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Scope of Sales Appointment Confirmation Form

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The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face or telephonic sales meeting to ensure understanding of what will be discussed between the agent and the Medicare candidate (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below in the box beside the plan type that you want the agent to discuss with you.

☐	Medicare Advantage Plans (Part C)
	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 emergencies).
	Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special healthcare needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in a nursing home, and people who have certain chronic medical conditions.

By signing this form, 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 this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Candidate Signature: _____ Date: _____

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

Authorized Representative Name: _____

Your Relationship to Candidate: _____

To be completed by Agent:

Agent Name:	Agent Phone:
Candidate Name:	Candidate Phone:
Candidate Address: *(optional)*	
Initial Method of Contact: *(Indicate here if candidate was a walk-in)*	
Agent Signature:	Date Appt. Completed:

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Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-866-255-4795, TTY 711.

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Understanding the Benefits

- [ ] Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit bndhmo.com/members/plan-details or call 1-866-255-4795, TTY 711 to view a copy of the EOC.
- [ ] Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- [ ] Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- [ ] In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- [ ] Benefits, premiums and/or Copayments/co-insurance may change on January 1, 2022.
- [ ] Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

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OMB No. 0938-1378
Expires: 7/31/2023

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

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Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area.

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance).
- Medicare Part B (Medical Insurance).

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1).
- Within 3 months of first getting Medicare.
- In certain situations where you're allowed to join or switch plans.

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card).
- Your permanent address and phone number.

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during Fall open enrollment (October 15 – December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Brand New Day
ATTN: Enrollment Department
PO Box 93122
Long Beach, CA 90809

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Brand New Day at 1-866-255-4795.

TTY users can call 711. The Member Services Department is available Monday – Friday 8 am – 8 pm and 7 days a week 8 am – 8 pm from October 1 – March 31.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users can call 1-877-486-2048.

En español: Llame a Brand New Day al 1-866-255-4795, TTY 711 (o a Medicare gratis al 1-800-633-4227, 24 horas al día/7 días a la semana) y oprima el 2 para asistencia en español y un representante estará disponible para asistirle. Brand New Day está disponible de lunes a viernes de 8 am – 8 pm y los 7 días de la semana de 8 am – 8 pm del 1 de octubre al 31 de marzo.

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Section 1 – All fields on this page are required (unless marked optional)

Proposed Effective Coverage Date:

Select the plan you want to join:

Brand New Day Classic Care I Plan (HMO) 25

☐ Kern, Los Angeles, Orange, Riverside, San Bernardino, and San Diego counties

$0 per month

Brand New Day Classic Care II Plan (HMO) 37

☐ Alameda, Fresno, Imperial, Kern, Kings, Los Angeles, Madera, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Stanislaus, Tulare, and Yolo counties

$0 per month

Brand New Day Classic Care III Plan (HMO) 46

☐ Contra Costa, Santa Cruz, and Solano counties

$60 per month

Brand New Day Part B Savings Plan (HMO) 49

☐ Los Angeles, Orange, Riverside, San Bernardino, and San Diego counties

$0 per month

Brand New Day Dual Access Plan (HMO D-SNP) 24

☐ Alameda, Contra Costa, Fresno, Imperial, Kern, Kings, Los Angeles, Madera, Orange, Placer, Riverside, Sacramento, San Bernardino, San Francisco, San Joaquin, Santa Cruz, Solano, Stanislaus, Tulare, and Yolo counties

$0 per month: your premium may be more if you are not receiving Extra Help

Brand New Day Classic Choice Plan (HMO) 33

☐ Fresno, Imperial, Kern, Kings, Los Angeles, Madera, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Tulare counties

$0 per month

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Section 1 – All fields on this page are required (unless marked optional)

Proposed Effective Coverage Date:

Select the plan you want to join:

Brand New Day Embrace Care Plan (HMO C-SNP) 39-1

☐ Kern, Los Angeles, Orange, Riverside, San Bernardino, and San Diego counties

$0 per month

Brand New Day Embrace Care Plan (HMO C-SNP) 39-2

☐ Alameda, Fresno, Imperial, Kings, Madera, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Stanislaus, Tulare, and Yolo counties

$0 per month

Brand New Day Embrace Care (HMO C-SNP) 47

☐ Contra Costa, Santa Cruz, and Solano counties

$55 per month

Brand New Day Valor Care Plan (HMO) 48

☐ Fresno, Imperial, Kern, Kings, Los Angeles, Madera, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Tulare counties

$0 per month

Brand New Day Embrace Choice Plan (HMO C-SNP) 40-1

☐ Kern, Los Angeles, Orange, Riverside, San Bernardino, and San Diego counties

$0 per month: your premium may be more if you are not receiving Extra Help

Brand New Day Embrace Choice Plan (HMO C-SNP) 40-2

☐ Alameda, Contra Costa, Fresno, Imperial, Kings, Madera, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Stanislaus, Tulare, and Yolo counties

$0 per month: your premium may be more if you are not receiving Extra Help

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Information About You

FIRST Name | **LAST Name** | **M.I. (Optional)**

Birth Date (MM/DD/YYYY) | **Sex** | **Phone Number:**

☐ **Male** ☐ **Female**

☐ **Alternate Phone Number – Cellular**
Check the box to authorize Brand New Day to text you information about your plan to your cell phone.

Permanent Residence Street Address (Don't enter PO Box) | **County (Optional)**

City | **State** (CA) | **Zip Code**

Mailing Address if different from your Permanent Address (PO Box Allowed)

Street Address | **City** | **State** | **Zip Code**

Emergency Contact Name (Optional) | **Relationship To You** | **Phone Number**

☐ **Email Address (Optional)**
Check the box to authorize Brand New Day to contact you about your benefits and health information by email.

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Your Medicare Information

Please use your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

  -OR-

- Attach a copy of your Medicare card or your letter from Social Security or Railroad Retirement Board.

Name (as is appears on your Medicare card):

_____

Medicare Number _____

IS ENTITLED TO:	**EFFECTIVE DATE:**
HOSPITAL (Part A)	_____ /_____ /_____
MEDICAL (Part B)	_____ /_____ /_____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Answer these important questions:

1) Will you have other prescription drug coverage (like VA, TRICARE) in addition to Brand New Day? ☐ Yes ☐ No

Name Of Other Coverage | **ID # For This Coverage** | **Group # For This Coverage**

2) Are you a resident in a long-term care facility, such as a nursing home? If "yes," please provide the following information: ☐ Yes ☐ No

Name Of Institution

Address & Phone Number of Institution (number and street)

3) Are you enrolled in your State Medicaid (Medi-Cal) program? If yes, please provide your Medicaid (Medi-Cal) number: ☐ Yes ☐ No

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Pre-Enrollment Qualification Assessment Tool

If you are enrolling into one of our Special Needs Plan (SNP), please complete our Pre-Enrollment Qualification Assessment Tool.

IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Brand New Day.
- By joining this Medicare Advantage Plan, I acknowledge that Brand New Day will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 Brand New Day coverage begins, I must get all of my medical and prescription drug benefits from Brand New Day. Benefits and services provided by Brand New Day and contained in my Brand New Day "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Brand New Day will pay for benefits or services that are not covered.

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IMPORTANT: Read and sign below (continued)

- 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.

Enrollee Signature **Today's Date**

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

Name **Address**

Phone Number **Relationship To Enrollee**

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Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Traditional Chinese ☐ Korean ☐ Vietnamese

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large Print ☐ Audio CD

Please contact Brand New Day at 1-866-255-4795, TTY 711 if you need information in an accessible format or language other than what is listed above. Our office hours are Monday - Friday, 8 am - 8 pm and 7 days a week from October 1 - March 31.

Do you work? ☐ Yes ☐ No **Does your spouse work?** ☐ Yes ☐ No

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Section 2 – All fields on this page are optional (continued)

List your Primary Care Physician (PCP), Medical Group or IPA, and Contracted Dentist:

List your Primary Care Physician (PCP), clinic, or health center

PCP Provider Code

Are you an existing patient of this doctor? ☐ Yes ☐ No

Please Choose The Name Of The Medical Group Or IPA

Medical Group/IPA Code

Are you an existing patient of this medical group/IPA? ☐ Yes ☐ No

Contracted Dentist (One Will Be Assigned If Left Blank)

Dental Facility Code

Are you an existing patient of this Dentist? ☐ Yes ☐ No

I want to get the following materials via email. Select one or more.

☐ ANOC ☐ EOC ☐ Formularies ☐ Provider Directories ☐ Pharmacy Directories

☐ Health Education Materials

Email Address:

Opt-Out of Electronic Materials:

☐ Check this box to OPT-OUT from receiving electronic correspondences. We will NOT contact you via email.

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Paying Your Plan Premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, "Electronic Funds Transfer (EFT)", or "credit card" 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.**

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 Brand New Day the Part D-IRMAA.

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(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.)

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a monthly bill ☐ Electronic funds transfer (EFT) from your bank account each month.

Please enclose a VOIDED check or provide the following:

Account Name: _____

Bank Name: _____

Bank Routing No.: _____

Bank Account No.: _____

Account Type: ☐ Checking ☐ Saving

PRIVACY ACT STATEMENT

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

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Brand New Day Office Use Only

Name of Staff Member/Agent/Broker (if assisted in enrollment):

Plan ID#:

Effective Date of Coverage:

☐ ICEP/IEP ☐ AEP ☐ SEP(type) ☐ Not Eligible ☐ LIS ☐ OEP

Date of Receipt: Date Entered:

Date E4 Letter Sent: Date E6 Letter Sent: Initials of Verification:

Group #: Part D Premium:

Notes: _____

_____

_____

Sales Agent Information

If someone helped you fill out this application he/she must complete the information below and sign:

Name Of Staff/Agent/Broker (Print Name)

Agent Signature **Date**

Relationship To Enrollee **Date Application Was Received** **Agent NPN**

Agent Phone Number **Agent License Number** **FMO**

Please fax application with Scope of Appointment, Pre-Enrollment Qualification Assessment Tool, Continuity of Care form, and any other required documents to Brand New Day's Enrollment Department fax number at 1-657-400-1207.

Application receipt location:

☐ Appointment ☐ Sales event ☐ Walk-in ☐ Mail

☐ Other:

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Attestation Of Eligibility For An Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ **I am new to Medicare.**

☐ **I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).**

☐ **I have a diagnosis that qualifies me for a Special Needs Plan (C-SNP, D-SNP or I-SNP).**

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.

☐ **I recently had a change in my Medi-Cal (newly got Medi-Cal, had a change in level of Medi-Cal assistance, or Extra Help/Low Income Subsidy, or lost Medi-Cal) on (insert date)** _____.

☐ I have both Medicare and Medi-Cal (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.

☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.

Attestation Of Eligibility For An Enrollment Period *continued*

☐ I am leaving employer or union coverage on (insert date) _____.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ **I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.**

☐ Other: _____

_____

_____

_____

_____

_____

If none of these statements applies to you or you're not sure, please contact Brand New Day at 1-866-255-4795, TTY 711 to see if you are eligible to enroll. We are open Monday - Friday, 8 am - 8 pm and 7 days a week from October 1 - March 31.

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Pre-Enrollment Qualification Assessment Tool For Cardiovascular Disease & Diabetes (HMO C-SNP)

This form must be submitted with the enrollment application for Brand New Day Embrace Care Plan (HMO C-SNP) 39, Embrace Choice Plan (HMO C-SNP) 40, and Embrace Care (HMO C-SNP) 47.

First Name:	MI:	Last Name:
Gender: ☐ Male ☐ Female	DOB:	

Clinical Qualifying Questions

If any of the following are checked, candidate pre-qualifies.
Have you ever been told by a doctor that you have any of the following illnesses?
(Check all that apply)

☐ Cardiovascular Disease
☐ Diabetes
☐ Heart Failure (of any kind)
☐ Hypertension/High Blood Pressure (Stage A CHF)
☐ Hypertensive Heart with Chronic Kidney Disease
☐ History of Stroke

Medication Questions

1. Are you now or have you ever taken medication for an illness listed above? ☐ Yes ☐ No
2. Have you ever been on Insulin injections? ☐ Yes ☐ No
3. Have you ever taken Metformin? ☐ Yes ☐ No
4. What medications are you currently taking? _____

_____

_____

Primary Physician: _____
Name of Physician

_____
His/her clinic or location and phone number

Specialist: _____
Name of Specialist

_____
His/her clinic or location and phone number

Candidate Signature: _____ Date: _____

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Post Enrollment Continuity of Care Form

After you complete the Enrollment Packet, please complete the following information and fax to 1-657-400-1207.

Member Name: _____ Phone: _____ Date: _____

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Post Enrollment Questions

1. Are you currently using durable medical equipment or medical devices? ❑ Yes ❑ No

1a. If "Yes" Please specify which one of the following:	❑ Bath Chair ❑ Cane ❑ Catheters ❑ Commode ❑ CPAP machine /Sleep Apnea ❑ Diapers ❑ Hospital Bed ❑ Oxygen ❑ Pressure mattress ❑ Toilet seats ❑ Walker ❑ Wheel chair ❑ Other: _____ ❑ Other: _____
1b. If "Yes" Who is servicing the equipment or medical devices?	Name: _____ Phone: _____ Address: _____ _____
2. Are you receiving active care from a medical specialist, or do you see a special doctor for treatment of cancer, a heart condition, diabetes, or other medical condition?	❑ Yes ❑ No (If Yes, who?) Name: _____ Phone: _____ Address: _____ _____
3. Are you currently receiving home health services?	❑ Yes ❑ No (If Yes, who?) Company: _____ Phone: _____ Address: _____ _____
4. Do you have transportation to and from your appointments?* ** Not all plans provide transportation coverage.*	❑ Yes ❑ No If no, please call Brand New Day Member Services at 1-866-255-4795, TTY 711

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Additional contact information: caretaker, relative(s) or support person(s)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____