Enrollment HUB – How to Create a Practice Application

PURPOSE: This job aid shows the steps to create a practice application in Enrollment HUB.
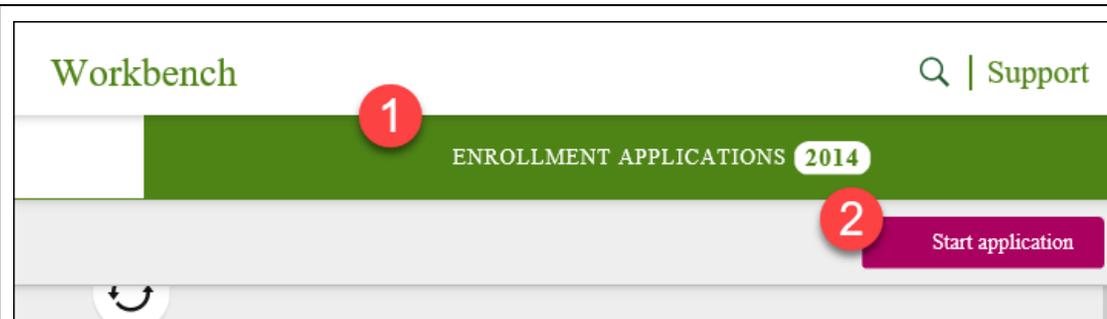**SCOPE:** Enrollment HUB users

Important Note:

There is no training environment for Enrollment HUB. All practice applications will be completed in the production version of Enrollment HUB. When completing a practice application it is very important that you:

- Use **1aa1aa1aa1** as the Medicare ID
- **DO NOT** sign and submit the Post Enrollment Forms. Once you have filled-out the post enrollment forms click on **SAVE** and return to the Workbench. Locate the practice application and click on **CANCEL** to remove it from the Workbench.
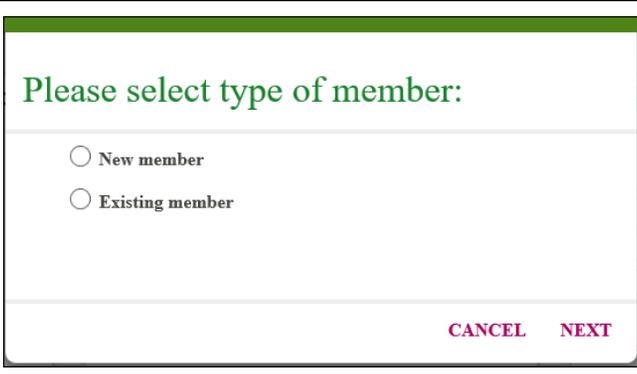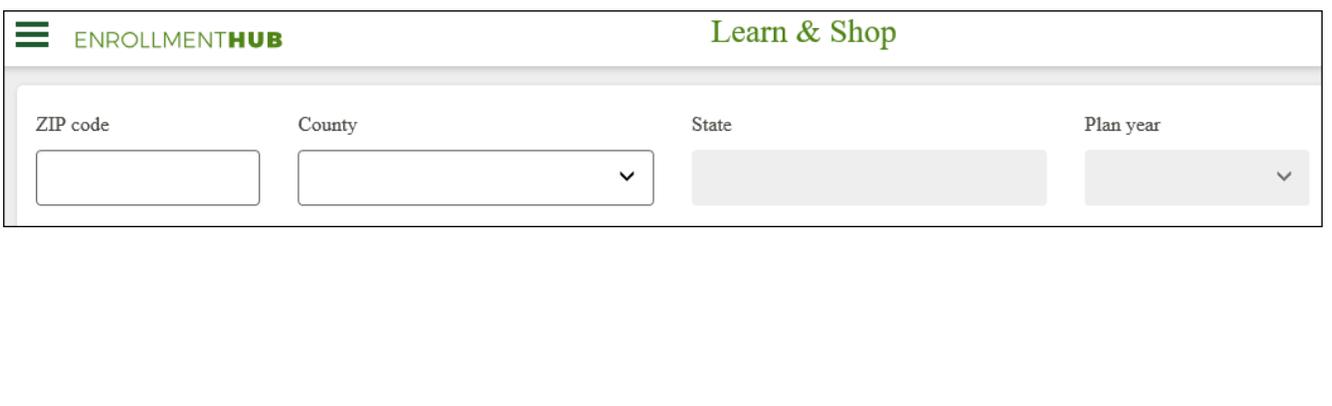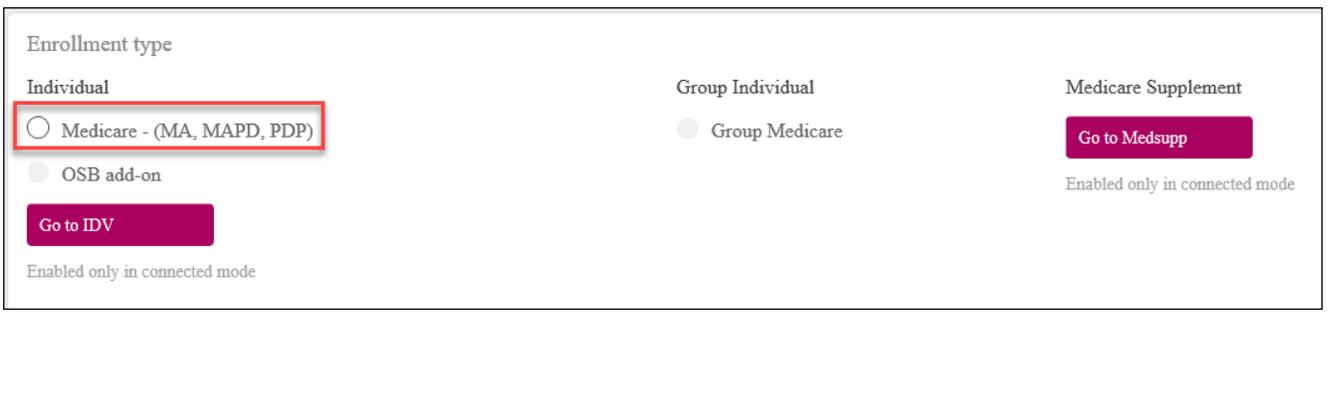
Process:

From the Workbench, click on the **ENROLLMENT APPLICATIONS** tab. Then click on **START APPLICATION**.	

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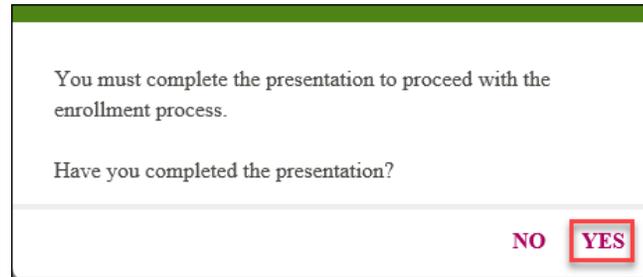|	
Select **NEW MEMBER** to fill-out an application for a new member. Select **EXISTING MEMBER** to fill-out an abbreviated enrollment form for a plan-to-plan change or to add an Optional Supplemental Benefit (OSB) to a member's existing plan.	Please select type of member: ○ New member ○ Existing member CANCEL NEXT
Enter the applicant's zip code in the **ZIP CODE** field. The **COUNTY** and **STATE** fields will auto-complete. The **PLAN YEAR** will auto-populate with the applicable plan year. ⚠ *The Plan Year drop-down menu will require you to select the appropriate year during AEP. Otherwise, it is populated for you.*	ENROLLMENT**HUB** Learn & Shop ZIP code County State Plan year
In the **ENROLLMENT TYPE** section under Individual, select the **MEDICARE – (MA, MAPD, PDPD) OPTION**. ⚠ *The OSB add-on is grayed out since the Existing Member flow is required for an OSB application. The IDV and Medsupp buttons link out to a different tool for completion. The group Medicare option is grayed out since it will not be available until a later time.*	Enrollment type Individual Group Individual Medicare Supplement ○ Medicare - (MA, MAPD, PDP) ● Group Medicare Go to Medsupp ● OSB add-on Enabled only in connected mode Go to IDV Enabled only in connected mode

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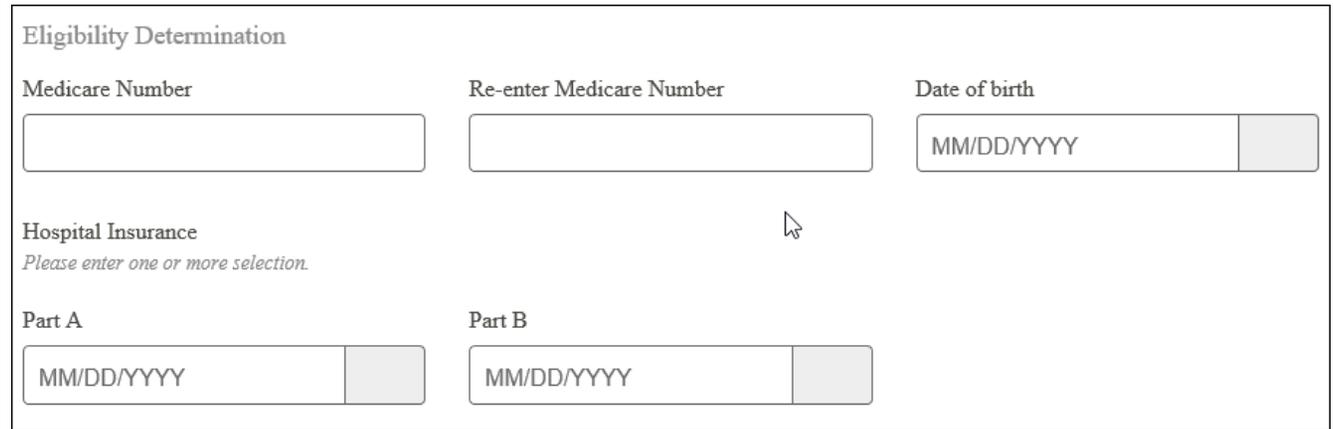|	
The pop-up message **"You Must complete the presentation to proceed with the enrollment process. Have you completed the presentation?"** will display. You need to confirm that you have completed a compliant sales presentation. Click **YES** to continue.	You must complete the presentation to proceed with the enrollment process. Have you completed the presentation? NO **YES**
In the **ELIGIBILITY DETERMINATION** section, complete the fields with the beneficiary's information. Enter the corresponding data: • Medicare Number **(for practice applications enter 1aa1aa1aa1)** • Re-enter Medicare Number • Date of Birth • Part A and Part B effective date ⚠ *You must enter the information on this section as it appears on the client's Medicare Card. The application could pend if the information does not match.*	Eligibility Determination Medicare Number Re-enter Medicare Number Date of birth MM/DD/YYYY Hospital Insurance *Please enter one or more selection.* Part A Part B MM/DD/YYYY MM/DD/YYYY

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Click on the **RADIO BUTTON** next to the plan the applicant wants to enroll in. Then click on **ENROLL**. ⚠ *To access the plan's Summary of Benefits (SB) click on the plan name.*	

2019 - Individual Medicare Plan Listing ☑ All (14) ☑ MAPD (10) ☑ MA (1) ☑ PDP (3)

Benefit Summary	Monthly Premium	Rx	Office PCP/ Specialist Co-pays	MMOOP	Hospital you pay	OSB plans	LIS Premium	
HMO Plans								
● Humana Gold Plus HMO H1036-054	**$0.00**	Yes	$0.00 / $0.00	$2,000.00	See plan details	No		
○ Humana Gold Plus HMO H1036-237-002	**$0.00**	Yes	$0.00 / $15.00	$3,400.00	See plan details	No		
○ Humana Value Plus HMO H1036-264	**$20.20**	Yes	$0.00 / $0.00	$3,400.00	See plan details	No	Details	

Enroll

Read the **DISCLOSURE STATEMENT** verbatim to the applicant before moving forward.	**Disclosure Statement** **Read this information verbatim to the applicant:** The person that is discussing plan options with you is either employed by or contracted with Humana. This person may be compensated based on your enrollment in the plan.

In the **ACKNOWLEDGEMENT** section select either: • Yes, to move forward. • No, if the applicant does not understand or agree with the statements.	**Acknowledgement** Based on what we have discussed, do you understand that this plan has coverage for medical and prescription drugs? ○ Yes ○ No Based on the plan you selected are you aware that this is NOT a Medicare Supplement Plan? ○ Yes ○ No

Continue on next page.

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In the **DECISION MAKER** section specify who is completing the application.	Decision maker Please tell us who is completing your application form. ◯ I'm completing my application on my own. ◯ I have Power of Attorney (POA) or other authorization under state law and am applying on someone's behalf.
Complete the following fields in the **MEDICARE INFORMATION** section: • Last Name • Middle Initial (optional) • First Name • Gender The Medicare Number, Hospital Insurance Part A and Part B, and Date of Birth fields will auto-populate. ⚠ *You can always edit the fields by selecting the Edit pencil and updating them on the Learn & Shop page.*	Medicare Information To complete this section, refer to your Medicare card. Please fill in the information exactly as it appears on your card. Last Name [ ] Middle Initial (optional) [ ]

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Select the appropriate **ELECTION PERIOD** type. Your options are: • AEP • IEP • ICEP • OEP • OEP New • OEP-I • SEP Then select the Proposed Effective Date from the drop-down menu. ⚠ *All election periods will display in the application. However, based on the current date or plan type, not all election types will be available to choose.*	**Election Period** Typically you may only enroll in a Medicare Advantage or Prescription Drug Plan during the Annual Election Period (AEP) between October 15th and December 7th of each year. However, there are exceptions that may allow you to enroll in a Medicare Advantage or Prescription Drug Plan outside of those election periods. Selection of an option below certifies that to the best of your knowledge, the consumer is eligible for the Enrollment Period selected. If we later determine that this information is incorrect, the consumer may be dis-enrolled. **Proposed effective date** [⌄]
Read the **ESRD** question to the applicant, and select the corresponding answer: • If the answer is **YES**, continue to the additional questions • If the answer is **NO**, continue to the next section	**End-Stage Renal Disease (ESRD)** Have you been diagnosed with End-Stage Renal Disease (ESRD)? ○ Yes ○ No

Continue on next page.

In the **APPLICANT ADDRESS** section, complete the following sections: • Street Address 1 • Street Address 2 (optional) • City The County, State and Zip Code fields will auto-populate with the information entered on the **LEARN & SHOP** page. ⚠ *You can edit the County, State and Zip Code fields by clicking the Edit pencil icon.*	Applicant Address (Physical street address required - No P.O. Boxes) Street Address 1 Street Address 2 (optional) City County MIAMI-DADE
If the applicant's mailing address is different from their physical address, check the box and enter the following information: • Street Address 1 • Street Address 2 (optional) • City • County • State • Zip Code	Applicant Mailing Address (If different from physical address) ☑ Check if your mailing address is different from your physical address Street Address 1 Street Address 2 (optional)

Continue on next page.

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In the **CONTACT INFORMATION** section, complete the Applicant Phone Number field (optional) and select the corresponding phone type. If the applicant has an Email address that they would like to provide enter it in the Applicant Email field (optional).	Contact Information Applicant Phone Number (optional) 305-666-5555 × Phone Type ○ Cell Phone ○ Home (land line) Applicant Email (optional)
If the applicant provides a Cell Phone number in the Contact Information section an additional disclosure and questions will display. You are required to read the disclosure and the questions to the applicant and select the corresponding response.	Phone Type ● Cell Phone ○ Home (land line) Your consent is voluntary and allows us to contact you via text message, artificial or pre-recorded voice messages, or automatic dialing. You may contact us to change your preferences at any time. Changing your preferences will not affect your eligibility for Humana benefits and enrollment, payment for coverage of services, or ability to get treatment. Data use charges and rates from your Cellular carrier may apply. May we contact you at the number regarding your Humana plan for informational or service purposes, such as information about your plan, health tips, reminders, preventive screenings, general health education, awareness and care coordination? ○ Yes ○ No May we have your permission to call your cell phone for Humana marketing purposes, such as letting you know about new or different plan offerings that could help you save money or healthcare costs or other out of pocket expenses or other Humana offerings such as mail order pharmacy? ○ Yes ○ No

Continue on next page.

If the applicant would like to provide **EMERGENCY CONTACT** information check the box and enter: • Last Name • Middle Initial (optional) • First Name • Relationship to applicant • Phone Number	Emergency Contact Information ☐ I wish to provide an Emergency Contact
In the **PREFERRED LANGUAGE** section, click the **PRIMARY LANGUAGE** drop-down menu and select the applicable language. If the applicant has a visual or auditory impairment and would prefer to receive information in an alternative format, click the **ALTERNATIVE FORMAT** drop-down menu and select one of the options.	Preferred Language Primary Language English Spanish Chinese Other ...format, please select one of the alternative options below. Alternative Format (optional) ---None--- Audio Large Print Accessible Screen Reader PDF Oral Over the Phone Braille 1-800-457-4708 (TTY users should call 711) if you need information in ...above. Hours are from 8 a.m. to 8 p.m. local time, Monday through

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In the **DIGITAL ON-BOARDING** section, ask the applicant *"Would you like to learn more about receiving materials electronically?"* and select the corresponding answer.

If the applicant would like to learn more about receiving materials electronically, select **YES**. A message will appear. Read the message with all available online materials to the applicant.

After reading the message ask the applicant *"Would you like to receive these communications online?"* and select the corresponding response.

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

⚠ *If the applicant wants to receive materials electronically, the Email field in the Contact Information section must be complete.*

Digital on-Boarding

Would you like to learn more about receiving materials electronically?

○ Yes   ○ No

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

Go Digital!
You have the option to receive many plan materials online rather than mailed to you. If you choose to access online, we will send you an email with a link to register for secure, MyHumana account. After you register, you will be able to view your plan materials in your MyHumana account when they are available. You may change your preference at any time. These are the materials you can access online:

• Verification of Enrollment
• Plan Coverage Package (Evidence of Coverage, Summary of Benefits, Plan Stars Ratings, and Value-Added Services)
• Annual Notice of Change
• Smart Summary ® - Explanation of Benefits (EOB)
• Plan messages and notifications

Registering for your MyHumana account is easy. Visit Humana.com to get started.

Want to learn more about the features of MyHumana?
Take a Tour of MyHumana by visiting Humana.com/TourMyHumana.

Would you like to receive these communications online?

○ Yes   ○ No

Continue on next page.

In the **COMMUNICATION METHOD** section, select the applicants Preferred Method of Communication. ⚠ *If the applicant chooses a Preferred Method of Communication that has not been provided, you must return to the Demographic section and update the information.*	Communications method Preferred Method of Communication ○ Phone ○ Email ○ USPS
In the **PRIMARY CARE PHYSICIAN** section: • Read the disclosure statement to the applicant • Complete the **NAME OF PRIMARY CARE PHYSICIAN (PCP)** field • Complete the **PCP ID NUMBER** field • Read the "***Are you an established patient of the physician you selected***?" question and select the corresponding answer. ⚠ *If working in connected mode, you can use the Search For My Doctor button and use Physician Finder to locate the PCP information.*	PCP Note to agent: The plan selected requires identification of a Primary Care Physician (PCP) in order to process the enrollment. If connected, you can use the "Search for my doctor" button below to locate the appropriate PCP and then enter the information requested for the Primary Care Physician for the plan that the applicant is enrolling. **Search for my doctor** Name of Primary Care Physician (PCP) [ ] PCP ID Number [ ] Are you an established patient of the physician you selected? ○ Yes ○ No

Continue on next page.

In the **OTHER COVERAGE** section, read each question to the applicant and select the appropriate answer. Applicants can answer **YES** or **NO** to each question. If the applicant will have other medical health coverage and/or other prescription drug coverage in addition to the plan for which they are applying for, you will need to enter information about the other coverage on the application.	**Other Coverage** Once enrolled, will you or your spouse work? ◯ Yes ◯ No Once enrolled, will you or your spouse have other medical health coverage? ◯ Yes ◯ No Some people may have other drug coverage including 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 the plan for which you are applying? ◯ Yes ◯ No
Next, read the question **"*Are you enrolled in your state's Medicaid coverage?*"** to the applicant and select **YES** or **NO**. If the answer is **YES**, complete the Applicant Medicaid Number and Effective Date fields. If the applicant is unable to provide the Medicaid Number, you will still be able to complete and submit the application. ⚠ *Optional Supplemental Benefits (OSB) are not available on every plan.*	**Medicaid** Are you enrolled in your state's Medicaid coverage? ◯ Yes ◯ No Applicant Medicaid Number (optional) Critical Reminder, please make sure the correct Medicaid ID number is provided [ ] Effective Date [MM/DD/YYYY]

Continue on next page.

In the **OPTIONAL SUPPLEMENTAL BENEFIT (OSB) QUESTIONS** section, the applicant has the chance to add an OSB to their MA/MAPD plan. Read the **"Are you interested in a supplemental benefit plan?"** question, and select **YES** or **NO**. If the answer is **YES,** you will be required to select the OSB plan(s) that the applicant wants to add.	**Optional Supplemental Benefits (OSB) questions** Are you interested in a supplemental benefit plan (Dental, Vision, etc.)? ◯ Yes　　　　　　　　　◯ No Optional Supplemental Benefits for this plan: ☐ MyOption Enhanced Dental HMO　　　　　　　　**$19.50** ☐ MYOPTION TOTAL DENTAL HMO　　　　　　　　**$23.30** Total estimated monthly OSB fee　　　　　　　　**$0.00**
In the **PAYMENT AMOUNT** section select the corresponding Payment Option: ● Automatic Checking or Savings Account Deduction ● Social Security Benefit Check Deduction ● Railroad Retirement Board Benefit check Deduction ● Automatic Credit Card Deduction ● Pay Directly	Monthly premium for base plan　　　　　　$0.00 Please select a payment method to pay your monthly premium and/or late enrollment penalties: Humana has automated options to help you pay your monthly premiums. The options are to have your monthly premium deducted automatically from your bank account, credit card, Social Security or Railroad Retirement Board check. The other option is that we can send you a payment book. For your conveniece would you like to be set up on an automated option for deductions from a bank account or credit card, or from your Social Security or Railroad Retirement Board Check? Payment Options ◯ Automatic Checking or Savings Account Deduction ◯ Social Security Benefit Check Deduction ◯ Railroad Retirement Board Benefit check deduction ◯ Automatic Credit Card Deduction ◯ Pay Directly

Continue on next page.

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The next section is the **LICENSED SALES AGENT DATA**. Agent name, Location and Agent SAN are already populated.

Make sure to complete:
- Agency name (optional)
- Agency SAN (optional)
- MGA (optional)
- Licensed Sales Agent email address
- Affinity partner selection. If no Affinity Partner you **MUST** select **NONE** from the drop-down menu.

Licensed Sales Agent data

Licensed Sales Agent name

SMART TEST AGENT

Location

KY

Licensed Sales Agent SAN

1129696

Agency name (optional)

Agency SAN (optional)

MGA (optional)

Licensed Sales Agent email address

agent@humana.com

Affinity partner selection

Please Select

Continue on next page.

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The **SALE DATE** section is next. You will find that the GR number and BN number fields are pre-populated

In the **VETERAN STATUS** drop-down menu, select the corresponding status of the applicant:

- Veteran
- Veteran spouse
- Veteran referral
- None of the above

In the **LEAD SOURCE** drop-down menu, select the corresponding source (optional):

- Business
- Campaign
- Contact

From the **SOA SOURCE** list, select the corresponding options based on the method that you have used to secure the Scope of Appointment (optional).

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

Sale Data

GR number

301813

BN number

001

Veteran status

[⌄]

Lead source (AKA "source") (optional)

[⌄]

SOA Source (optional)
- ◯ Humana Paper
- ◯ IVR
- ◯ DMS
- ◯ Non-Humana Paper
- ◯ Enrollment Hub

Products discussed

☐ MA/MAPD   ☐ PDP   ☐ Med Supp   ☐ Dental

☐ Vision   ☐ Hospital Indemnity   ☐ Other

Continue on next page.

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Complete **TIER 1**, **TIER 2**, and **TIER 3** by selecting the appropriate response in each drop-down menu.	Business segment (Tier 1) ⌄ Marketing source (Tier 2) Where did you hear about us? ⌄ Sale Location (Tier 3) Where did this enrollment application happen? ⌄
There are two signature types available in Enrollment HUB: • **Electronic Signature** - An email will be sent to the applicant with a link that can be accessed to sign the application electronically. • **Digital Signature** – Captures a digital signature using a touchscreen, mouse, mouse pen or signature pad ⚠ *The signature box will be enabled once you have completed all of the required fields on the application.*	Select signature type Choose the preferred signature method for this enrollment ◯ Electronic Signature ⓘ ◯ Digital Signature ⓘ

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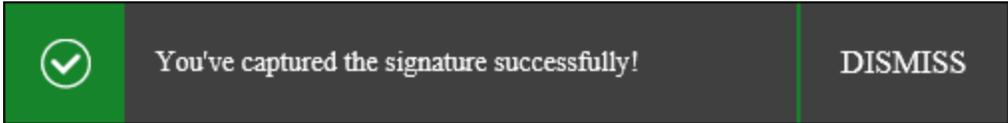|	
If **ELECTRONIC SIGNATURE** is selected, there are two questions you must ask your applicant. 1. The applicant must answer **YES** to this question to use the electronic signature method 2. The applicant can answer **YES** or **NO** to this question The last two statements are messages to you, **THE AGENT**. These are not to be read to the applicant. You must read each statement and select **I CONFIRM** to continue.	Consents **1** Do you give consent for Humana to send the Electronic Signature email with the required link to sign your application to the email address provided on this application? ◉ Yes　　　　○ No **2** Do you give consent for Humana to contact you in the event that your electronic signature is not completed in order to avoid delayed submission of your application. ◉ Yes　　　　○ No In order to be considered a valid electronic signature, the email address on the application MUST be the applicant's. If the applicant does not have a valid email address, you must click - I Do Not Confirm and select an alternative signature option or method of enrollment. By selecting "I Confirm" I confirm that to the best of my knowledge the email address listed on the application is valid and belongs only to the applicant completing the application. I acknowledge that if I send an e-signature request to an email address that I know does not belong to the applicant I may be subject to disciplinary consequences up to and including termination of contract or employment with Humana ◉ I confirm　　　　○ I Do Not Confirm
Click on **ENROLL NOW**.	Save　　Enroll now
A pop-up box will appear displaying the Application ID number. Click on **CONTINUE TO WORKBENCH**.	Thank you. Your enrollment application has been successfully submitted. Your App ID is JXL64T7VU5YEIXK4. You can check the updated status in Workbench. **CONTINUE TO WORKBENCH**

Continue on next page.

For **PRACTICE APPLICATIONS** locate the practice application on the Workbench and click on **CANCEL**.	Pending Esig COPY **PRACTICE APPLICATION** LOUISVILLE, KY 40202 100200300A Humana Gold Plus HMO H5619-073 **APP ID:** JXL6BH4ZD4HMCMS6 **Create date:** 07/01/2019 **Expiration date:** 07/15/2019 eSig Log ReSend eSig Cancel Edit
Select a reason then click on **YES, CANCEL THE APPLICATION**.	**Cancel application request** Please select a reason ○ Applicant No Longer Require Plan ○ Mistake On App, Created New One ○ System/Technical Issue NO, DON'T CANCEL YES, CANCEL THE APPLICATION

Continue on next page.

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If **DIGITAL SIGNATURE** is selected a series of disclosures and disclaimers will appear that must be reviewed with your applicant prior to capturing their signature.	Digital Signature **Authorizations** **Consent to Electronic Transactions:** I (the User) and Humana acknowledge and agree that any and all transactions performed during the term of this Agreement that are conducted through the utilization of electronic transactions and verified by the use of electronic signatures are binding per 15 U.S.C Â§ 7001- 7006. I understand that My consent, when issued electronically by use of My unique identifiers or passwords, bears the same legal authority as My written signature and is binding per 15 U.S.C Â§ 7001- 7006. • I will be bound by this Agreement throughout the term of such Agreement. • I may request that this Agreement be terminated and that Humana default to providing paper access to services by submitting an address, phone number and contact name for distribution of paper forms, as needed, to my Humana representative. Such request will be processed within forty eight (48) hours. • I may obtain a paper copy of any electronic transaction by printing the Internet screens on which such information is present. Some types of information will be provided automatically in paper form. Examples of paper forms include, but are not limited to: any notice of cancellation of policies or termination of coverage and any information pertaining to an appeal of a denied claim or adverse benefit decision. I and Humana acknowledge and agree that all transactions conducted electronically bear the same legal authority as paper
Once you have reviewed all of the required information, allow the applicant to sign the application using your touchscreen, mouse, mouse pen, or signature pad. Click on **CAPTURE SIGNATURE**.	Please inform the applicant of the following: Signature of applicant or authorized legal representative (as indicated in the Decision maker section above) *[signature]* **Clear signature** **Capture signature**
A message will display informing you that the signature was captured successfully. Click on **DISMISS**.	✓ You've captured the signature successfully! **DISMISS**

Continue on next page.

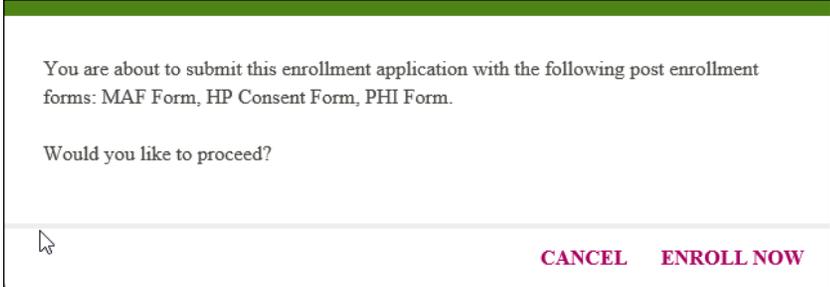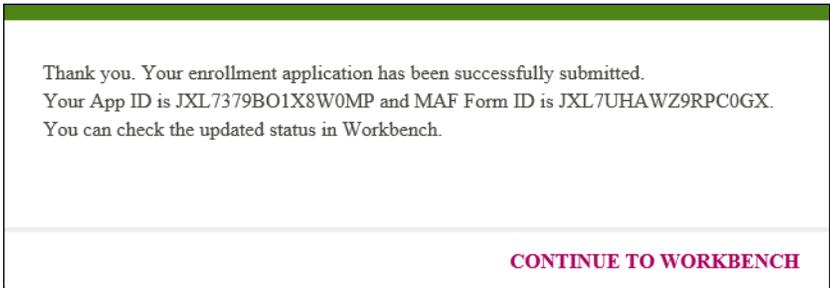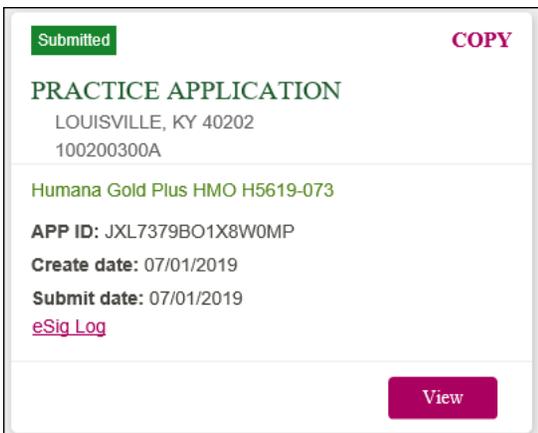|	
Click on **CONTINUE**.	Save Continue
When **DIGITAL SIGNATURE** is selected you will be able to fill-out the **POST ENROLLMENT** forms before submitting the application for processing. Once in the Post Enrollment Form screen, read each consent form description to the applicant and ask if they would like to complete the form(s). Select **YES** or **NO**. ⚠️ *Post Enrollment Forms are optional and are not required to submit the application.*	Protected Health Information (PHI) Consent Form *You have the option to complete the Protected Health Information (PHI) Consent Form that is used to authorize consent for Humana to communicate protected health information to the person or organization you designate to receive it. You can also complete this form later by accessing MyHumana.* Does the applicant want to complete a PHI Consent Form today? ○ Yes ○ No Humana Pharmacy (HP) Consent Form *This form allows Humana Pharmacy to contact you to discuss possible pharmacy savings. You can also complete this form later by accessing MyHumana.* Does the applicant want to complete an HP Consent form today? ○ Yes ○ No ○ Left Booklet Member Authorization (MAF) Form *This MAF form allows you to receive information on additional products and services not related to health. You can also complete this form later by accessing MyHumana.* Does the applicant want to complete the MAF Consent form today? ○ Yes ○ No
The form(s) that the applicant would like to fill-out will display on the navigation pane on the left side of the screen. Click on the Post Enrollment form name to open the form(s) and complete.	**PROTECTED HEALTH INFORMATION FORM** ✔ Disclaimer ✔ Member information ● PHI disclosure details ● Information Disclosed to ● Auth & Sign

Continue on next page.

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For **PRACTICE APPLICATIONS** click on **SAVE** then locate the practice application on the **WORKBENCH** and **CANCEL** the application following the steps on page 18 of this job aid. For **REAL APPLICATIONS** click on **CONTINUE**.	Save Continue
On the **ENROLLMENT SUMMARY** page you will be able to review and/or print the Enrollment Application and the Post-Enrollment forms.	✓ POST ENROLLMENT FORMS ✓ ENROLLMENT SUMMARY ✓ MEMBER AUTHORIZATION SUMMARY ✓ HUMANA PHARMACY CONSENT SUMMARY ✓ PROTECTED HEALTH INFORMATION SUMMARY
Click on **ENROLL NOW**.	Enroll now

Continue on next page.

Click on **ENROLL NOW**.	You are about to submit this enrollment application with the following post enrollment forms: MAF Form, HP Consent Form, PHI Form. Would you like to proceed? **CANCEL ENROLL NOW**
Click on **CONTINUE TO WORKBENCH**.	Thank you. Your enrollment application has been successfully submitted. Your App ID is JXL7379BO1X8W0MP and MAF Form ID is JXL7UHAWZ9RPC0GX. You can check the updated status in Workbench. **CONTINUE TO WORKBENCH**
The completed application will be displayed on the Workbench.	Submitted COPY PRACTICE APPLICATION LOUISVILLE, KY 40202 100200300A Humana Gold Plus HMO H5619-073 **APP ID:** JXL7379BO1X8W0MP **Create date:** 07/01/2019 **Submit date:** 07/01/2019 eSig Log View

Process complete

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