SCRIPT: MA Enrollment Long Form

(Purpose: This script is to be used for Medicare Advantage plan telephone enrollment for new enrollments only. Telephone enrollment may be offered:

1. If the telephone call was accepted as an inbound call.
2. Once the applicant has provided enough information to the Agent/Customer Service associate and the Agent/Customer Service associate has asked if the applicant would like to enroll, and the individual has said yes.
3. Upon the receipt of an unsolicited request to enroll over the phone.

Script Instructions: Information in (parentheses) and/or italics indicates this is the telephone enrollment agent script and/or instruction. This information is not voiced in the conversation.)

(INTRO SCREEN)

Thank you for calling <Brand >. This call will be recorded for verification, quality control and training purposes. My name is <First and Last Name>. Have you placed this call to <Brand> today to enroll in a Medicare Advantage plan?

(*Actively listen to caller response/questions/comments. Direct any non-Medicare Advantage enrollment inquiries to appropriate department).*

Before we begin I want to inform you that you are not required to provide health related information unless used to determine enrollment eligibility. May I have your name please?

If our call is disconnected, do I have your permission to call back?

(If "yes":) [May I have your phone number please?] (*Repeat back for confirmation*.)

(If "no":) [Okay, please know that if we are disconnected, you will need to call back the same number and begin the enrollment again.] *(Continue with call.)*

Are you the Medicare beneficiary and the person who will be enrolling in the plan?

(If "yes" continue with enrollment below)

(If "no":) [Are you the representative for the Medicare beneficiary?]

(If "yes" caller is a representative:) [During the enrollment process, you will be asked to certify that you are authorized under state law to complete the enrollment application. You will be asked to provide written certification on behalf of <First Name> <Last Name>. If you are unable to provide this certification, this new enrollment application will not be processed. Are you able to provide this documentation?]

(If "no" caller (representative) cannot provide documentation:) [Without your certification that this documentation can be provided upon request, I cannot process this telephone enrollment. Please call Customer Service **(provide the Customer Service and TTY phone numbers, with days and hours of operation)** and the rep can mail an application to you. Thank you and have a good <day/evening>. Goodbye. **(End call.)]**

(If "yes" caller is representative and can provide documentation:) [May I have the name of the beneficiary please?] **(Capture name and continue.)**

(If caller does not provide beneficiary name:) [Without this information, I cannot process the telephone enrollment I can send you an application, you can download one from <Brand website URL>, or you may call <Customer Service/your agent> to discuss your options for enrollment. Which will work best for you? **(Provide Customer Service and TTY/TDD phone number with days and hours of operation or Agent contact information or capture mailing address to send application by mail.)** Thank you for calling <Brand> and have a good <day/evening>. Goodbye. **(End call.)]**

Do you have [your] [<Mr./Ms.> <Last Name>'s] Medicare card or the information from your Medicare card available? *(Medicare claim number, Part A & B effective date)*

(If "yes" continue)

(If "no":) [Without this information, I cannot process the telephone enrollment. I can send you an application, you can download one from <Brand website URL>, or you may call <Customer Service/your agent> to discuss your options for enrollment. Which will work best for you? **(Provide Customer Service and TTY/TDD phone number with days and hours of operation or Agent contact information or capture mailing address to send application by mail.)** Thank you for calling <Brand> and have a good <day/evening>. Goodbye. **(End call.)]**

We also need to verify you have the following pieces of information provided by your licensed agent: The quote ID, the complete name of the plan [you] [<Mr./Ms.> <Last Name> wish to enroll in, the requested effective date of coverage, the premium amount and reason for enrollment. Can you please confirm if you have this information?

(If "no":) [Without this information, I cannot process [your] [<Mr./Ms.> <Last Name>'s] telephone enrollment. I can send you an application, you can download one from <Brand website URL>, or you may call <Customer Service/your agent> to discuss your options for enrollment. Which will work best for you? **(Provide Customer Service and TTY/TDD phone number with days and hours of operation or Agent contact information or capture mailing address to send application by mail.)** Thank you for calling <Brand> and have a good <day/evening>. Goodbye. **(End call.)]**

May I have the Quote ID number?

(Capture and continue to next question)

Based on the Quote ID you provided, the complete name of the plan is <Plan Name/Type>. Is this correct?

(Verify and continue to next question)

The requested effective date of coverage is <mm/dd/yyyy>, correct?

(Verify and continue to next question)

The premium amount for the plan is <$XX>, correct?

(If quote ID and plan information not confirmed:) [Without this information, I cannot process [your] [<Mr./Ms.> <Last Name>'s] telephone enrollment. I can send you an application, you can download one from <Brand website URL>, or you may call

<Customer Service/your agent> to discuss your options for enrollment. Which will work best for you? **(Provide Customer Service and TTY/TDD phone number with days and hours of operation or Agent contact information or capture mailing address to send application by mail.)** Thank you for calling <Brand> and have a good <day/evening>. Goodbye. **(End call.)]**

(If quote ID and plan information provided:) Thank you**,** I am confirming that [you are] [<Mr./Ms.> <Last Name> is] enrolling in <Plan Name and type>, which is a Medicare Advantage plan that has a contract with the federal government. This coverage will become effective <mm/dd/yyyy>, with a plan premium amount of <$XX> per month. This plan [<does include Medicare Part D prescription drug coverage>]/[<does not include Medicare Part D prescription drug coverage and cannot be combined with any stand-alone Part D prescription drug plan>.]

(If adding Optional Supplemental Benefits:) [And [you are] [<Mr./Ms.> <Last Name> is] adding <Package Name>.]

If [you currently have] [<Mr./Ms.> <Last Name> currently has] health coverage from an employer or union, joining <Plan Name> could affect [your] [<his/her>] employer or union health benefits. [You] [<He/She>] could lose [your] [<his/her>] employer or union health coverage if [you] [<he/she>] join this plan. Please read the communications [your] [<Mr./Ms.> <Last Name>'s] employer or union sends [you] [<him/her>]. If [you have] [<he/she> has] questions, visit their website or call the office listed in the communications. If there isn't any information on whom to call, [your] [<his/her>] benefits administrator or the office that answers questions about [your] [<his/her>] coverage can help.

(IF MA Only:) [Medicare Advantage only plans generally do not cover prescribed drugs. Enrollment in this plan will automatically end [your] [<Mr./Ms.> <Last Name>'s] enrollment in another Medicare health plan or prescription drug plan. A Medicare eligible person who is enrolled in this Medicare Advantage plan may not be enrolled at the same time in a separate Prescription Drug Plan. The last enrollment request [you make] [<Mr./Ms.> <Last Name> makes] during an enrollment period will be accepted as the plan for which [you intend] [<he/she> intends] to enroll. For example, if [you enroll] [<he/she> enrolls] in this plan and subsequently enroll in a standalone PDP plan, [you] [<he/she>] will lose coverage in this MA plan and only be enrolled in the standalone PDP plan. To find out if an MA or MAPD plan is right for [you] [<Mr./Ms.> <Last Name>], please call licensed sales agent <Licensed Agent Name> at <phone number> or TTY/TDD line at 711. Agents are available <seven days a week>, <8AM to 8PM>.]

(APPLICANT INFO SCREEN)

In order to complete your enrollment, I need to verify the following pieces of information:

(Verify & spell all information for verification of accuracy.)

- I have the spelling of [your] [<Mr./Ms.> <Last Name>'s] last name as **(spell last name).** Is this how it appears on [your] {<his/her>] Medicare card?
- I have the spelling of [your] [<Mr./Ms.> <Last Name>'s] first name as **(spell first name).** Is this how it appears on [your] [<his/her>] Medicare card?
- Please provide [Your] [<Mr./Ms.> <Last Name>'s] middle initial as it appears on [your] [<his/her>] Medicare card.
- Please provide [your] [<Mr./Ms.> <Last Name>'s] gender as it appears on [your] [<his/her>] Medicare card.
- I have [your] [<Mr./Ms.> <Last Name>'s] date of birth as <mm/dd/yyyy>
- I have [your] [<Mr./Ms.> <Last Name>'s] telephone number as <phone number>
- I have an alternate telephone number as <phone number>
    - **(If no alternate number present)** Is there an alternate telephone number you would like to provide?
- I have [your] [<Mr./Ms.> <Last Name>'s] county of residence as <county>
- I have [your] [<Mr./Ms.> <Last Name>'s] home street address as **(spell address, city, state and zip)**
- Is there a different mailing address I should note? **(If yes, capture address, city, state and zip)**
- I have [your] [<Mr./Ms> Last Name>'s] e-mail address as <e-mail>
    - **(If no e-mail address present)** [Email is the fastest, easiest way to get important information about your plan, and some fun extras too!] [Would you like to provide an email address?]
        - **(If email address provided:) [**Do you agree to receive your welcome kit by email? This includes the first year *Evidence of Coverage, List of Covered Drugs (Formulary),* tips for finding and ordering a Provider and Pharmacy Directory, and other helpful information.]
        - [Do you agree to receive your Annual Notice of Changes by email? This Notice comes every year with the new *Evidence of Coverage, List of Covered Drugs (Formulary),* and tips for finding and ordering a Provider and Pharmacy Directory.]
- [By giving your email address, you agree to receive email about your benefits, health programs and other plan services. You understand you may change email preferences at any time by logging into your member profile or calling Customer Service.] Please provide [your] [<Mr./Ms.> <Last Name>'s] Medicare claim number.
- Please provide the Part A and Part B effective dates from [your] [<Mr./Ms.> <Last Name>'s] Medicare card.

(ELIGIBILITY INFORMATION SCREEN)

(If MAPD:) [People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for up to 75% or more of [your] [<his/her>] drug costs, including monthly prescription drug premiums, annual deductibles and coinsurance. Also, if [you qualify] [<he/she> qualifies], [you] [<he/she>] will not be subject to the coverage gap or a late enrollment penalty. For more information about this Extra Help, call your local Social Security office or call 1-800-MEDICARE, 1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You also can apply for Extra Help online at **www.socialsecurity.gov/prescriptionhelp**.]

If [you qualify] [<Mr./Ms.> <Last Name> qualifies] for Extra Help with [your] [<his/her>] Medicare prescription drug coverage costs, Medicare will pay all or part of [your] [<his/her>] plan premium. If Medicare pays only a portion of this premium, we will bill [you] [<Mr./Ms.> <Last Name>] for the amount that Medicare doesn't cover.

(Agent cannot and will not request any bank information during the call. This information will be requested by the plan once the application is processed.)

(If plan has a premium:) [We will not collect any premium at this time, but we do need to know how [you] [<Mr./Ms.> <Last Name>] would like to pay any premium in the future.]

(If $0 premium plan:) [The next question may seem odd since [you're] [<Mr./Ms. <Last Name> is] enrolling into a $0 premium plan, but we need to know how [you] [<he/she>] would like to pay if there was ever a premium in the future such as for a late enrollment penalty.]

[You] [<Mr./Ms.> <Last Name>] can receive a monthly bill by mail, an automatic bank account deduction or automatic deduction from [your] [<his/her>] Social Security check or Railroad Retirement Board (RRB) Deduction each month. Which option works best?

(If caller chooses the automatic bank account deduction option:) [Direct bills will continue until EFT forms have been processed.]

(If caller chooses the Social Security check or RRB automatic deduction option:) [After Social Security or RRB approves the automatic deduction, it may take two or more months for the deduction to begin. In most cases, the first deduction from [your] [<his/her>] Social Security or RRB benefit check will include all premiums due from [your] [<his/her>] enrollment effective date up to the date withholding begins. If Social Security or RRB delays or does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.]

(IMPORTANT QUESTIONS)

Now I have a few additional questions that the Center for Medicare and Medicaid Services

requires us to ask:

[Do you] [Does <Mr./Ms.> <Last Name>] have End Stage Renal Disease?

(If "no" continue with enrollment:)

(If "yes":) [Please provide the following information: Dialysis center name, Dialysis center identification number and Nephrologist name. If you have had a successful kidney transplant and/or you don't need regular dialysis any more, you will be asked to send a note or records from your doctor verifying this; otherwise we may need to contact you to obtain additional information.]

If you have other drug coverage, will [your] [<Mr./Ms.> <Last Name's>] current prescription drug coverage be ending?]
(Note some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs. Capture response & continue with enrollment)

(If applicant is applying for a plan with Medicare Prescription Drug coverage:) [Will [you] [<Mr./Ms.> <Last Name] have other prescription drug coverage in addition to this plan?]

(If "no" continue with enrollment:)

(If "yes":) [Please tell me [your] [<his/her>] other coverage and [your] [<his/her>] identification number or numbers for this coverage.] **(Capture Name of other coverage, ID# for this coverage and Group# for this coverage. *VA benefits do not have an ID#, mark NA on application)**

[Are you] [Is <Mr./Ms.> <Last Name>] a resident in a long-term care facility, such as a nursing home?

(If "no" continue with enrollment:)

(If "yes":) [Please tell me the name, address and phone number of the facility.] **(Capture name, address and phone Number of facility.)**

[Are you] [Is <Mr./Ms. > <Last Name>] enrolled in [your] [<his/her>] State Medicaid Program?

(If "no" continue with enrollment:)

(If "yes":) [Please provide [your] [<his/her>] Medicaid ID Number.] **(Capture ID#.)**

Will [you] [<Mr./Ms.> <Last Name>] or [your] [>his/her>] spouse be employed once [you have] [<he/she> has] enrolled in this plan? **(Capture response.)**

[(**If HMO:)** [Please provide [your] [<Mr./Ms.> <Last Name>'s] primary care physician's name, address and ID number.

(If no primary care physician:) If [you do] [<he/she> does] not have a primary care

physician, one will be assigned to [you] [<him/her>]. [You] [<Mr./Ms.> <Last Name>] can call Customer Service if [you want] [<he/she> wants] to change it.]

[(**If primary care physician provided:)** Is this physician new for you?]

(ELIGIBILITY ATTESTATION)

I will read the following statements carefully. Please tell me which statement applies to [you] [<Mr./Ms.> <Last Name>]. By confirming any of the following statements you are certifying that, to the best of your knowledge, [you are] [<Mr./Ms.> <Last Name> is] eligible for an Enrollment Period. If we later determine that this information is incorrect, [you] [<he/she>] may be disenrolled.

(Read only if during Annual Election Period) [[You are] [<Mr./Ms.> <Last Name> is] enrolling during the Annual Open Enrollment Period that begins October 15 and ends on December 7, <2014>.]

(If SEP has already been identified, provide this option first to caller. If SEP has NOT been identified, read the following statements in order below. Once the caller has identified the SEP that applies, do not read remaining statements in this section):
(Read if at any time other than during AEP)

- [[You are] [<Mr./Ms.> <Last Name> is] new to Medicare.
- [[You are] [<Mr./Ms.> <Last Name> is] turning 65 and not new to Medicare.
- [[You] [<Mr./Ms.> <Last Name>] recently moved outside of the service area for [your] [<his/her>] current plan or [you] [<he/she>] recently moved and this plan is a new option for [you] [<him/her>]. [You] [<He/She>] moved on **(Capture date)**.
- [[You have] [<Mr./Ms.> <Last Name> has] both Medicare and Medicaid or [your] [<his/her>] state helps pay for [your] [<his/her>] Medicare premiums.
- [[You get] [<Mr./Ms.> <Last Name> gets] Extra Help paying for Medicare prescription drug coverage.
- [[You no longer qualify] [<Mr./Ms.> <Last Name> no longer qualifies] for Extra Help paying for [your] [<his/her>] Medicare prescription drugs. [You] [<He/She>] stopped receiving Extra Help on **(Capture Date)**.
- [[You are] [<Mr./Ms.> <Last Name> is] moving into, live in, or recently moved out of a Long-Term Care Facility - for example, a nursing home or other long term care facility. [[You] [<Mr./Ms.> <Last Name>] moved/will move into/out of the facility on **(Capture Date)**.
- [[You] [<Mr./Ms.> <Last Name>] recently left a Program of All-Inclusive Care for the Elderly {PACE}. [You] [<He/She>] left this PACE program on **(Capture Date)**.
- [[You] [<Mr./Ms.> <Last Name>] recently involuntarily lost [your] [<his/her>] creditable prescription drug coverage - coverage as good as Medicare's. [You]

[<He/She>] lost [your] [<his/her>] drug coverage on **(Capture Date)**.

- [[You are] [<Mr./Ms.> <Last Name> is] leaving employer or union coverage on **(Capture Date)**.
- [[You] [<Mr./Ms.> <Last Name>] belong to a pharmacy assistance program provided by [your] [<his/her>] state.
- [[You] [<Mr./Ms.> <Last Name>] recently returned to the United States after living permanently outside of the U.S. [You] [<He/She>] returned to the U.S. on **(Capture Date)**.
- [[You] [<Mr./Ms.> <Last Name>'s] plan is ending its contract with Medicare, or Medicare is ending its contract with [your] [<his/her>] plan.
- [[You] [<Mr./Ms.> <Last Name>] was enrolled in a Special Needs Plan (SNP) but lost the special needs qualifications required to be in the plan. [You] [<Mr./Ms.> <Last Name>] was disenrolled from the SNP on _____ **(Applicant must provide date.)**
- Other _____ **(Applicant must provide special election statement.)**

(Reread statements as necessary and capture which applies to applicant.)

(SUBMISSION SCREEN)

(At this point, agent will verify all information gathered.)
Now to finish [your] [<Mr./Ms.> <Last Name>'s] enrollment, we need to go through some important legal information. Please listen carefully and if you are comfortable, state "I agree and understand" at the end of the recording.

(Agent will play recorded verbatim disclaimers found on the carrier's enrollment form in the section listed below:)

<Plan Name> is a Medicare Advantage plan and has a contract with the federal government. You will need to keep your Medicare Parts A and B. You can be in only one Medicare Advantage plan at a time, and you understand that enrollment in this plan automatically will end enrollment in another Medicare health plan or prescription drug plan. It is your responsibility to inform this plan of any prescription drug coverage that you have or may get in the future. You understand that if you don't have Medicare prescription drug coverage, or creditable prescription drug coverage as good as Medicare's, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once you enroll, you may leave this plan or make changes only at certain times of the year when an enrollment period is available, for example, October 15 – December 7 of every year, or under certain special circumstances.

<Plan Name> serves a specific service area. If you out of the area that this plan serves, you need to notify <Brand> so you can disenroll and find a new plan in your new area. Once you are a

member of this plan you have the right to appeal plan decisions about payment or services if you disagree . You will read the Evidence of Coverage document from <Brand> when you get it to know which rules you must follow to get coverage with this Medicare Advantage plan. You understand that people with Medicare usually aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

(If PPO:) [You understand that beginning on the date <Plan Name & Type> coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If services are medically necessary, <Brand > will refund all covered benefits, even if you get services out-of-network. Services authorized by <Brand > and other services contained in your new plan's Evidence of Coverage document – also known as a member contract or subscriber agreement – will be covered. Without authorization, neither Medicare nor <Brand> will pay for the services.]
(If HMO:) [You understand that, beginning on the date coverage in <Plan Name & Type> begins you must get all your health care from that plan, except for emergencies or urgently needed services, or out-of-area dialysis services. Services authorized by your new plan and other services contained in your new plan's Evidence of Coverage document – also known as a member contract or subscriber agreement – will be covered. Without authorization, neither Medicare nor <Brand> will pay for the services.

You understand that if you are getting help from a sales agent, broker, or other individual employed by, or contracted with, <Brand >, that individual may be paid based on your enrollment in <Plan Name & Type>.

By joining this Medicare health plan, you acknowledge that <Brand> will release your information to Medicare and other plans as is necessary for treatment, payment and health care operations. You also acknowledge that <Brand> will release your information (including your 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 your knowledge. You understand that if you intentionally provide false information on this form, you will be disenrolled from the plan.

Please state "I agree and understand."

(If applicant does not affirm the statement, repeat and clarify or state:) [I cannot process [your] [<Mr./Ms.> <Last Name>'s] enrollment over the phone without you stating that you agree and understand the information that I have just provided and that it is [your] [<Mr./Ms.> <Last Name>'s] intention to enroll. If you have questions, I can assist you with those. However, if you would like to proceed with [your] [<Mr./Ms.> <Last Name>'s] enrollment please state, "I agree and understand."]

(If applicant still does not affirm the statement, state:) [Without your agreement to

this statement, I cannot process [your] [<Mr./Ms.> <Last Name>'s] telephone enrollment. I can send you an application or, if it is more convenient, you can download one from <Brand website URL>. You may also call <Customer Service/your agent> to discuss your options for enrollment or to have an application mailed to you. What will work best for you? **(Provide Customer Service and TTY/TDD phone number with days and hours of operation or Agent contact information or capture mailing address to send application by mail.)** Thank you for calling <Brand> and have a good <day/evening>. Goodbye.] **(End call.)**

(AGENT SCREEN)

(If the caller is the applicant:) [Can you please confirm that you are the person listed on this enrollment form?]
(Capture response.)

(If applicant does not affirm the statement, repeat and clarify or state:) [I cannot process your enrollment over the phone without your confirmation and that it is your intention to enroll. If you have questions, I can assist you with those. However, if you would like to proceed with your enrollment please confirm]

(If applicant still does not affirm the statement, state:) [Without your agreement to this statement, I cannot process your telephone enrollment. I can send you an application or, if it is more convenient, you can download one from <Brand website URL>. You may also call <Customer Service/your agent> to discuss your options for enrollment or to have an application mailed to you. What will work best for you? **(Provide Customer Service and TTY/TDD phone number with days and hours of operation or Agent contact information or capture mailing address to send application by mail.)** Thank you for calling <Brand> and have a good <day/evening>. Goodbye.] **(End call.)**

(If the caller is the authorized representative of the applicant and NOT the applicant themselves:) [If you are the authorized representative for the applicant I will need to obtain additional information. As an authorized representative, you are authorized under state law to complete the enrollment application. Again, you may be asked to provide written certification on behalf of <applicant name>. If you are unable to provide this certification, this new enrollment application will not be processed.]

[Please provide your first and last name.] **(Capture information.)**
[Please provide your telephone number.] **(Capture information.)**
[What is your relationship to the applicant?] **(Capture information.)**
[Please provide your residence street address, City, State and Zip code.] **(Capture information.)]**

(AGENT OBTAINS VERBAL SIGNATURE:)

Today is <today's date>. To confirm [your] [<Mr./Ms.> <Last Name>'s] application, please state your Full Name and today's date.

(If caller does not comply, state:) [I cannot process [your] [<Mr./Ms.> <Last Name>'s] enrollment over the phone without you providing this information as it completes [your] [<his/her>] application and affirms [your] [<his/her>] intention to enroll. If you have questions, I can assist you with those. However, if you would like to proceed with [your] [<Mr./Ms.> <Last Names>'s] enrollment, please provide your full name and today's date.]

(If applicant still does not comply, state:) [Without this information, I cannot process [your] [<Mr./Ms.> <Last Name>'s] telephone enrollment. I can send you an application, or if more convenient, you can download one from <Brand website URL>. You may also call <Customer Service/your agent> to discuss your options for enrollment or to have an application mailed to you. What will work best for you? **(Provide Customer Service and TTY/TDD phone number with days and hours of operation or Agent contact information or capture mailing address to send application by mail.)** Thank you and have a good <day/evening>. Goodbye.] **(End call.)**

Please state the City and State you are calling from.

(If caller does not comply, state:) [I cannot process [your] [<Mr./Ms.> <Last Name>'s] enrollment over the phone without you providing this information as it completes [your] [<his/her>] application and affirms [your] [<his/her>] intention to enroll. If you have questions, I can assist you with those. However, if you would like to proceed with [your] [<Mr./Ms.> <Last Names>'s] enrollment, please provide your full name and today's date.]

(If applicant still does not comply, state:) [Without this information, I cannot process [your] [<Mr./Ms.> <Last Name>'s] telephone enrollment. I can send you an application, or if more convenient, you can download one from <Brand website URL>. You may also call <Customer Service/your agent> to discuss your options for enrollment or to have an application mailed to you. What will work best for you? **(Provide Customer Service and TTY/TDD phone number with days and hours of operation or Agent contact information or capture mailing address to send application by mail.)** Thank you and have a good <day/evening>. Goodbye.] **(End call.)**

That completes the application process. <Brand> will send you a confirmation that [your] [<Mr./Ms.> <Last Name>'s] application was received. We will also notify [you] [<him/her>] by mail of the status of [your] [<his/her>] enrollment.

Also we'd like to make sure this sales experience was conducted appropriately so we may contact you at a later point in time. May we call you at <phone number> if we have any additional questions?

(If 'no', place note in system and continue.)

I will now provide you with a unique identification number for today's call. The confirmation number for your enrollment is <identification number>. Can you please read the confirmation number back to me so that I can verify it for you?

(If caller does not comply, place note in system and continue.)

Before we get off the phone, I just want to remind you that if you have any questions or would like to check [your] [<Mr./Ms.> <Last Name>'s] enrollment status or benefits, you may call Customer Service. **(Provide Customer Service and TTY phone number with days and hours of operation.)** Please be sure to have your confirmation number and the date and time of this enrollment when calling for status.

Is there anything else I can assist you with today?

(If "yes" determine need and use appropriate scripting.)

(If "no":) Thank you for contacting <Brand Name>. It was a pleasure to help you enroll in [your] [<Mr./Ms.> <Last Name>'s] Medicare Plan. Have a nice <day/evening>. Goodbye. **(End call.)**