••• < > 🗉	0	🗎 brokerportalalignment.b2clogin.com	Č	• • • •
				1
	A	lignment Healthcar	e	
		Agent Portal Login		
		AHC Employee Login		
		Email Address		
		Email Address		ľ
		Password		
		Password		
		Sign in		
		Forgot your password?		
	Alignment a	NEED AN ACCOUNT? gent and agency receive access to our broker portal upon Contact our Partner Experience team for help	certification	

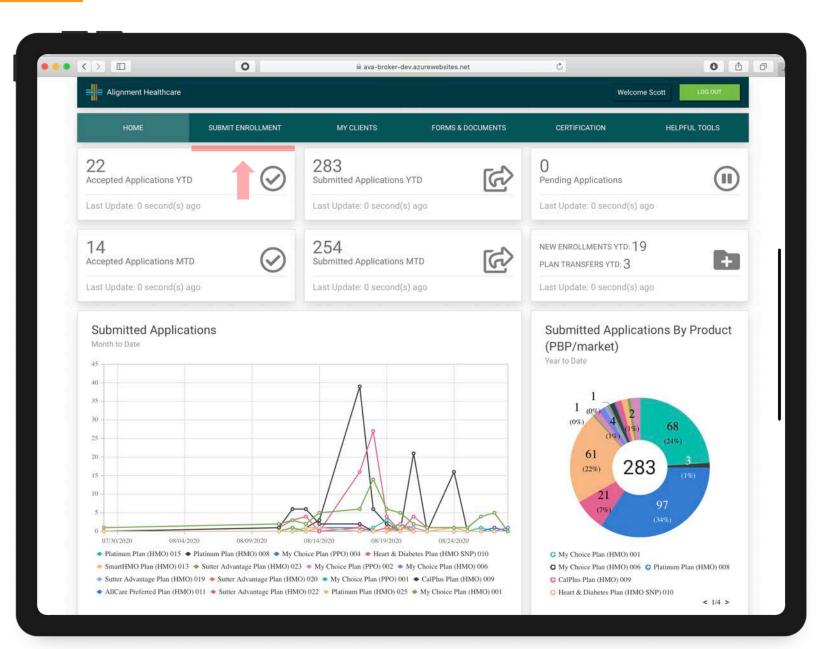
STEP 1

Go to: www.AlignmenthHealthPlan.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**

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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	: fits your client's r	needs	
	Fillu		. Ins your chemis i	neeus.	
		Zip Code *			
		c	ontinue		

STEP 3

Enter the beneficiaries' **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

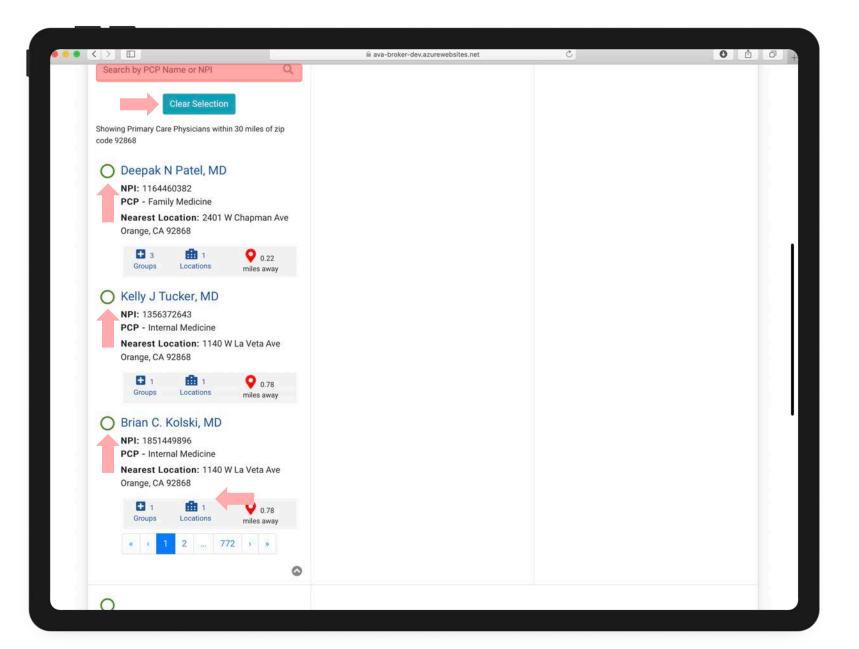
Select Coverage Year, and click Continue

			🗎 ava	-broker-dev.azurewebs	ites.net	C		0 0
	Healthcare						Welcome Scott	LOG OUT
номі	E SUE	BMIT ENROLLMENT	MY CLIENTS	FOR	MS & DOCUMENTS	CERTIFICAT	ION H	ELPFUL TOOLS
Enroll in	to an Alignn	nent Health	care plan					
<u> (</u>	Find a Plan	View, Comp	are, Select	3 SOA Confirma	ation	Enroll	Beview and Sub	omit
Available	plans in zip c	ode 92868 (O	range County	()		Sc	ort by Lowest Mor	nthly Premium 💲
My Choice I	Plan (HMO) 001	Compare Plans	Platinum Plan	(HMO) 008	Compare Plans	Heart & Diabo	etes Plan (HM0	D SNP)
	\$0			\$0			\$0	
	Monthly Premiun	n		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/Mon 24/7 Conciery Telehealth Member Rewa	ge Care	ccess	OTC \$20/Month 24/7 Concierge (Telehealth Member Rewards	Ac	cess Cess	OTC \$2 <mark>0</mark> /Month 24/7 Concierge Telehealth Member Reward	Care	CESS CESS
View plan details Select primary ca Search for other p	re physician >		View plan details > Select primary care p Search for other prov			View plan details > Select primary care Search for other pro	physician >	
PRIMARY CAR	E PHYSICIAN SELEC	TION						
physician (PC assigned auto	ncourage selection o P) at time of enrollm matically to HMO en ere. For PPO plans, F	ent. A PCP will be rollees if one is						

STEP 5

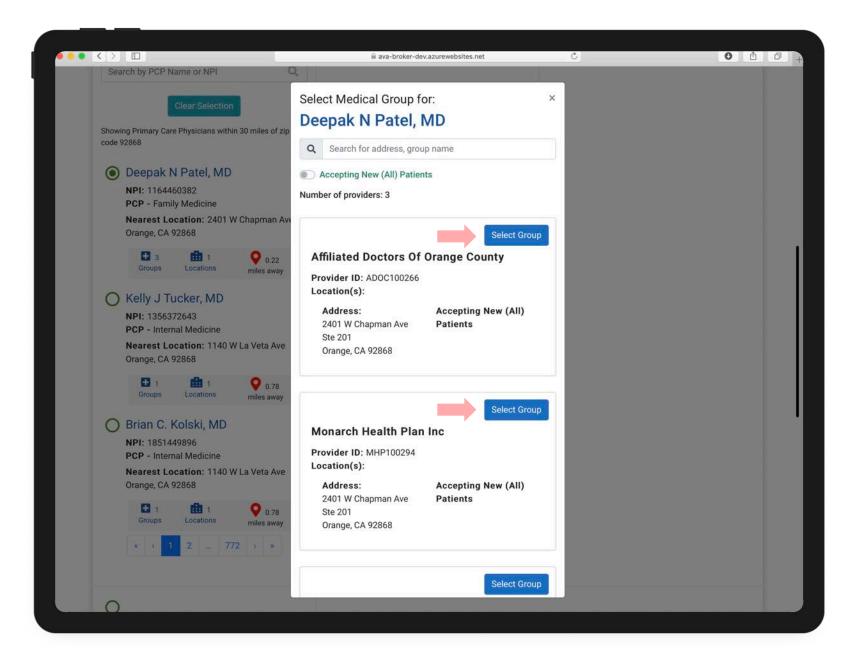
Select the **Desired Plan**

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			
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 >			
	Dark Darking -		
	Back Continue		
		P	

STEP 6 (cont)

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



FUL TOOLS
ng to ensure his 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				Welce	ome Scott
НОМЕ	SUBMIT ENROLLMENT	MY CLIENTS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into an <i>i</i>	Alignment Health	care plan			
Find a P	lan 🔰 😰 View, Comp	are, Select 3	SOA Confirmation	Enroll 6 Revie	ew and Submit
Zip code: 92868 -	My Choice Plan (HMO) 001 - Plan Year 2	020		
Who's completing the E	nrollment Application?				
Field Agent			\$		
The Centers for Medicard Inderstanding of what w confidential and should b		res agents to document th gent and the Medicare be with Medicare or his/her a			
65	y applicant or authoriz	// 31			
	Medicare Prescripion I	er menne ann anna			
	Drug Plan (PDP) - A stand- -Servive Plans, and Medicare N		prescription drug coverage to Or Plans	iginal Medicare, some Medio	care Cost Plans, some
Medicare Private-Fee-for					

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			
To 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	\$
	Agreement electronically. You agree yo	our electronic signature is the legal equivale	nt of your manual signature on this <i>i</i>	Agreement.
8 48	Agreement electronically. You agree yo		nt of your manual signature on this a	Agreement.
By signing below, you are signing this A AGENT SIGNATURE AND SIGNATURE D	Agreement electronically. You agree yo		nt of your manual signature on this <i>i</i>	Agreement.
By signing below, you are signing this A GENT SIGNATURE AND SIGNATURE D Signature - First and Last Name * Signature - First and Last Name Scope of Appointment documentation explanation why SOA was not document Provide brief explanation	Agreement electronically. You agree yo PATE Date Appointmen 2020-09-04 is subject to CMS record retention red			
By signing below, you are signing this A AGENT SIGNATURE AND SIGNATURE D Signature - First and Last Name * Signature - First and Last Name Scope of Appointment documentation explanation why SOA was not document	Agreement electronically. You agree yo PATE Date Appointmen 2020-09-04 is subject to CMS record retention red	it Completed *		

STEP 7 (CONT)

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



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Alignment Healthcare	ė			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 Info	ormation 3 Additional Inf	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	
	allow you to enroll in a Medicare A ving statements carefully and che			ny of the following boxes w	ou are certifying that to	
	ledge, you are eligible for an Enrol				10.00	
I am new to Medica	ire.					
🔲 I am enrolled in a N	ledicare Advantage plan and want	t to make a change durin	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	noved and this plan is a new opt	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	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	ing for my Medicare prescri	ption drug coverage,	

STEP 8

Select applicable Enrollment Reason

Scroll down and click **CONTINUE**

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Alignment Healthcare				Welc	ome Scott	
НОМЕ	SUBMIT ENROLLMENT	MY CLIENTS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS	
nroll into an Ali	gnment Healtho	care plan				
Find a Plan	View, Compa	are, Select 3	SOA Confirmation	Enroll (5 Revi	ew and Submit	
1 Medicare Ad	lvantage Eligibility Veri	fication 2 Client In	formation 3 Additional In	formation		
7:		0) 001 - Diag V	2022			
Zip code: 92868 - N	ly Choice Plan (HM	0) 001 - Plan Year	2020			
Proposed Effective Date						
2020-10-01		\$				
Effective Dates for your Pa	white, and blue Medicare ca		on. In the spaces provided, enter	your Medicare Number (do n	oot enter dashes) and the	
EG4-TE5-WK72 HOSPITAL (PART A) 03-01-2016 MEDICAL (PART B) 03-01-2016						
Medicare ID # *	Last Nam	e *				
Medicare ID #	Last Nam	ne	Verify			
Medicare Part A Eligibility	v Date * Medicare	Part B Eligibility Date *				
Medicare Part A Eligibilit	y Date Medicare	Part B Eligibility Date				
Client Details						

STEP 9

The **VERIFY** feature will allow you to input the beneficiaries' Medicare number & last name and automatically fill in effective dates

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

lient Details				
First Name *	Middle Initial	Last Name *	Date Of Birth *	
Ozzy	Middle Initial	Torres	9/12/1945	
			thod of Contact *	
Gender *	Primary Language *	5		
Male	¢ English	¢ Cell Phon	ie	\$
ermanent Address			21.752	
Address Line 1 *	Address Line 2	City *	State *	
123 Street Ave	Address Line 2	Oragne	CA	\$
Zip Code *				
92868 mailing address the same as p contact Information	permanent address? * Yes			10.000
92868 mailing address the same as p contact Information Primary Phone # *	Cell Phone #	Email *	Preferred Method o	
92868 mailing address the same as p contact Information Primary Phone # * 909-782-1217	Cell Phone # Cell Phone #		Preferred Method o	f Contact
92868 mailing address the same as p contact Information Primary Phone # *	Cell Phone # Cell Phone #	Email *	Preferred Method of Relationship to Clier	\$
92868 mailing address the same as p contact Information Primary Phone # * 909-782-1217 mergency Contact Infor	Cell Phone # Cell Phone # rmation	Email * otorres@ahcusa.com		\$
92868 mailing address the same as p contact Information Primary Phone # * 909-782-1217 mergency Contact Infor First Name	Cell Phone # Cell Phone # rmation Middle Initial	Email * otorres@ahcusa.com Last Name		\$

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

Scroll down and click **CONTINUE**



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Alignment Healthcare				Welco	ome Scott
HOME	SUBMIT ENROLLMENT	MY CLIENTS	FORMS & DOCUMENTS	CERTIFICATION	HELPFUL TOOLS
Enroll into an Al	lignment Healtho	care plan			
Find a Plan	View, Compa	rre, Select 3	SOA Confirmation	Enroll 5 Revie	ew and Submit
1 Medicare A	Advantage Eligibility Verif	ication 2 Client Info	ormation 3 Additional Info	ormation	
Zip code: 92868 -	My Choice Plan (HM	0) 001 - Plan Year 2	2020		
Additional Informa	tion				
1. Do you have End Stage	e Renal Disease (ESRD)? *				
2. Are you a resident in a	long-term care facility, such	as a nursing home? *			
and the second			ance, TRICARE, Federal employe verage in addition to Alignment H		VA benefits or State
4. Are you eligible for Sta	te Medicaid (Medi-Cal)? *				
5. Are you enrolled in you	ır State Medicaid Program (N	/ledi-Cal)? *			
6. Do you or your spouse	work?*				
🔘 Yes 🔘 No					

STEP 10

Complete all **Additional** information



Paying your plan pr	emium			
You can pay your monthly	plan premium (including any la	te enrollment penalty that you currently have o ecurity or Railroad Retirement Board (RRB) ber		can also choose to pay
paying this extra amount i	것은 그는 가지는 것같이 많은 것은 것을 알았다. 같이 같은 것은 것을 못했다.	ustment Amount, you will be notified by the Soo n. You will either have the amount withheld from Part D-IRMAA.		5월 2월
monthly prescription drug enrollment penalty. Many	premiums, annual deductibles, people are eligible for these say ity at 1-800-772-1213. TTY/TDD	pay for their prescription drug costs. If eligible and co-insurance. Additionally, those who qua vings and don't even know it. For more informa 0 users should call 1-800-325-0778. You can al	lify will not be subject to the coverage tion about this extra help, contact you	gap or a late
a militarili suran manifer sana ang 1969.		on drug coverage costs, Medicare will pay all o care doesn't cover. If you don't select a payme		
Please select a plan pr	emium and/or late enrollme	ent payment option: *		
O Get a Bill				
two or more months automatic deduction	to begin after Social Security of the first deduction from your solding begins. If Social Security	urity or Railroad Retirement Board (RRB) benef or RRB approves the deduction. In most cases, Social Security or RRB benefit check will includ y or RRB does not approve your request for aut	if Social Security or RRB accepts your le all premiums due from your enrollm	request for ent effective date

STEP 10 (cont)

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

Scroll down and click **CONTINUE**



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Alignment Healthcar	e				Welcome S	cott LOG OUT	
HOME	SUBMIT ENROLLMENT	MY CLIENTS	FORMS & DOCUMEN	ITS CERTIFIC	ATION	HELPFUL TOOLS	
Enroll into an	Alignment Health	care plan					
1 Find a	Plan 🔰 🙆 View, Comp	are, Select 3	SOA Confirmation	O Enroll	5 Review and	I Submit	
Z	ip code: 92868 - My Ch	oice Plan (HMO) 00	1 - Effective Date:	: 2020-10-01 - Oz	zy Torres		
D	eview Enrollment A	nnligation					
ĸ	eview Enronment A	phication					
M	ly Choice Plan (HMO) 00	01 🥒					
	rimary Care Physician 🖋						
	CP: Deepak N Patel, MD none Number: 6572364909						
	edical Group: Affiliated Docto	rs Of Orange					
	ounty ADOC100266						
w	ho is completing the Enr	ollment Application?	1				
	Ill Name: SCOTT LUCAS		ss: 5819 CHENAULT D	R			
Pł	none Number: (209) 574-0858	City: City: State:	IODESTO CA				
м	ledicare Information 🖋						
	our Medicare Beneficiary Numbe	20112-2023	tal Insurance Benefits (P	Part A) Date:			
13	BG4TE5MK72		-2016	10) 0.1			
			al Insurance Benefits (Pa	art b) bate.			

STEP 11

Review all information and **Scroll Down**



	a ava-broker-dev.azurewebsites.net	0 <u></u>
No	obtain a Provider Directory?	
39290	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 A		
Last Name:	Email:	
First Name:	Relationship to Enrollee:	
Phone Number:	and sector is a rest from a result of the sector is	
Payment Option 🥒		
Payment Option 🖋 Get a Bill		
	• Yes No	
Get a Bill	9 Yes 🔿 No	
Get a Bill Do you want to upload a paper application?	Yes No PLOAD APPLICATION Or drop files here	
Get a Bill Do you want to upload a paper application?		
Get a Bill Do you want to upload a paper application?		
Get a Bill Do you want to upload a paper application? Please upload a paper application Signature Date on Paper		
Get a Bill Do you want to upload a paper application?		
Get a Bill Do you want to upload a paper application? Please upload a paper application Signature Date on Paper		
Get a Bill Do you want to upload a paper application? Please upload a paper application Signature Date on Paper Application *		
Get a Bill Do you want to upload a paper application? Please upload a paper application Signature Date on Paper Application *		
Get a Bill Do you want to upload a paper application? Please upload a paper application Signature Date on Paper Application *		
Get a Bill Do you want to upload a paper application? Please upload a paper application Signature Date on Paper Application *		
Get a Bill Do you want to upload a paper application? Please upload a paper application Signature Date on Paper Application * Signature Date on Paper Applicatio	PLOAD APPLICATION Or drop files here	
Get a Bill Do you want to upload a paper application? Please upload a paper application Signature Date on Paper Application * Signature Date on Paper Applicatio		
Get a Bill Do you want to upload a paper application? Please upload a paper application Signature Date on Paper Application * Signature Date on Paper Applicatio	PLOAD APPLICATION Or drop files here	

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**



i ava-broker-dev.azurewebsites.net	C	
Payment Option 🖋		
Get a Bill		
Do you want to upload a paper application? O Yes • No		
Please Read This Important Information. If you currently have health coverage from an employer or union, joining Alignment union health benefits. You could lose your employer or union health coverage if you communications your employer or union sends you. If you have questions, visit the their communications. If there isn't any information on whom to contact, your bene answers questions about your coverage can help.	i join Alignment Health Plan. Read the ir website, or contact the office listed in	
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 Fe Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, an plan will automatically end my enrollment in another Medicare health plan or prescon Read More	d I understand that my enrollment in this	
Electronic Signature Agreement By signing below, you are signing this Agreement electronically. You agree your elec your manual signature on this Agreement.	ctronic 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 electronically agree your electronically agree your electronical signature on this Agreement.	ctronic 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**

the second se		■ ava-broker-d	ev.azurewebsites.net	C	O ć
Alignment Healthcar	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.			
	Iment application was received a	일종 방법에 여러 있는 것을 가지 않는 것을 많이 많다.			
-	u provided an email address earli _Torres_09042020141952.pc		rmation number to the beneficial	y or authorized representat	lve.
-	II_H3815_PBP001_Torres_09				
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

