•••• < > •••	0	i brokerportalalignment.b2clogin.com	Ċ	0 6 0 -
				I
	А	lignment Healthcar	e	
		Agent Portal Login		
		AHC Employee Login		
		Email Address		
		Email Address		
		Password		
		Sign in		
		Forgot your password?		
	Alignment a	NEED AN ACCOUNT? gent and agency receive access to our broker portal upor Contact our Partner Experience team for help	n certification	

STEP 1

Go to: www.AlignmentHealthPlan.com

and click on **AGENTS**

Click on AGENT PORTAL LOGIN





STEP 2

Welcome to the new Agent Portal Home Page

To submit an enrollment, click on **Submit Enrollment**

		🗎 ava-broker-	dev.azurewebsites.net	C	0 0
Alignment Healthcare				Welco	Dome Scott LOG OUT
HOME	SUBMIT ENROLLMENT	MY CLIENTS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into an a	Alignment Health	care plan			
1 Find a P	tan 📀 View, Comp	are, Select 💿	SOA Confirmation	Enroll	w and Submit
	Find	Dian that heat	fite your client's r	needs	
	Fillu	a Fidii tiidt Desi	. IIIS your chefits i	neeus.	
		Zip Code *			
		c	ontinue		

STEP 3

Enter the beneficiarie's **Zip Code**, and click **Continue**



HOME	SUBMIT ENROLLMENT	MY CLIENTS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into an Ali	gnment Healthca	re plan			
1 Find a Plan	2 View, Compare,	Select	SOA Confirmation	Enroll	w and Submit
	Find a F	Plan that best	t fits your client's ne	eds.	
	Zip Code	*	Coverage Year *		
	92868		2020	\$	
	Orange Co	unty			
		C	ontinue		

STEP 4

Select Coverage Year, and click Continue

			i ava-	broker-dev.azurewebs	ites.net	C		0 0
Alignment I	Healthcare						Welcome Scott	LOG OUT
HOME	SUB	MIT ENROLLMENT	MY CLIENTS	FOR	MS & DOCUMENTS	CERTIFICATI	ION H	IELPFUL TOOLS
Enroll int	o an Alignn	nent Health	care plan					
	Find a Plan	View, Comp	are, Select	SOA Confirma	ation	Enroll	Beview and Sub	omit
Available	olans in zip c	ode 92868 (O	range County)		So	Lowest Mor	nthly Premium 💲
My Choice P	lan (HMO) 001	Compare Plans	Platinum Plan	(HMO) 008	Compare Plans	Heart & Diabo	etes Plan (HM0	D SNP)
	\$0			\$0			\$0	
	Monthly Premium	1		Monthly Premium			Monthly Premium	1
\$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	Out-Of-Pocket Max In-Network
OTC \$10/Mont 24/7 Concierge Telehealth Member Rewar	ds	CESS CESS	OTC \$20/Month 24/7 Concierge C Telehealth Member Rewards	are	cess AA	OTC \$2 <mark>0</mark> /Month 24/7 Concierge Telehealth Member Reward	Care	CESS CESS CESS
View plan details Select primary care Search for other pr	physician >		View plan details > Select primary care pl Search for other provi	hysician > ders >		View plan details > Select primary care Search for other pro	physician > oviders >	
PRIMARY CARE	PHYSICIAN SELEC	TION						
We strongly en physician (PCP assigned auton not selected he	courage selection of) at time of enrollme natically to HMO en re. For PPO plans, F	f a primary care ent. A PCP will be rollees if one is PCP selection is						

STEP 5

Select the **Desired Plan**

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



STEP 6

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



STEP 6 (cont)

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

	📾 ava-broker-dev.azurewebsites.net	Ċ	0 1
O Brian C. Kolski, MD NPI: 1851449896 PCP - Internal Medicine Nearest Location: 1140 W La Veta Ave Orange, CA 92868			
Image: 1 groups Image: 1 Locations 0.78 miles away « < 1			
CalPlus Plan (HMO) 009			
\$0 \$0 \$6,700 PCP Copay Specialist Copay Out-Of-Pocket Max In-Network In-Network In-Network			
OTC \$40/Month 24/7 Concierge Care Telehealth Member Rewards			
View plan details > Select primary care physician > Search for other providers >			
	Back Continue		

STEP 6 (cont)

When desired **PCP** has been selected, scroll down and click on **CONTINUE**



HOME	SUBMIT ENROLLMENT	MY CLIENTS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into an A	lignment Health	care plan			
1 Find a Plan	1 2 View, Comp	are, Select 3	SOA Confirmation	Enroll	ew and Submit
Zip code: 92868 - M	ly Choice Plan (HMO) 001 - Plan Year 20	20		
Field Agent	oliment Application?		÷		
s information being provid	ed by the beneficiary author	ized representative2 *	Ves No		
s information being provid Scope of Sales App The Centers for Medicare a understanding of what will confidential and should be	ed by the beneficiary author ointment Confirmation and Medicaid Services requir be discussed between the a completed by each person v	ized representative? * O ON Form es agents to document the gent and the Medicare ber with Medicare or his/her au	Yes No No escope of a marketing appointreficiary (or their authorized representative.	nent prior to any face-to-face resentative). All information (e sales meeting to ensure provided on this form
s information being provid SCOPE Of Sales App The Centers for Medicare a inderstanding of what will confidential and should be No you have a Scope of Sa	ed by the beneficiary author ointment Confirmation and Medicaid Services requir be discussed between the a completed by each person v les Appointment Form to up	ized representative? * O ON Form es agents to document the gent and the Medicare ber vith Medicare or his/her au load? * • Yes N	Yes No	nent prior to any face-to-face resentative). All information (e sales meeting to ensure provided on this form
s information being provid SCOPE Of Sales App The Centers for Medicare a understanding of what will confidential and should be No you have a Scope of Sa	ed by the beneficiary author Ointment Confirmation and Medicaid Services requir be discussed between the a completed by each person v les Appointment Form to up	ized representative? * O ON Form res agents to document the gent and the Medicare ber vith Medicare or his/her au load? * • Yes N UPLOAD SOA	Yes No escope of a marketing appointreficiary (or their authorized representative.	nent prior to any face-to-face resentative). All information (e sales meeting to ensure provided on this form
s information being provid Scope of Sales App The Centers for Medicare a understanding of what will confidential and should be Do you have a Scope of Sa Yease upload Scope of Sales Ap	ed by the beneficiary author Ointment Confirmations and Medicaid Services requir be discussed between the a completed by each person v les Appointment Form to up pointment Form SOA *	ized representative? * O ON Form res agents to document the gent and the Medicare ber vith Medicare or his/her au load? * • Yes N UPLOAD SOA	Yes No escope of a marketing appointreficiary (or their authorized representative.	nent prior to any face-to-face resentative). All information	e sales meeting to ensure provided on this form

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**



Alignment Healthcare				Welca	ome Scott
HOME	SUBMIT ENROLLMENT	MY CLIENTS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into an <i>i</i>	Alignment Health	care plan			
Find a P	an 🔰 😰 View, Comp	bare, Select 3	SOA Confirmation	Enroll	ew and Submit
Zip code: 92868 -	My Choice Plan (HMO) 001 - Plan Year 20	020		
Who's completing the E	nrollment Application?				
Field Agent			\$		
Scope of Sales Ap The Centers for Medicare understanding of what w confidential and should b Do you have a Scope of S	pointment Confirmati e and Medicaid Services requi ill be discussed between the a be completed by each person v Gales Appointment Form to up	on Form res agents to document th agent and the Medicare be with Medicare or his/her a load? * Yes I	e scope of a marketing appointn neficiary (or their authorized repr uthorized representative. No	nent prior to any face-to-face resentative). All information (sales meeting to ensure provided on this form
To be completed by Please enter initials beside	y applicant or authoriz de the type of product you war	ed representative			
Stand-alone	Medicare Prescripion I	Drug Plans (Part D)			
Medicare Prescription Medicare Private-Fee-for	Drug Plan (PDP) - A stand- Servive Plans, and Medicare N	alone drug plan that adds Medical Savings Account F	prescription drug coverage to Or Plans	iginal Medicare, some Medio	care Cost Plans, some

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)



Signature - First and Last Name *	Date *			
Signature - First and Last Name	2020-09-04			
Fo be completed by agent				
Agent Name *	Agent Phone *	Beneficiary Name	Beneficiary Phone	
SCOTT LUCAS	(209) 574-0858	Beneficiary Name	Beneficiary Phone	
Beneficiary Address		Initial Method of Contact	Represented Plans *	
Beneficiary Address			Alignment Health Plan	\$
Electronic Signature Agreeme by signing below, you are signing this A	ent Igreement electronically. You agree yo	our electronic signature is the legal equivale	nt of your manual signature on this <i>i</i>	Agreement.
Electronic Signature Agreeme sy signing below, you are signing this A GENT SIGNATURE AND SIGNATURE D Signature - First and Last Name *	Agreement electronically. You agree yo ATE Date Appointmen	our electronic signature is the legal equivale It Completed *	nt of your manual signature on this a	Agreement.
Electronic Signature Agreeme By signing below, you are signing this A IGENT SIGNATURE AND SIGNATURE D Signature - First and Last Name *	ent Agreement electronically. You agree your VATE Date Appointmen 2020-09-04	our electronic signature is the legal equivale It Completed *	nt of your manual signature on this <i>i</i>	Agreement.
Electronic Signature Agreeme By signing below, you are signing this A IGENT SIGNATURE AND SIGNATURE D Signature - First and Last Name * Signature - First and Last Name Coope of Appointment documentation Explanation why SOA was not document Provide brief explanation	ent Agreement electronically. You agree yount Date Appointmen 2020-09-04 is subject to CMS record retention red inted prior to meeting:	our electronic signature is the legal equivale It Completed * quirements. Agent, if the form was signed by	nt of your manual signature on this any set of your manual signature on this any set of appointment of appointm	Agreement. nent, provide
Electronic Signature Agreeme By signing below, you are signing this A GENT SIGNATURE AND SIGNATURE D Signature - First and Last Name * Signature - First and Last Name Coope of Appointment documentation Explanation why SOA was not document Provide brief explanation Provide brief explanation	ent Agreement electronically. You agree your Date Appointmen 2020-09-04 is subject to CMS record retention reconted prior to meeting:	our electronic signature is the legal equivale at Completed * quirements. Agent, if the form was signed by	nt of your manual signature on this any set of your manual signature on this any the beneficiary at time of appointment of app	Agreement. hent, provide

STEP 7 (CONT)

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



		🗎 ava-broker-	dev.azurewebsites.net	C	0	Ê
Alignment Healthcare	à			Welco	ome Scott	
HOME	SUBMIT ENROLLMENT	MY CLIENTS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS	
Enroll into an	Alignment Healthca	are plan				
Find a l	Plan 2 View, Compare	, Select	SOA Confirmation	Enroll 6 Revie	ew and Submit	
1 Medicar	e Advantage Eligibility Verific	ation 2 Client Infe	ormation 3 Additional Info	ormation		
Zip code: 92868	3 - My Choice Plan (HMO) 001 - Plan Year 2	2020			
MEDICARE ADVANTA	GE ELLIGIBILITY VERIFICATION					
Typically, you may en	roll in a Medicare Advantage plan	only during the annual e	nrollment period from October th	rough 15 December 7 of ea	ach year. There are	
exceptions that may a	allow you to enroll in a Medicare A	dvantage plan outside o	of this period.	ny of the following boxes w	ou are certifying that to	
the best of your know	ledge, you are eligible for an Enrol	llment Period. If we later	r determine that this information	is incorrect, you may be dis	enrolled.	
I am new to Medica	ire.					
🔲 I am enrolled in a N	ledicare Advantage plan and want	to make a change durir	ng the Medicare Advantage Open	Enrollment Period (MA OEF	P).	
I recently moved ou	Itside of the service area for my c	urrent plan or I recently r	moved and this plan is a new opti	ion for me.		
I recently was relea	sed from incarceration					
I recently returned t	o the United States after living pe	rmanently outside of the	e U.S.			
I recently obtained	lawful presence status in the Unite	ed States				
I recently had a cha	nge in my Medicaid (newly got M	edicaid, had a change in	level of Medicaid assistance, or	lost Medicaid).		
Extra Help).	nge in my Extra Help paying for M	ledicare prescription dru	ig coverage (newly got Extra Help	o, had a change in the level o	of Extra Help, or lost	
I have both Medica but haven't had a cl	re and Medicaid (or my state help: nange.	s pay for my Medicare p	remiums) or I get Extra Help payi	ng for my Medicare prescri	ption drug coverage,	

STEP 8

Select applicable Enrollment Reason

Scroll down and click **CONTINUE**

		🗎 ava-broker-d	lev.azurewebsites.net	C	0 1
Alignment Healthcare				Welco	me Scott
НОМЕ	SUBMIT ENROLLMENT	MY CLIENTS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
nroll into an Alio	gnment Health	care plan			
Find a Plan	2 View, Comp	are, Select 3	SOA Confirmation	Enroll 👩 Revie	w and Submit
1 Medicare Adv	vantage Eligibility Veri	fication 2 Client Info	ormation 3 Additional Info	ormation	
Proposed Effective Date 2020-10-01 Medicare Informatio Please take out your red, wi	n n hite, and blue Medicare ca	ard to complete this section	n. In the spaces provided, enter y	our Medicare Number (do n	ot enter dashes) and the
Effective Dates for your Par You must have Medicare Pa	t A and Part B coverage. art A and Part B to join a N	Medicare Advantage plan.			
MEDICARE HEALTH HEALMARKE JOHN L SMITH TECHTES MATZ HOGHTAL (PART A) 83-01-016 MEDICAL (PART B) 53-01-2016					
Medicare ID # *	Last Nam	ne *	Verify		
Medicale ID #	Last Nall	iie)			
Medicare Part A Eligibility	Date * Medicare	Part B Eligibility Date *			
Medicare Part A Eligibility	Date Medicare	e Part B Eligibility Date			
Client Details					
	121201	141 - I	The second s		

STEP 9

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

If the system does not automatically fill in the effective dates, please complete manually

First Name *	Middle Initial	Last Name *	Date Of Birth *	
0777	Middle Initial	Torres	9/12/1945	
			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Gender *	Primary Language *	Initial Me	thod of Contact *	
Male	English	Cell Phor	le	\$
Permanent Address				
Address Line 1 *	Address Line 2	City *	State *	
123 Street Ave	Address Line 2	Oragne	CA	\$
Zip Code *				
Zip Code * 92868 s mailing address the same as p Contact Information	permanent address?* 🧿 Yes 🔷 N	No		
Zip Code * 92868 s mailing address the same as p Contact Information Primary Phone # *	permanent address? * Yes N Cell Phone #	No Email *	Preferred Method o	f Contact
Zip Code * 92868 s mailing address the same as p Contact Information Primary Phone # * 909-782-1217	cell Phone #	No Email * otorres@ahcusa.com	Preferred Method o	f Contact
Zip Code * 92868 s mailing address the same as p Contact Information Primary Phone # * 909-782-1217 Emergency Contact Infor	Cell Phone #	No Email * otorres@ahcusa.com	Preferred Method o	f Contact
Zip Code * 92868 s mailing address the same as p Contact Information Primary Phone # * 909-782-1217 Emergency Contact Infor First Name	Cell Phone # Cell Phone # Cell Phone # mation Middle Initial	No Email * otorres@ahcusa.com Last Name	Preferred Method of Relationship to Clien	f Contact
Zip Code * 92868 s mailing address the same as p Contact Information Primary Phone # * 909-782-1217 Emergency Contact Infor First Name First Name	Cell Phone # Cell Phone # Cell Phone # mation Middle Initial Middle Initial	No Email * otorres@ahcusa.com Last Name Last Name	Preferred Method of Relationship to Clier	f Contact nt
Zip Code * 92868 smailing address the same as p Contact Information Primary Phone # * 909-782-1217 Emergency Contact Infor First Name First Name Primary Phone #	Cell Phone # Cell Phone # Cell Phone # rmation Middle Initial Middle Initial Email	No Email * otorres@ahcusa.com Last Name Last Name	Preferred Method o Relationship to Clier	f Contact t nt

STEP 9 (cont) Fill in all **Required Fields**

Scroll down and click **CONTINUE**



10 ·····					
Alignment Healthcare				Welc	come Scott
HOME	SUBMIT ENROLLMENT	MY CLIENTS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into an A	lignment Healtho	care plan			
1 Find a Plar	1 View, Compa	rre, Select 3	SOA Confirmation	Enrol 🐻 Revi	iew and Submit
1 Medicare	Advantage Eligibility Verif	ication 2 Client Info	ormation 3 Additional Info	ormation	
	36 , 6 55 (6.98				
Zip code: 92868 -	My Choice Plan (HM	0) 001 - Plan Year 2	2020		
Additional Informa	ition				
1. Do you have End Stag	e Renal Disease (ESRD)? *				
2. Are you a resident in a	long-term care facility, such	as a nursing home? *			
3. Some individuals may pharmaceuticals assista Yes No	have other drug coverage, in nce programs. Will you have	cluding other private insur other prescription drug co	ance, TRICARE, Federal employee verage in addition to Alignment H	e health benefits coverage, lealth Plan? *	, VA benefits or State
4. Are you eligible for Sta	ate Medicaid (Medi-Cal)? *				
		/ledi-Cal)? *			
5. Are you enrolled in you Yes No	ur State Medicaid Program (N				
 5. Are you enrolled in you Yes No 6. Do you or your spouse Yes No 	ır State Medicaid Program (N e work? *				

STEP 10

Complete all Additional information

Paying your plan pro	emium			
You can pay your monthly your premium by automati	plan premium (including any late er c deduction from your Social Secur	nrollment penalty that you currently have or m ity or Railroad Retirement Board (RRB) benefi	hay owe) by mail each month. You t check each month.	can also choose to pay
If you are assessed a Part paying this extra amount in Medicare or RRB. DO NOT	D-Income related Monthly Adjustm n addition to your plan premium. Yo pay Alignment Health Plan the Part	ent Amount, you will be notified by the Social u will either have the amount withheld from y : D-IRMAA.	Security Administration. You will b our Social Security benefit check c	e responsible for or be billed directly by
People with limited incom- monthly prescription drug enrollment penalty. Many p office, or call Social Securi www.socialsecurity.gov/pr	es may qualify for extra help to pay premiums, annual deductibles, and people are eligible for these savings ty at 1-800-772-1213. TTY/TDD use escriptionhelp.	for their prescription drug costs. If eligible, M co-insurance. Additionally, those who qualify and don't even know it. For more information rrs should call 1-800-325-0778. You can also	edicare could pay for 75% of drug will not be subject to the coverage n about this extra help, contact you apply for extra help online at	costs including e gap or a late ır local Social Security
If you qualify for extra help of this premium, we will bi	with your Medicare prescription dr Il you for the amount that Medicare	ug coverage costs, Medicare will pay all or pa doesn't cover. If you don't select a payment o	art of your plan premium. If Medica option, you will get a bill each mont	are pays only a portion h.
Please select a plan pr	emium and/or late enrollment	payment option: *		
🗿 Get a Bill				
 Automatic deduction two or more months automatic deduction up to the point withb 	from your monthly Social Security to begin after Social Security or RR , the first deduction from your Socia olding begins. If Social Security or F	or Railroad Retirement Board (RRB) benefit cl B approves the deduction. In most cases, if S al Security or RRB benefit check will include al RRB does not approve your request for autom	heck. (The Social Security/RRB dec ocial Security or RRB accepts your Il premiums due from your enrollm atic deduction, we will send you a	duction may take request for lent effective date paper bill for your
monthly premiums.)				

STEP 10 (cont)

Select how the member would like to pay for their **Monthly Plan Premium**

Scroll down and click **CONTINUE**



		■ ava-broker-	ev.a2urewebsites.net	0		0	ت ا
Alignment Healthcar	e				Welcome Sc	ott LOG OUT	
HOME	SUBMIT ENROLLMENT	MY CLIENTS	FORMS & DOCUMEN	ITS CERTIFIC	ATION	HELPFUL TOOLS	
Enroll into an	Alignment Health	care plan					
Find a	Plan 🔰 🙆 View, Comp	are, Select 3	SOA Confirmation	O Enroll	5 Review and	Submit	Ĩ
Z	ip code: 92868 - My Ch	oice Plan (HMO) 00	1 - Effective Date:	: 2020-10-01 - Oz	zy Torres		
R	eview Enrollment A	nnlication					
I.		ppication					
M	ly Choice Plan (HMO) 0	01 🖉					
P	rimary Care Physician 🖋 CP: Deepak N Patel, MD						
PI	none Number: 6572364909						
C (edical Group: Affiliated Docto ounty	rs Of Orange					
ID	ADOC100266						
W	ho is completing the Enr	ollment Application?					
Fu	Ill Name: SCOTT LUCAS	Addre	ss: 5819 CHENAULT D	R			
Pł	none Number: (209) 574-0858	City: City: State:	IODESTO CA				
м	ledicare Information 🖋						
Yo	our Medicare Beneficiary Numbe	er: Hosp	tal Insurance Benefits (P	Part A) Date:			
13	3G4TE5MK72	03-0	-2016	art P) Data:			
		Wedic	ai moutance benefits (P	art by bate.			

STEP 11

Review all information and **Scroll Down**



	ava-broker-dev.azurewebsites.net	
No	obtain a Provider Directory?	
3-25-0	Yes	
Applicant Information 🖋		
Last Name: Torres	Mailing Address: 123 Street Ave	
First Name: Ozzy	Phone Number: 909-782-1217	
Residence Address: 123 Street Ave	Gender: Male	
City: Oragne	Date of Birth: 9/12/1945	
State: CA	Email: otorres@ahcusa.com	
Zip Code: 92868		
Emergency Contact 🖋		
Last Name:	Email:	
First Name:	Relationship to Enrollee:	
Phone Number:	A SA PROPERTY AND A TO STORE TO SAFE TO SAFE THE SAFE THE	
Payment Option @		
Payment Option <i>F</i>		
Get a Bill		
Payment Option <i>F</i> Get a Bill Do you want to upload a paper application?	Yes 🔿 No	
Payment Option <i>F</i> Get a Bill Do you want to upload a paper application?	9 Yes 🔿 No	
Payment Option <i>F</i> Get a Bill Do you want to upload a paper application?	Yes No PLOAD APPLICATION Or drop files here	
Payment Option <i>F</i> Get a Bill Do you want to upload a paper application?	Yes No	
Payment Option <i>P</i> Get a Bill Do you want to upload a paper application?	Yes No	
Payment Option <i>P</i> Get a Bill Do you want to upload a paper application?	Yes No PLOAD APPLICATION Or drop files here	
Payment Option <i>P</i> Get a Bill Do you want to upload a paper application?	PLOAD APPLICATION Or drop files here	
Payment Option / Get a Bill Do you want to upload a paper application? Image: Please upload a paper application Signature Date on Paper Application * Signature Date on Paper Application	Yes No PLOAD APPLICATION Or drop files here	
Payment Option / Get a Bill Do you want to upload a paper application? Image: Please upload a paper application Signature Date on Paper Application * Signature Date on Paper Application	Yes No PLOAD APPLICATION Or drop files here	
Payment Option / Get a Bill Do you want to upload a paper application? Image: Please upload a paper application Signature Date on Paper Application * Signature Date on Paper Application	Yes No PLOAD APPLICATION Or drop files here	
Payment Option / Get a Bill Do you want to upload a paper application? Image: Please upload a paper application Signature Date on Paper Application * Signature Date on Paper Application	Yes No PLOAD APPLICATION Or drop files here	
Payment Option / Get a Bill Do you want to upload a paper application? Image: Please upload a paper application Signature Date on Paper Application * Signature Date on Paper Application	Yes No PLOAD APPLICATION Or drop files here	
Payment Option / Get a Bill Do you want to upload a paper application? Image: I	Yes No PLOAD APPLICATION Or drop files here Submit Application	
Payment Option / Get a Bill Do you want to upload a paper application? Image: Please upload a paper application Signature Date on Paper Application * Signature Date on Paper Application	Yes No PLOAD APPLICATION Or drop files here Ick Submit Application	
Payment Option / Get a Bill Do you want to upload a paper application? Image: Please upload a paper application Please upload a paper application Signature Date on Paper Application * Signature Date on Paper Application	Yes No PLOAD APPLICATION Or drop files here Ick 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**



ava-broker-dev.azurewebsites.net	Ċ	• • • +
Payment Option 🖋		
Get a Bill		
Do you want to upload a paper application? O Yes O No		
Please Read This Important Information. If you currently have health coverage from an employer or union, joining Alignme union health benefits. You could lose your employer or union health coverage if y communications your employer or union sends you. If you have questions, visit their their communications. If there isn't any information on whom to contact, your ben answers questions about your coverage can help.	nt Health Plan could affect your employer or ou join Alignment Health Plan. Read the heir website, or contact the office listed in nefits administrator or the office that	
Please Read and Sign Below. <u>By completing this enrollment application, I agree to the following:</u> Alignment Health Plan is a Medicare Advantage plan and has a contract with the Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, plan will automatically end my enrollment in another Medicare health plan or pre- Read More	Federal government. I will need to keep my and I understand that my enrollment in this scription drug plan.	
Electronic Signature Agreement By signing below, you are signing this Agreement electronically. You agree your e your manual signature on this Agreement.	lectronic signature is the legal equivalent of	
Signature of Beneficiary or Authorized Representative *	Signature Date *	
Signature of Beneficiary or Authorized Representative	2020-09-04	
AGENT SIGNATURE AGREEMENT By signing below, you are signing this Agreement electronically. You agree your e your manual signature on this Agreement.	lectronic signature is the legal equivalent of	
Agent Signature *	Signature Date *	
Agent Signature	2020-09-04	

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**

		ava-broker-o	ev.azurewebsites.net	0	0
Alignment Healthca	re				Welcome Scott
HOME	SUBMIT ENROLLMENT	MY CLIENTS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into an	Alignment Health	care plan			
		Submitting	Application		
			C		

STEP 12

You've now submitted the **Enrollment Application**



HOME	SUBMIT ENROLLMENT	MY CLIENTS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into an	Alignment Healthc	are plan			
Your e	enrollment was suc	cessfully subr	nitted!		
Congra	tulations! Thank you for	applying to My Ch	oice Plan (HMO) 001.		
Your co	nfirmation number: ZM0	C450.			
Your enrol	Iment application was received a	nd will now be processed	d. It may take up to 10 days befor	e a confirmation letter is re	ceived in the
	Torros 00042020141052 pc	er, we will email the confi	rmation number to the beneficial	y or authorized representat	lve.
	_1011es_09042020141952.pc	042020141058 = 4			
Enito	II_H3815_PBP001_10(les_09	042020141958.pdi			
			Close		

STEP 12 (cont)

You've now submitted the **Enrollment Application**

You'll be able to see a copy of the **Enrollment Application** of **Scope of Appointment**

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

