VRA

Scope of Appointment Options

The Plan strongly recommends the Voice Recorded Appointment (VRA) as the preferred method of satisfying the scope of appointment prior to a presentation. Our VRA process is a brief, beneficiary driven call that mirrors the Scope of Appointment model document. A successful VRA call is one where the agent has educated the prospective member on what to expect when they call.

VRA

Voice Recorded Appointment Steps

1) Agent will refer the prospect to call the VRA line.

2) Operators at the VRA line will read the CMS required statements and gather the prospect's contact information. The beneficiary will be asked, but not required to provide their phone number and address. It is an optional element of the scope.

3) The prospect will record their agreement to discuss the plan's products.

4) The prospect will be asked the agent's name and tentative appointment time.

5) The prospect will be given a VRA confirmation number.

6) You will need the VRA confirmation number prior to visiting the prospect. You may arrange to have the prospect call you with the number, or you may call the prospect following the VRA call.

7) In addition, the VRA line will have a database of the Plan's certified agents, license numbers and will be able to provide you the VRA#.

8) You may also call Agent Services at 1-877-877-0539 to look up a completed VRA confirmation number.

FREEDOM VRA

ENG: 1-800-425-5187

SPAN: 1-800-452-3031

PAPER SOA

Paper Scope of Appointment

The paper scope of appointment is another option to securing the required scope. Please review the required elements for completion.

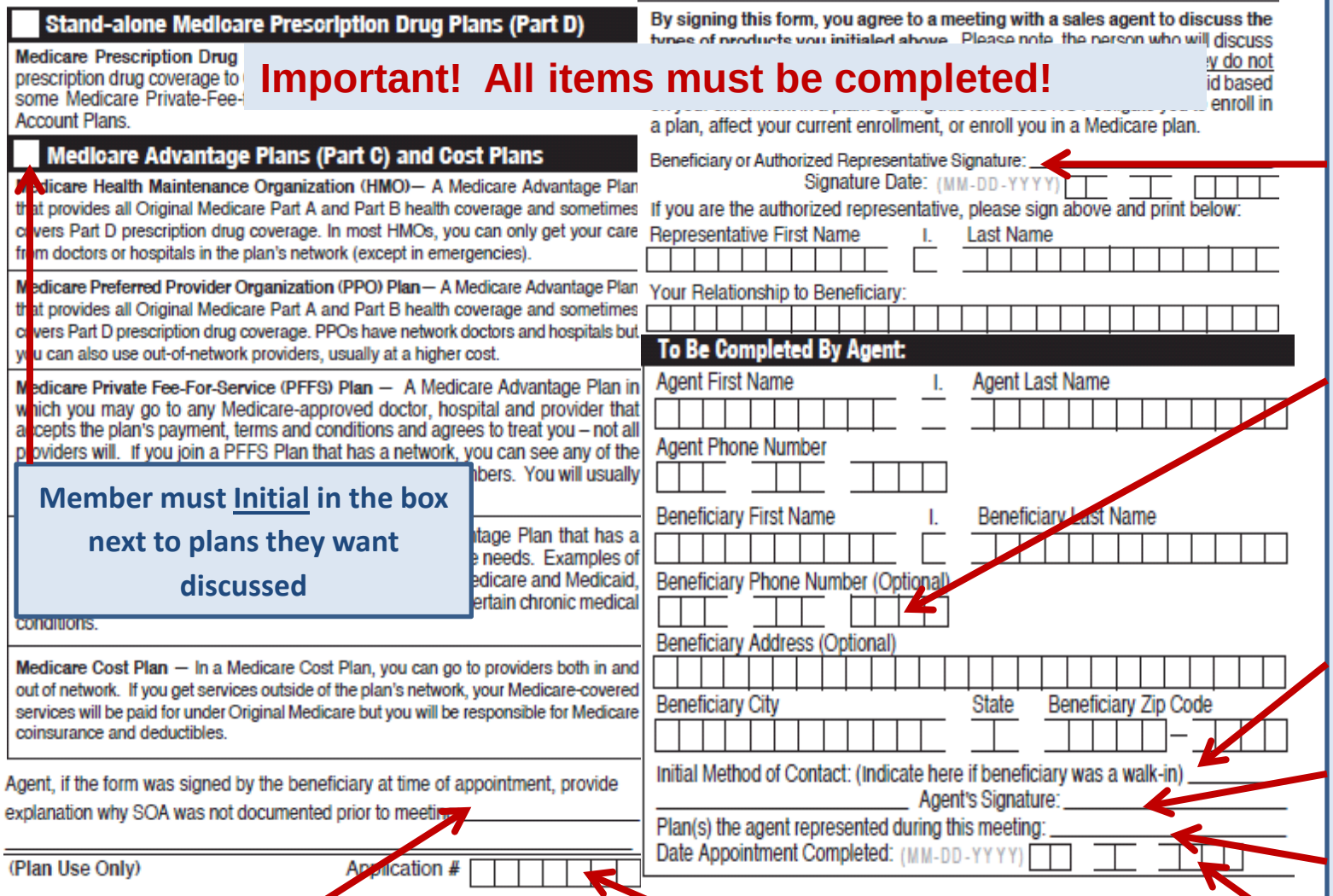
Submission of a complete SOA is required.

For scanning purposes, please use black ink, print legibly following the box structure.

Original Paper scopes are not required if it was properly submitted by fax along with the enrollment applications. As part of CMS retention requirements, it is highly recommended you maintain a copy of all submissions.

Please Note: If doing an online enrollment, the SOA must still be faxed in using a coversheet identifying the member it is associated with. Indicate on the coversheet the submission is an SOA for online enrollment only.

Paper Scope of Appointment



☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**

Medicare Prescription Drug prescription drug coverage to some Medicare Private-Fee-Account Plans.

Important! All items must be completed!

☐ **Medicare Advantage Plans (Part C) and Cost Plans**

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

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

Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the ...bers. You will usually

...tage Plan that has a ...e needs. Examples of ...edicare and Medicaid, ...ertain chronic medical conditions.

Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

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

(Plan Use Only) Application #

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 ...y do not ...id based ... enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature:

Signature Date: (MM-DD-YYYY)

If you are the authorized representative, please sign above and print below:

Representative First Name I. Last Name

Your Relationship to Beneficiary:

To Be Completed By Agent:

Agent First Name I. Agent Last Name

Agent Phone Number

Beneficiary First Name I. Beneficiary Last Name

Beneficiary Phone Number (Optional)

Beneficiary Address (Optional)

Beneficiary City State Beneficiary Zip Code

Initial Method of Contact: (Indicate here if beneficiary was a walk-in)

Agent's Signature:

Plan(s) the agent represented during this meeting:

Date Appointment Completed: (MM-DD-YYYY)

Member must Initial in the box next to plans they want discussed

Agent must provide an explanation if SOA completed at time of the appointment

Fill in the application form number associated with the SOA found in lower right of application

Fill in as required.

-Beneficiary or Rep Signature and date

Please note: It is optional for the beneficiary to provide a phone number or address

-Fill in initial method of contact with prospect

-Your Signature

-Fill in PBP# of plans discussed

-Date you held appointment

Enrollment Application PG 1 &2

FREEDOM HEALTH

H54272015E1

Please contact Freedom Health, Inc. if you need information in another language or format

To Enroll in Freedom Health, Inc. Please Provide the Following Information:

Please check which plan you want to enroll in:

- ❑ Freedom Platinum Plan Rx (HMO): **$0** per month
- ❑ Freedom Medicare Plan Rx (HMO): **$0** per month
- ❑ Freedom Medi-Medi Partial (HMO SNP): **$25.80** per month
- ❑ Freedom Medi-Medi Full (HMO SNP)*: **$25.80** per month
  *(For QMB full-benefit dual eligible only)
- ❑ Freedom VIP Savings (HMO SNP): **$0** per month
- ❑ Freedom VIP Care (HMO SNP): **$0** per month
- ❑ Freedom VIP Savings COPD (HMO SNP): **$0** per month
- ❑ Freedom Savings Plan (HMO)**: **$0** per month
  **(MA Only Plan, No Drug Coverage)

LAST Name: (use boxes below) ❑ Mr. ❑ Mrs. ❑ Ms. FIRST Name: MI:

Birth Date: M M D D Y Y Y Y Sex: ❑ M ❑ F Home Phone Number:

Alternate Phone Number: (optional)

Permanent Residence Street Address 1: (PO Box is not allowed)

Street Number Street Name Lot/Apartment

City: State: Zip Code:

E-mail Address: (optional)

Mailing Address (only if different from your Permanent Residence Address):

Street Number Street Name Lot/Apartment

City: State: Zip Code:

Emergency contact: (optional)

FIRST Name: MI: LAST Name:

Phone Number: Relationship to You:

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card
- OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

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

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name:

Medicare Claim Number: Sex: ❑ M ❑ F

Is Entitled To Effective Date: M M D D Y Y Y Y

HOSPITAL (Part A)

MEDICAL (Part B)

Paying Your Plan Premium (If Applicable)

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. You can also choose to pay your premium by 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 RRB. DO NOT pay Freedom Health 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 711. 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 each month.

Please select a premium payment option:

❑ Get a bill.

❑ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums).

H54272015E2

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 Freedom Health? ❑ YES ❑ NO
   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:
   Name of other coverage:
   ID # for this coverage: Group # for this coverage:

3. Are you a resident in a long-term care facility, such as a nursing home? ❑ YES ❑ NO
   If "yes" please provide the following information:
   Name of Institution: Phone Number: Address: (Number and Street)

4. Are you enrolled in your State Medicaid program? ❑ YES ❑ NO
   If yes, please provide your Medicaid number:

5. Do you or your spouse work? ❑ YES ❑ NO

Special Needs Plans Criteria: If you are applying for any one of the following plans then please fill out 'Chronic Special Needs Plan (SNP) Pre-Qualification Form' attached at the end of this Application Form.

- Freedom VIP Care (HMO SNP)
- Freedom VIP Savings (HMO SNP)
- Freedom VIP Savings COPD (HMO SNP)

Please choose the NAME of a Primary Care Physician (PCP), Clinic or Health Center: PCP ID Number:

FIRST Name: (use boxes below) MI: LAST Name:

Are you an existing member of this PCP? ❑ 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 another format: ❑ Spanish ❑ Large Print

Please contact Freedom Health at 1-800-401-2740 if you need information in another format or language than what is listed above. Our office hours are from October 1, 2014 to February 14, 2015 from 8 a.m. to 8 p.m. 7 days a week, from February 15, 2015 to September 30, 2015 from 8 a.m. to 8 p.m. Monday through Friday and from October 1, 2015 to December 31, 2015 from 8 a.m. to 8 p.m. 7 days a week. TTY users should call 711.

Please Read This Important Information for MA-PD Plans

If you currently have health coverage from an employer or union, joining Freedom Health could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Freedom Health. 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:

Freedom Health, Inc. 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. For MA-Only Plan, I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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.

(Continued on next page)

Enrollment Application PG 3 & 4

H54272015E3

Please Read and Sign Below

Freedom Health serves a specific service area. If I move out of the area that Freedom Health 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 Freedom Health, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Freedom Health when I get 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 Freedom Health coverage begins, I must get all of my health care from Freedom Health, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Freedom Health and other services contained in my Freedom Health Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FREEDOM HEALTH 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 Freedom Health, he/she may be paid based on my enrollment in Freedom Health.

Release of Information: By joining this Medicare health plan, I acknowledge that Freedom Health will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Freedom Health 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.

Signature: Today's Date: (M M) (D D) (Y Y Y Y)

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

Name: Phone Number:

Address:

Relationship to Enrollee:

OFFICE USE ONLY:

Name of staff member/agent/broker (if assisted in enrollment): _____

Effective Date: (MM/DD/YYYY) Agent Received Date Signature:

Election Type: ☐ ICEP/IEP ☐ AEP ☐ SEP(type) ☐ Not Eligible

COUNTY: Plan ID#

Agency of Agent: Current Insurance:

Agent Name: (First) (Last) Agent ID#:

TR K-1 ☐ Referral by Provider ☐ Referral by MCR ☐ Company Website ☐ Direct Mail
☐ Local Community Event ☐ Media (TV, News Ad, Mag) ☐ DNR save ☐ Referred by Member

TR K-2 ☐ Personal Appt; Benefit Reply Card (SOA/BRC) ☐ Walk-in; Other site (SOA) ☐ Seminar, Sales Event (Submit)
☐ Application Mailed by Beneficiary ☐ Routine Marketing Site (Submit) ☐ Voice Recorded Appt (VRA)

Online/Telephonic Application Confirmation #

Date Received: Member ID # – 0 1

FREEDOM HEALTH

Information to Include with Enrollment Mechanism

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.

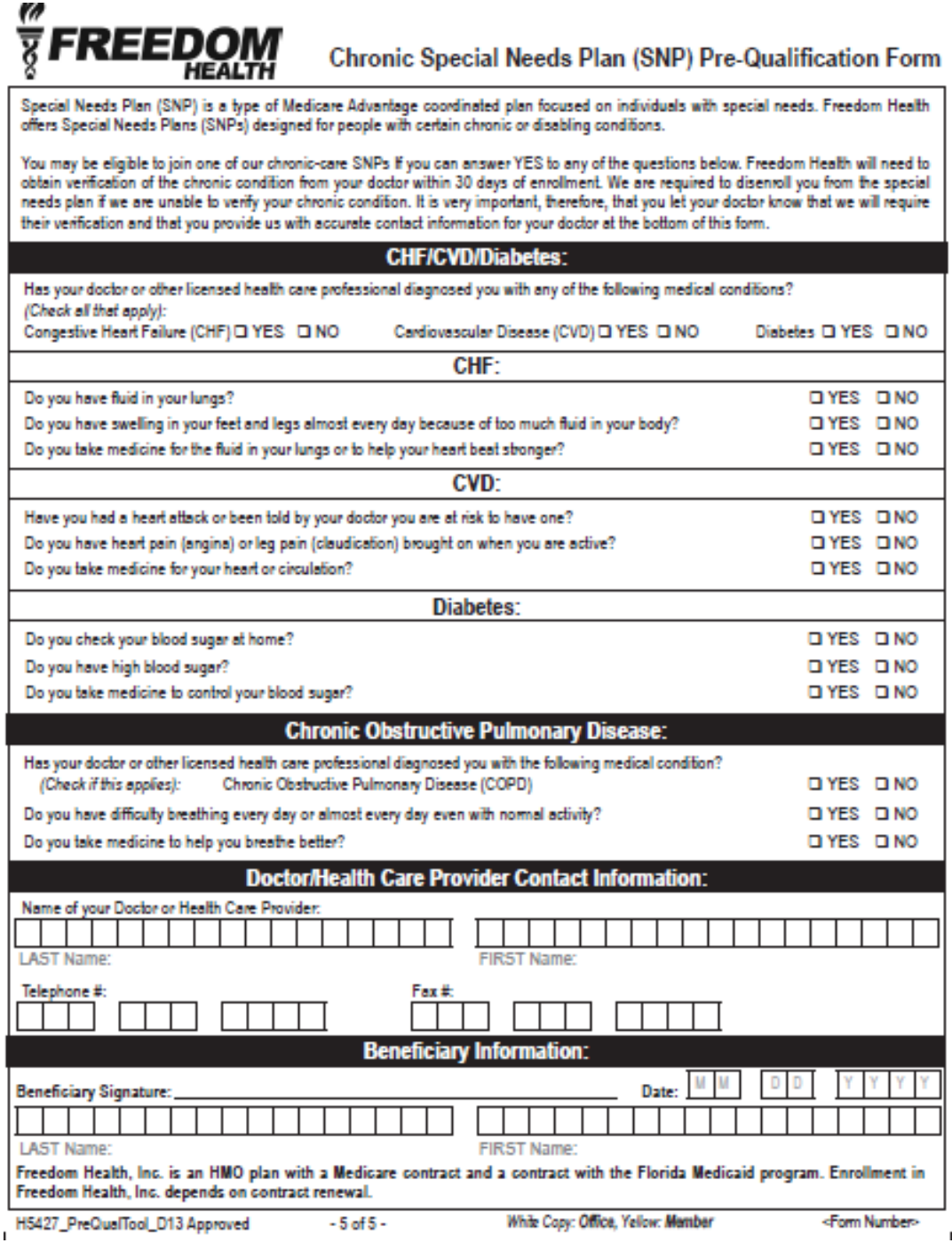
- ☐ I am new to Medicare.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (MM-DD-YYYY)
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (MM-DD-YYYY)
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (MM-DD-YYYY)
- ☐ 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 (MM-DD-YYYY)
- ☐ I recently left a PACE program on (MM-DD-YYYY)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (MM-DD-YYYY)
- ☐ I am leaving employer or union coverage on (MM-DD-YYYY)
- ☐ 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 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 (MM-DD-YYYY)
- ☐ Other: _____

If none of these statements applies to you or you're not sure, please contact Freedom Health at 1-800-401-2740 (TTY users should call 711) to see if you are eligible to enroll. We are open from October 1, 2014 to February 14, 2015 from 8 a.m. to 8 p.m. 7 days a week, from February 15, 2015 to September 30, 2015 from 8 a.m. to 8 p.m. Monday through Friday and from October 1, 2015 to December 31, 2015 from 8 a.m. to 8 p.m. 7 days a week.

OFFICE USE ONLY

Enrollee's LAST Name: (use boxes below) FIRST Name: MI:

Medicare Claim # Effective Date: (M M) (D D) (Y Y Y Y)



FREEDOM HEALTH

Chronic Special Needs Plan (SNP) Pre-Qualification Form

Special Needs Plan (SNP) is a type of Medicare Advantage coordinated plan focused on individuals with special needs. Freedom Health offers Special Needs Plans (SNPs) designed for people with certain chronic or disabling conditions.

You may be eligible to join one of our chronic-care SNPs if you can answer YES to any of the questions below. Freedom Health will need to obtain verification of the chronic condition from your doctor within 30 days of enrollment. We are required to disenroll you from the special needs plan if we are unable to verify your chronic condition. It is very important, therefore, that you let your doctor know that we will require their verification and that you provide us with accurate contact information for your doctor at the bottom of this form.

CHF/CVD/Diabetes:

Has your doctor or other licensed health care professional diagnosed you with any of the following medical conditions?
(Check all that apply):
Congestive Heart Failure (CHF) ❑ YES ❑ NO Cardiovascular Disease (CVD) ❑ YES ❑ NO Diabetes ❑ YES ❑ NO

CHF:

Do you have fluid in your lungs?	❑ YES ❑ NO
Do you have swelling in your feet and legs almost every day because of too much fluid in your body?	❑ YES ❑ NO
Do you take medicine for the fluid in your lungs or to help your heart beat stronger?	❑ YES ❑ NO

CVD:

Have you had a heart attack or been told by your doctor you are at risk to have one?	❑ YES ❑ NO
Do you have heart pain (angina) or leg pain (claudication) brought on when you are active?	❑ YES ❑ NO
Do you take medicine for your heart or circulation?	❑ YES ❑ NO

Diabetes:

Do you check your blood sugar at home?	❑ YES ❑ NO
Do you have high blood sugar?	❑ YES ❑ NO
Do you take medicine to control your blood sugar?	❑ YES ❑ NO

Chronic Obstructive Pulmonary Disease:

Has your doctor or other licensed health care professional diagnosed you with the following medical condition?

(Check if this applies): Chronic Obstructive Pulmonary Disease (COPD)	❑ YES ❑ NO
Do you have difficulty breathing every day or almost every day even with normal activity?	❑ YES ❑ NO
Do you take medicine to help you breathe better?	❑ YES ❑ NO

Doctor/Health Care Provider Contact Information:

Name of your Doctor or Health Care Provider:

LAST Name: FIRST Name:

Telephone #: Fax #:

Beneficiary Information:

Beneficiary Signature: _____ Date: M M D D Y Y Y Y

LAST Name: FIRST Name:

Freedom Health, Inc. is an HMO plan with a Medicare contract and a contract with the Florida Medicaid program. Enrollment in Freedom Health, Inc. depends on contract renewal.

Enrollment Application PG 5