

SCRIPT: MAPD Applicant Voice Enrollment Attestation or Voice Signature

Purpose:

This script will be used by internal Field Sales Representatives and External Brokers (Agents) to capture an MAPD or D-SNP Applicant's Voice Enrollment Attestation or Voice Signature.

Voice Enrollment may only be offered under these circumstances:

1. After the Agent has reviewed the [approved sales presentation/materials](#), including the review of required elements of the enrollment application.
2. After the Applicant has received or been directed to the **Summary of Benefits** and **Star Ratings** Documents found on the [Denver Health Medical Plan website](#) for Elevate Medicare Advantage.

[Elevate Medicare Choice \(HMO D-SNP\) Summary of Benefits](#)

[Elevate Medicare Select \(HMO\) Summary of Benefits](#)

[Elevate Medicare Advantage Star Ratings](#)

3. **Voice Enrollment Attestation:** The Applicant has stated to the Agent that they would like to enroll over the phone.
4. **Voice Signature:** The Applicant has stated to the Agent that they would like to enroll during an electronic meeting.

Script Instructions:

- Information in **(parentheses)** should not be spoken, it contains instruction for you.
- Information in **[square brackets]** indicates optional language – depends on the scenario.
- Information in **<carets>** should be populated with the applicable information. For example, for <Agent First and Last Name> you should say your first and last name.

Script: Voice Enrollment Attestation – Applicant enrolled over the phone

(Start the Voice Recording)

1. Before we get started, I want you to know that this call is being recorded for verification, quality control and training purposes.
2. My name is <Agent First and Last name> and today's date is <today's date>.
3. The purpose of this call is to confirm the enrollment of <Applicant's Name> into <Elevate Medicare Advantage Medical Plan <Select or Choice>.
4. I attest that I have reviewed all required enrollment application information with <Applicant's Name / Authorized representative's name>.
5. (If caller is an Authorized Representative of the Applicant)
 - ☐ (If not previously provided) [Please provide your first and last name; your telephone number and your relationship to the applicant.]
 - ☐ [You will be asked to certify that you are authorized under state law to complete the enrollment application, and to provide written certification on behalf of <him/her>].

6. To complete your enrollment, we need to go through some important information. I will read several statements. When I am finished, I will ask you if you understand and agree. By completing this enrollment, you agree to the following:

- ☐ You can be in only one <Medicare Advantage/Prescription Drug> plan at a time, and enrollment in Elevate Medicare Advantage will automatically end your enrollment in another Medicare Advantage plan or prescription drug plan.
- ☐ Your enrollment in this plan is generally for the entire year, and you may only leave this plan or make changes at certain times or under certain special circumstances.
- ☐ By joining this <Medicare Advantage/Prescription drug> plan, you acknowledge that <Denver Health Medical Plan> will release your information to Medicare and other plans as is necessary for treatment, payment and health care operations.
- ☐ You also acknowledge that the <Denver Health Medical Plan> will release your information to Medicare, including prescription drug event data, 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 understand and agree."

(If applicant does not affirm the statement)

- ☐ [Without your agreement to this statement, I cannot submit your enrollment application. I can send you an application or if it is more convenient, you can download one from our website.]

(Obtain verbal signature)

- ☐ You understand that your signature means that you understand the contents of your enrollment application.

(or)

[You understand that your signature, as the person authorized to act on Applicant's behalf, means that you understand the contents of their enrollment application].

(If signed by an authorized representative)

This signature certifies that:

- ☐ You are authorized under State law to complete this enrollment, and
- ☐ Documentation of this authority is available upon request from Medicare.

Thank you!

(End the Voice Recording.)