coast			
Medicare Advantage Eligibi	ility Verification			
Typically, you may enroll in a Mec exceptions that may allow you to	licare Advantage plan only during enroll in a Medicare Advantage p	the annual enrollment period lan outside of this period.	from October 15 throug	gh December 7 of each year. There are
Please read the following statem the best of your knowledge, you a	ents carefully and check the box i are eligible for an Enrollment Perio	if the statement applies to yo od. If we later determine that	u. By checking any of the this information is incorr	e following boxes you are certifying that, to rect, you may be disenrolled.
I am new to Medicare.				
I am enrolled in a Medicare Ad	lvantage plan and want to make a	a change during the Medicare	Advantage Open Enrolln	nent Period (MA OEP).
I recently moved outside of the	e service area for my current plan	or I recently moved, and this	plan is a new option for	me.
I recently was released from ir	ncarceration.			
I recently returned to the Unite	ed States after living permanently	outside of the U.S.		
I recently obtained lawful pres	ence status in the United States.			
I recently had a change in my l	Medicaid (newly got Medicaid, ha	d a change in level of Medica	id assistance, or lost Me	edicaid).
I recently had a change in my l Extra Help).	Extra Help paying for Medicare pr	escription drug coverage (ne	wly got Extra Help, had a	change in the level of Extra Help, or lost
I have both Medicare and Med haven't had a change.	licaid (or my state helps pay for m	ny Medicare premiums) or I g	et Extra Help paying for r	my Medicare prescription drug coverage, but

STEP 8

Select applicable Enrollment Reason

If enrolling during AEP, there is no need to select anything.

Scroll down and click CONTINUE



ONLINE ENROLLMENT INSTRUCTIONS

1 Find a Plan	2 View, Compare, Select	3 SOA Confirmation	4 Enroll	5 Review and Submit
- Medicare Advantage	Eligibility Verification 2 - Client	Information 3 - Additior	al Information	
• Zip code: 92868	- Alignment Health Platinum + Ir	nstacart (HMO) 008 - Pla	n Year 2024 - \$0.00 🧪	
Physician Name: Ang Provider ID: OCNSC1 Medical Group: Optu	gel Guillen Perez, MD I 1477654440 Im Care Network - South Coast			
Applicant Information				
ead ID # (Alignment Inter	nal Use Only)			
		Get Lead		
roposed Effective Date				
01/01/2024	~			
Aedicare Information Please take out your red, w	white, and blue Medicare card to comple	ete this section. In the spaces	provided, enter your Medicar	e Number (do not enter dashes) and the
ffective Dates for your Pa	art A and Part B coverage.			
ou must have Medicare F	Part A and Part B to join a Medicare Adv	vantage plan.		
MEDICARE HEALTH INSURANCE				
JOHN L SMITH				
ICONN L SMITH IEGA-1753-MK72 ICOSPTAL (PART A) 03-01-2016 IEGICAL (PART B) 03-01-2016				
OWN L SMITH EGATES-MK72 IODIFITAL (PART A) 83-91-8916 Bedicare ID # *	Last Name *	Date Of Bir	th *	

STEP 9

Ensure you have the correct PROPOSED EFFECTIVE DATE

Enter the beneficiary's Medicare number, last name and DOB and click VERIFY to automatically fill in the effective dates

If the system does not automatically fill in the Part A/B effective dates, please complete manually

ONLINE ENROLLMENT INSTRUCTIONS

	Middle Initial	Last Name *	Date Of Birth *
inst wante			mm/dd/yyyy
			,,,
Gender *			
Select Y			
Are you Hispanic, Latino/a, or Spanish or	igin? Select all that apply.		
Select			~
What's your race? Select all that apply.			
Select			~
Select one if you want us to send you in	formation in a language other than Englisl	n	
Select 🗸			
Permanent Address			
Address Line 1 *	Address Line 2	City *	State *
			CA ~
Do not enter a P.U. Box			
Zip Code *			
92868			
Is mailing address the same as permane	ent address? * O Yes O No		
Contact Information			
Home Phone # *	Cell Phone #	Email *	
Emergency Contact Information			
First Name	Middle Initial	Last Name	Relationship to Client

STEP 9 (cont) Fill in all Required Fields

Scroll down and click CONTINUE

EMAIL REQUIREMENT WILL BE REVIEWED ON NEXT PAGE

ONLINE ENROLLMENT INSTRUCTIONS

	agents	s.alignmenthealthcare.com 🗎		•
92018				
Is mailing address the same as	s permanent address? * 🧿 Yes 🛛 🔿	No		
Contact Information				
Home Phone # *	Cell Phone #	Email *		
	Cell Phone #	Email		
Emergency Contact Inf	ormation			
First Name	Middle Initial	Last Name	Relationship to Client	
First Name	Middle Initial	Last Name	Select	٥
Primary Phone #	Email			
Primary Phone #	Email			
Please contact Alignment Our office hours are 8 a.m (except holidays) from Ap Do you work? Yes Does your spouse work? Y The following materials will be Part C Explanation of Bene Part D Explanation of Bene Annual Notice of Change (Health Plan at 1-866-634-2247 (TTY 711) i . to 8 p.m., 7 days a week (except Thanksg ril 1 through September 30. • No Yes No • sent to you via email unless you prefer to refits (EOB) efits (EOB). (ANOC) Back	if you need information in an accessi iving and Christmas) from October 1 receive a printed copy. Please check t	ble format other than what's listed abo through March 31, and Monday to Frid below if you prefer to receive a printed	vve. Jay version.



ONLINE ENROLLMENT INSTRUCTIONS

AM PROCE	agents.alignmenthealthcare.com ⋒	÷ 0470
1	 1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Alignment Health Plan? * Yes O No 	
2	2. Do you have a chronic condition that qualifies you for a special needs plan? * O Yes O No	
3	3. Are you eligible for State Medicaid? * O Yes O No	
	4. Are you enrolled in your State Medicaid Program? ★ ○ Yes ● No	
,	Paying your plan premiums	
י ר ז	You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.	
F	Please select a plan premium and/or late enrollment payment option: *	
	○ Get a Bill	
	 Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.) 	
I I 1	If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Alignment Health Plan the Part D-IRMAA.	



STEP 10 (cont)

Answer the required questions and select how the member would like to pay for their Monthly Plan Premium

Scroll down and click CONTINUE



ONLINE ENROLLMENT INSTRUCTIONS

Enroll into a	an Alignment Healthcare pla	n					
1 Find a Plan	2 View, Compare, Select	3 SOA Confirmation	(4) Enroll	5 Review and Submit			
	Zip code: 92868 - Alignment Health 01/01/2024 - Test Tester	n Platinum + Instacart	(HMO) 008 - Effective	e Date:			
	Review Enrollment Application						
	Alignment Health Platinum + Instacart (HMO) 008 🖋						
	Primary Care Provider 🖋						
	PCP: Angel Guillen Perez, MD Phone Number: 7147161830 Medical Group: Optum Care Network - South Coast ID: OCNSC11477654440						
	Who is completing the Enrollment Applicat	ion? 🥒					
	Full Name: BRYAN HO Phone Number: 4433222222	Address: TEST ADDRESS City: TEST CITY State: CA	UPDATED				
	Medicare Information 🌶			_			
	Your Medicare Beneficiary Number: 1EG4TE5MK74	Hospital Insurance Benefi Medical Insurance Benefit	ts (Part A) Date: s (Part B) Date:	Ļ			

STEP 11

Review all information and Scroll Down

Applicant Information 🖋

Last Name: Tester
First Name: Test
Residence Address: 123 Fake Street
City: Orange
State: CA
Zip Code: 92868

Emergency Contact 🖋

Last Name:	
First Name:	
Phone Number:	

Payment Option 🖋

Get a Bill

Do you want to upload a paper application? *

Yes	○ No

Mailing Address: 123 Fake Street

Phone Number: Gender: **Male**

Email:

Email:

Date of Birth: 02/15/1950

Relationship to Enrollee:

Upload Application	Or drop files here

:::

Back

Agent Signature Date on Paper Application *

mm/dd/yyyy

Submit Application

STEP 11 (cont)

If you have a physical copy of the Enrollment Application, you will upload a copy.

If you DO NOT have a physical copy of the Enrollment Application, click NO



ONLINE ENROLLMENT INSTRUCTIONS

Do you want to upload a paper application? * O Yes

IMPORTANT: Read and sign below:

- I must keep Hospital (Part A) or Medical (Part B) to stay in Alignment Health Plan.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Alignment Health
 Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other
 purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).

No

- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Alignment Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Alignment Health Plan. Benefits and services provided by Alignment Health Plan and contained in my Alignment Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Alignment Health Plan will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this
 application means that I have read and understand the contents of this application. If signed by an authorized
 representative (as described above), this signature certifies that:
 - 1. This person is authorized under State law to complete this enrollment, and
 - 2. Documentation of this authority is available upon request by Medicare.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefix. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiares as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Electronic Signature Agreement

By signing below, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement.

Signature of Beneficiary or Authorized Representative *	Signature Date *	
	11/15/2023	

AGENT SIGNATURE AGREEMENT

By signing below, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement.

Agent Signature *	Signature Date *	
		11/15/2023

STEP 11 (CONT)

If you DO NOT have a physical copy of the Enrollment Application, click NO

Complete the information, scroll down and click Submit Application

ONLINE ENROLLMENT INSTRUCTIONS

Image: Augment Healthcare SUBMITENROLLLMENT NY CLENTS CORMS & DOCUMENTS CERTIFICATION HELPFUL TOOLS			iii ava-broker-dev.azu	rewebsites.net	C		0
NOME SUBMIT ENROLLMENT NY CLENTS FORMS & DOCUMENTS CERTIFICATION MELPPUL TOOLS	Alignment Healthcare					Welcome Scott	LOG OUT
Enroll into an Alignment Healthcare plan Submitting Application C	HOME SU	BMIT ENROLLMENT M	IY CLIENTS	FORMS & DOCUMENTS	CERTIFICATION	HE	LPFUL TOOLS
Submitting Application	Enroll into an Alignr	ment Healthcare pl	lan				
C			Submitting Ap	plication			
			C				
© 2020 Alignment Healthcare. All Rights Reserved. Privacy Policy & Terms o							

STEP 12

You've now submitted the Enrollment Application

ALIGNMENT HEALTH PLAN ONLINE ENROLLMENT INSTRUCTIONS

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATI

Authorization: I authoriz pharmacy or other medi supplies to me to disclo

Effective Period: This au periods of health care.

Extent of Authorization

□ I authorize the rel healthcare, commu

Only the following

Use: Alignment Health F care as allowed by CMS

Benefits: I understand the conditioned on whether

Rights and Responsibil personal health informa required by these laws. Evidence of Coverage C it. I can do that at any tin

SIGNATURE
Signature of Member or Person

CONTINUITY OF CARE FORM

are scheduled for ON or AFTER you

Member Information		
Name:	DOB:	Language:
Address:		Phone #: Mobile Home
Who Cares for You Most Often?	Name/Phone#:	
Have you ever served, or currently serve, in the US military	Previously Served Currently Se Not Able to Obtain Refused to A	rving 🔲 No Inswer
Provider Information	•	
Medical Group:	PCP Name/Phone #:	
1. Do you currently rent any of the fo	llowing durable medical equipment o	medical supplies? 🛛 N/A
Wheelchair	Name of Supplier:	Phone #: Dwn
Hospital Bed	Name of Supplier:	Phone #: Dwn
Oxygen	Name of Supplier:	Phone #: Own
Power Operated Vehicle	Name of Supplier:	Phone #: Own
Nebulizer	Name of Supplier:	Phone #: Own
CPAP	Name of Supplier:	Phone #: Own
Ostomy Supplies	Name of Supplier:	Phone #: Own
Glucometer (brand of glucometer)	Name of Supplier:	Phone #: Own
Other:	Name of Supplier:	Phone #: Dwn
2. Do you currently see any specialis	ts	
Specialty 1:	Provider: Phone	#: Appts?
Specialty 2:	Provider: Phone	#: Appts?
Specialty 3:	Provider: Phone	#: Appts?
Are you receiving any chemotherapy or radiation services?	Yes No If Yes, Provider Name and Phone #:	
Are you receiving any home health Services by a nurse or physical therapist	Yes No If Yes, Provider Name and Phone #:	
Any other procedure or surgeries that	Procedure:	Date:

STEP 13

Continuity of Care Form

Continuity of Care (COC) form is not available through the online enrollment process and must be submitted to Alignment Health Plan either by:

FAX: 562.207.4623

EMAIL: [Encrypted] to COC@ahcusa.com

The COC form is available on your Broker portal under:

FORMS & DOCUMENTS

If signed by someone other that

Name of Member or Personal F

Dale: -

ONLINE ENROLLMENT INSTRUCTIONS

Alignment Healthc	are				Welcome Bryan	LOG OUT
HOME	SUBMIT ENROLLMENT	MY CLIENTS	MY COMMISSIONS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into :	an Alianment F	lealthcare pla	n			
Υοι	ır enrollment w	as successfu	Ilv submitted!			
					(111.40) 000	
Con	gratulations! Than	k you for applying	to Alignment Heal	th CalPlus Heroes	(HMO) 036.	
Your	confirmation num	ber: Z5Z149.				
Your e the m	enrollment application wa ail. If you provided an em	s received and will now ail address earlier, we w	be processed. It may take ill email the confirmation i	up to 10 days before a co number to the beneficiary	onfirmation letter is receiv or authorized representa	ved in tive.
	E&O Document_Ken_Ba	arahona_Test_111520	23202748.pdf			
	Enroll H3815 PBP036	Tester 11152023203	236 pdf			
			200.041	-		
			Go to My Clients			
					Start Health Assessment	>
]

STEP 12 (cont)

You've now submitted the Enrollment Application

You'll be able to:

- View a copy of the Enrollment Application
- View a copy of the Scope of Appointment
- Start the HRA

AS ALWAYS, IF YOU HAVE ANY QUESITONS CALL US / EMAIL TODAY 888-793-5700 / PartnerExperience@ahcusa.com

