SCOPE OF SALES APPOINTMENT CONFIRMATION FORM

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:

H0838_515.BND.SOA.180817_C Accepted

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.

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 www.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, 2019.
- ☐ 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).
- ☐ This plan is a chronic condition special needs plan (CSNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

Please contact Brand New Day if you need information in another language or format (Braille).

TO ENROLL IN BRAND NEW DAY, PLEASE PROVIDE THE FOLLOWING INFORMATION

PROPOSED EFFECTIVE COVERAGE DATE: ____________________

Please select which plan you want to enroll in.

BRAND NEW DAY HARMONY CARE PLAN (HMO CSNP) 32

☐ Fresno, Imperial, Kern, Kings, Los Angeles, Orange, Riverside, San Bernardino, Santa Clara, San Diego, San Mateo, and Tulare counties
$0 per month

BRAND NEW DAY HARMONY CHOICE PLAN (HMO CSNP) 20

☐ Fresno, Imperial, Kern, Kings, Los Angeles, Orange, Riverside, San Bernardino, Santa Clara, San Diego, San Mateo and Tulare counties
$34.80 per month

BRAND NEW DAY BRIDGES CARE PLAN (HMO CSNP) 28

☐ Fresno, Imperial, Kern, Kings, Los Angeles, Orange, Riverside, San Bernardino, Santa Clara, San Diego, San Mateo, and Tulare counties
$0 per month

BRAND NEW DAY BRIDGES CHOICE PLAN (HMO CSNP) 29

☐ Fresno, Imperial, Kern, Kings, Los Angeles, Orange, Riverside, San Bernardino, Santa Clara, San Diego, San Mateo and Tulare counties
$34.80 per month

BRAND NEW DAY SELECT CARE PLAN (HMO ISNP) 41

☐ Fresno, Imperial, Kern, Kings, Los Angeles, Orange, Riverside, San Bernardino, Santa Clara, San Diego, San Mateo and Tulare counties
$34.80 per month

INFORMATION ABOUT YOU

LAST NAME

FIRST NAME

M.I.

☐ MR. ☐ MRS. ☐ MS.

BIRTH DATE (MM/DD/YYYY)

/ /

SEX

☐ MALE ☐ FEMALE

HOME PHONE NUMBER

☐ 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 (PO BOX IS NOT ALLOWED)

APT # OR SPACE #

CITY

STATE

CA

ZIP CODE

MAILING ADDRESS (ONLY IF DIFFERENT FROM YOUR PERMANENT RESIDENCE ADDRESS)

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 send health education by email.

PLEASE PROVIDE YOUR MEDICARE INSURANCE 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.

PAYING YOUR PLAN PREMIUM

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Brand New Day the Part D-IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amounts (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT Pay Brand New Day the Part D-IRMAA.

People with limited incomes may qualify for *Extra Help* to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this *Extra Help*, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for *Extra Help* online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for *Extra Help* with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

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

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

PAYING YOUR PLAN PREMIUM *continued*

☐ 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.)

PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

1) Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No
   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2) Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to Brand New Day? If "yes", please list your other coverage and your identification (ID) number(s) for this coverage: ☐ Yes ☐ No

NAME OF OTHER COVERAGE	ID # FOR THIS COVERAGE	GROUP # FOR THIS COVERAGE

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

NAME OF INSTITUTION

ADDRESS & PHONE NUMBER OF INSTITUTION (NUMBER AND STREET)

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

5) Do you or your spouse work? ☐ Yes ☐ No

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.

PLEASE CHOOSE THE NAME OF A PRIMARY CARE PHYSICIAN (PCP), CLINIC OR HEALTH CENTER

PLEASE CHOOSE THE NAME OF A PRIMARY CARE PHYSICIAN (PCP) ____________________

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

PLEASE CHECK ONE OF THE BOXES BELOW IF YOU WOULD PREFER US TO SEND YOU INFORMATION IN A LANGUAGE OTHER THAN ENGLISH OR IN AN ACCESSIBLE FORMAT:

☐ **SPANISH** ☐ **CHINESE** ☐ **KOREAN** ☐ **VIETNAMESE**

☐ **LARGE PRINT** ☐ **AUDIO**

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 from 8 am to 8 pm between April 1 and September 30 and 7 days a week between October 1 and March 31 from 8 am to 8 pm.

☐ Brand New Day delivers some documents electronically like information about your enrollment, the Evidence of Coverage (EOC), Provider/Pharmacy Directories, and Formularies to the email address you provide on this form. You can opt to get paper versions of those documents instead by checking the box.

PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining Brand New Day could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Brand New Day. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

PLEASE READ AND SIGN BELOW

By completing this enrollment application, I agree to the following:
Brand New Day is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

Brand New Day serves a specific service area. If I move out of the area that Brand New Day serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Brand New Day, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Brand New Day when I request it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Brand New Day coverage begins, I must get all of my health care from Brand New Day, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Brand New Day and other services contained in my Brand New Day Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BRAND NEW DAY WILL PAY FOR THE SERVICES**.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Brand New Day, he/she may be paid based on my enrollment in Brand New Day.

Release of Information: By joining this Medicare health plan, I acknowledge that Brand New Day will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Brand New Day will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 from Medicare.

PLEASE READ AND SIGN BELOW *continued*

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

DOCUMENTATION TYPE: *Please submit documentation with enrollment paperwork.*

☐ DPOA ☐ DPAHC ☐ Written Advance Directive ☐ Legal Guardian

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)

SIGNATURE

DATE

RELATIONSHIP TO ENROLLEE

DATE APPLICATION WAS RECEIVED

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:

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 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 was released from incarceration. I was released on (insert date) _______________.

- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ______________________.

- ☐ I recently obtained lawful presence status in the United States. I got this status 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 lost Medi-Cal) on (insert date) __________________________.**

- ☐ **I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) 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) ________________________.

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

- ☐ I belong to a pharmacy assistance program provided by my state.

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

- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____________________________.

- ☐ 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 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.**

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 a.m to 8 p.m. between April 1 and September 30 and 7 days a week from October 1 to March 31, 8 a.m. to 8 p.m.

PRE-ENROLLMENT QUALIFICATION ASSESSMENT TOOL FOR DEMENTIA (HMO CSNP)

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)

- ☐ Dementia
- ☐ Parkinson's Disease
- ☐ Frontotemporal Dementia (FTD)
- ☐ Picks (PiD)
- ☐ Mild Cognitive Impairment (MCI)
- ☐ Dementia with Lewy Bodies (DLB)
- ☐ Alzheimer's Disease
- ☐ Creutzfeldt-Jakob Disease (CJD)
- ☐ Huntington's Disease (HD)
- ☐ Vascular Dementia
- ☐ Multi-Infarct Dementia (MID)
- ☐ Normal Pressure Hydrocephalus (NPH)

MEDICATION QUESTIONS

1. Are you now or have you ever taken medication for an illness listed above? ☐ Yes ☐ No
2. What medications are you currently taking? ______________________________

FORMER PRIMARY PHYSICIAN: ______________________________
Name of Physician

____
His/her clinic or location and phone number

FORMER SPECIALIST: ______________________________
Name of Specialist

____
His/her clinic or location and phone number

Candidate Signature:	Date:

brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

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:____________

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?	❑ 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?	❑ Yes ❑ No If no, Brand New Day will provide transportation. Call 1-866-255-4795.

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

Name:__________________________ Phone:__________________ Relationship:__________

Name:__________________________ Phone:__________________ Relationship:__________