
Agent Tools

Online Enrollment

Online Enrollment Tool

In this step-by-step guide, you will learn how to complete and submit a SelectHealth Advantage application using our online enrollment tool.

Online Enrollment

Simple to use:



You need an Internet connection.

Access the online application using desktop or laptop computers, tablets or smartphones.

Time savings:



There is no need to keep track of all the pages of a paper application and spend your time waiting for a fax to go through. Leave the hassle of paper behind.

Faster processed and more accurate enrollments:



This ensures that your clients are enrolled quickly and receive ID cards and new member communications right away.

Full record of the application:



All electronic enrollments you submit are securely stored in your Link Message Center.

Higher commission:



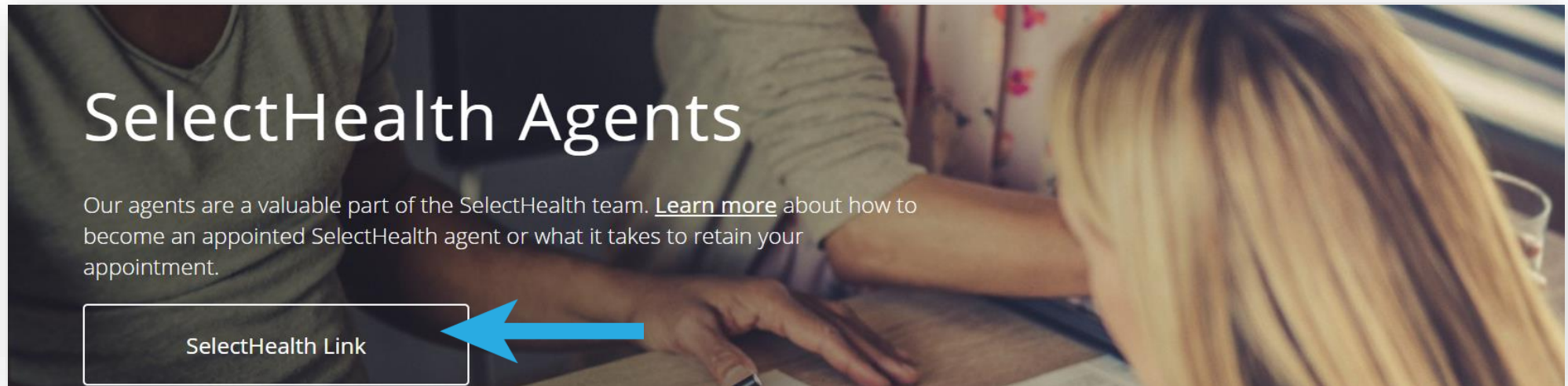
When you submit an application online through Link, we'll pay you the maximum fair market value commission the month coverage begins.

This payment arrangement applies to enrollees that are new to SelectHealth Advantage with no previous Medicare Advantage coverage.

Online Enrollment

To access the tool:

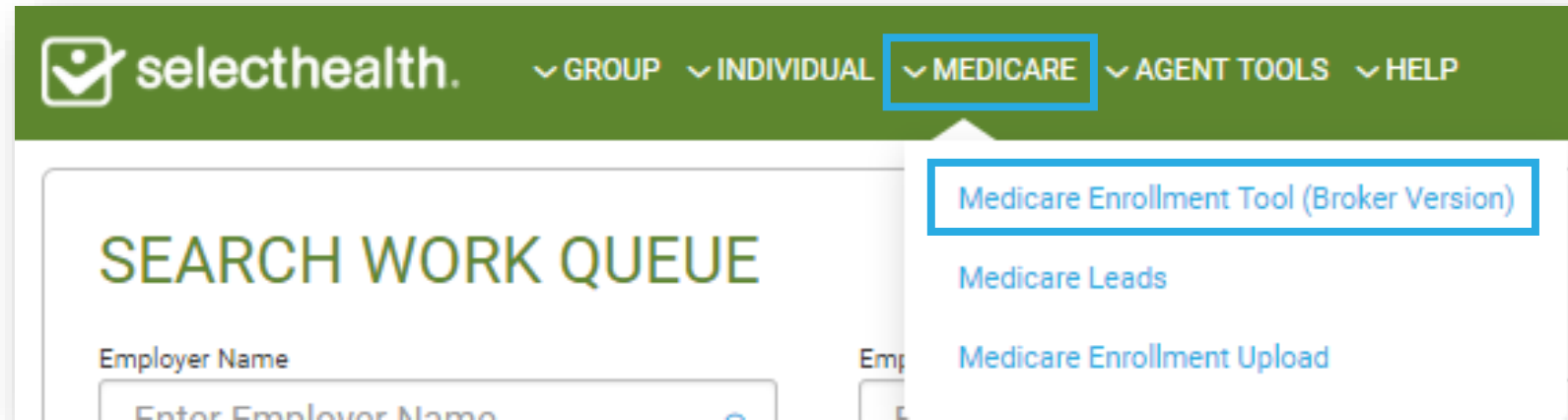
- Visit selecthealth.org/agents
- Click on SelectHealth Link
- You will need your Link username and password



Online Enrollment

To access the tool:

- Hover over the MEDICARE tab.
- Click on Medicare Enrollment Tool.
- The tool will load in a separate page.



Online Enrollment

- Enter zip code of member's primary residence.

The screenshot shows a web interface for Medicare enrollment. On the left is a vertical navigation menu with six steps: ELIGIBILITY (1), PERSONAL INFO (2), PAYING PREMIUM (3), OTHER COVERAGE (4), ALMOST DONE (5), and AGREE & SUBMIT (6). The main content area is titled 'MEDICARE INFO' and contains the instruction: 'Please tell us about your current Medicare coverage and related benefits information.' Below this is a sample Medicare card for Jane Doe. Red lines point from the card to input fields: one from the Medicare Claim Number (000-00-0000-A) to a field labeled 'Medicare Claim Number', and another from the Part A & B Effective Dates (07-01-07-01) to a field labeled 'Part A & B Effective Dates'. To the right of the card, text says 'Use your Medicare card to complete this section. In the spaces provided, enter:' followed by a bulleted list: 'Your Medicare Number', 'Your Part A Effective Date', and 'Your Part B Effective Date'. A modal dialog box is overlaid on the form, containing the text 'Please enter your zip code (primary residence)', a text input field, and 'OK' and 'Cancel' buttons. Below the dialog, a note states: 'Note: If you complete and submit the following form, you will be requesting enrollment in a SelectHealth Advantage plan.'

Step 1: Eligibility

- Provide Medicare Beneficiary Identifier or Medicare claim number type (railroad or non-railroad retiree).
- Medicare claim number must include letter or alpha suffix.
- Enter Parts A and B effective dates.

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MEDICARE INFO

Please tell us about your current Medicare coverage and related benefits information.

Use your Medicare card to complete this section. In the spaces provided, enter:

- Your Medicare Number
- Your Part A Effective Date
- Your Part B Effective Date

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

Please indicate your Medicare Number type* Non-Railroad Retiree Railroad Retiree

Medicare Number* Required

Part A Effective Date* mm/dd/yyyy

Part B Effective Date* mm/dd/yyyy

Step 1: Eligibility

- Choose the most accurate and applicable enrollment reason
- Certain enrollment reasons will require you to enter a date or provide additional information
- Request a coverage effective date
- Select a plan option

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ELIGIBILITY ①

PERSONAL INFO ②

PAYING PREMIUM ③

OTHER COVERAGE ④

ALMOST DONE ⑤

AGREE & SUBMIT ⑥

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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 recently returned to the United States (U.S.) after living permanently outside of the U.S.

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 am moving into, live in, or recently moved out of a Long-Term Care Facility (e.g., a nursing home or long-term care facility).

I recently involuntarily lost my creditable prescription drug coverage (i.e., coverage as good as Medicare's).

I recently left a program of All-Inclusive Care for the Elderly program.

I am leaving employer or union coverage.

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 recently was released from incarceration.

I recently obtained lawful presence status in the United States.

None of the above statements apply to me; however, I feel I have a special circumstance that allows me an exception to enroll. SelectHealth will contact you to determine if an exception can be granted. Please include the reason below.

What is your requested effective date of coverage with SelectHealth?*

08/01/2018

09/01/2018

10/01/2018

Please select the plan for your enrollment*

Wasatch Essential - \$0

Wasatch Enhanced - \$46

[Explore Plan Differences](#)

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Step 2: Personal Info

- Enter enrollee's personal information.
- You can provide emergency contact information by checking the "Provide Emergency Contact" box.

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ELIGIBILITY ✓

PERSONAL INFO 2

PAYING PREMIUM ③

OTHER COVERAGE ④

ALMOST DONE ⑤

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PERSONAL INFORMATION

First Name* Required ✘ First Name is required.

Middle Initials

Last Name* Required

Date of Birth* Required - mm/dd/yyyy

Gender* Male Female

Home Phone Number* Required

E-mail Address

Electronic Opt Out: You may elect to receive some post-enrollment materials electronically, including your Evidence of Coverage (EOC), which details your coverage under the plan, and Abridged Formulary, which provides a list of most commonly used, covered drugs and your Annual Notice of Changes document (ANOC) which details changes to the plan each year. To make this election, provide your email address above. You may change this election or request these items be mailed to you at any time by calling us. You can request other documents/materials be delivered electronically once you are a member of the plan.

Provide Emergency Contact (Optional)

PERMANENT RESIDENCE

Please enter your permanent residence address below. P.O. Box is not allowed. If you have more than one residence, enter your primary residence.

Address (Line 1)* Required

Address (Line 2)

City* Required

State* UT

ZIP Code* 84124 Change ZIP

Mailing address is different from my permanent address

*required fields

← Back Next →

Step 2: Personal Info

- If mailing address is different than permanent residence, check box and a new set of fields will appear allowing you to enter mailing address information.

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[ELIGIBILITY](#) ✓

PERSONAL INFO 2

[PAYING PREMIUM](#) 3

[OTHER COVERAGE](#) 4

[ALMOST DONE](#) 5

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PERMANENT RESIDENCE

Please enter your permanent residence address below. P.O. Box is not allowed. If you have more than one residence, enter your primary residence.

Address (Line 1)* Required

Address (Line 2)

City* Required

State* UT

ZIP Code* 84124 [Change ZIP](#)

Mailing address is different from my permanent address

MAILING ADDRESS

If different from above, please provide the address where you would like to receive correspondence.

Address (Line 1)* Required

Address (Line 2)

City* Required

State* Select State

ZIP Code*

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Step 3: Paying Premium

- Select a premium payment method.
- If automatic deduction from a banking account is selected, a new set of fields will appear asking for bank account information.

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[ELIGIBILITY](#) ✓

[PERSONAL INFO](#) ✓

[PAYING PREMIUM](#) 3

[OTHER COVERAGE](#) 4

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PAYING PREMIUM

Please select a premium payment option*

I prefer a paper invoice.

Automatic deduction from my monthly Social Security check.

I prefer automatic deductions from my bank account.

*required fields

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PAYING YOUR PLAN PREMIUM

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board 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 Railroad Retirement Board. DO NOT pay SelectHealth the Part D-IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a coverage gap or a late enrollment penalty. Many people qualify 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 1-800-325-0778. You can also apply for extra help online at <http://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.

(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.)

Step 4: Other Coverage

- Answer all five questions about other coverage.
- Answering “yes” to any of the questions will require additional information.
- If the enrollee has recently had a transplant, a physician note will need to be sent to SelectHealth.

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[ELIGIBILITY](#) ✓

[PERSONAL INFO](#) ✓

[PAYING PREMIUM](#) ✓

[OTHER COVERAGE](#) 4

[ALMOST DONE](#) 5

[AGREE & SUBMIT](#) 6

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COORDINATION OF BENEFITS (OTHER COVERAGE)

Some individuals may have additional prescription drug coverage, including other private insurance, TRICARE, federal employee health benefits, VA benefits, or state pharmaceutical assistance programs.

Do you have End Stage Renal Disease(ESRD)?*

Yes No **✖ Required**

Do you or your spouse work?*

Yes No

Are you enrolled in your state Medicaid program?*

Yes No

Once enrolled, will you have other medical or prescription drug coverage in addition to SelectHealth Advantage?*

Yes No

Are you a resident in a long-term care facility, such as a nursing home?*

Yes No

*required fields

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Step 5: Almost Done

- Choose a primary care doctor.
- PCP selection is REQUIRED.
- Clicking “Choose your doctor” will take you to the Find A Doctor search tool:
 - Search for PCP by name.
 - Select PCP by clicking “Add as Primary Care Provider.”
- Previous screen will now show name of PCP chosen by enrollee.

The screenshot shows the SelectHealth enrollment process at the 'ALMOST DONE' stage. On the left is a vertical navigation menu with the following items: 'ELIGIBILITY' (with a right-pointing arrow), 'PERSONAL INFO' (checked), 'PAYING PREMIUM' (checked), 'OTHER COVERAGE' (checked), 'ALMOST DONE' (highlighted with a green bar and a '5' in a circle), 'AGREE & SUBMIT' (with a '6' in a circle), 'Our Benefits', and 'Already a Member?'. The main content area is titled 'ALMOST DONE' and contains the following text and options:

ALMOST DONE

Please select your Primary Care Physician from our list of doctors.

[Choose your doctor](#)

*If your doctor is not listed, please leave this field blank.

I do not have a Primary Care Provider (PCP), please call me to help me find a PCP.

OPTIONAL SUPPLEMENTAL BENEFITS

You may add one of the following optional benefits

- SelectHealth Dental Comprehensive Benefit (additional \$35/month)
- SelectHealth Dental Comprehensive Plus Eyewear (additional \$40/month)
- I do not wish to add any optional benefits

Please select the statement that best describes your relationship to the person with Medicare listed on this enrollment form*

- I am the person listed on this enrollment form or I am helping to complete this enrollment form.
- I am the person authorized to act on behalf of the individual listed on this enrollment form under the laws of the state where the individual resides.

*required fields

At the bottom of the form are two green buttons: 'Back' with a left arrow and 'Next' with a right arrow.

Step 5: Almost Done

- Add or decline optional dental and/or vision coverage.
- Electing this coverage will result in a note indicating that the coverage has been added.
- If an authorized representative is involved, check the appropriate box.
- Additional fields will appear asking authorized rep to identify relationship to enrollee.

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[ELIGIBILITY](#) ✓

[PERSONAL INFO](#) ✓

[PAYING PREMIUM](#) ✓

[OTHER COVERAGE](#) ✓

ALMOST DONE 5

[AGREE & SUBMIT](#) 6

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ALMOST DONE

Please select your Primary Care Physician from our list of doctors.

[Choose your doctor](#)

*If your doctor is not listed, please leave this field blank.

I do not have a Primary Care Provider (PCP), please call me to help me find a PCP.

OPTIONAL SUPPLEMENTAL BENEFITS

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Please select the statement that best describes your relationship to the person with Medicare listed on this enrollment form*

- I am the person listed on this enrollment form or I am helping to complete this enrollment form.
- I am the person authorized to act on behalf of the individual listed on this enrollment form under the laws of the state where the individual resides.

*required fields

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Step 6: Agree and Submit

- Agents may not click the electronic signature on the member's behalf. Under state law, only the member or the member's authorized representative may electronically sign the enrollment form on the member's behalf by checking the box.

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AGREE AND SUBMIT

ELIGIBILITY ✓

PERSONAL INFO ✓

PAYING PREMIUM ✓

OTHER COVERAGE ✓

ALMOST DONE ✓

AGREE & SUBMIT 6

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AGREE AND SUBMIT

READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining SelectHealth Advantage (HMO) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join SelectHealth Advantage (HMO). 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. By completing this enrollment application, I agree to the following:

SelectHealth Advantage (HMO) 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. 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.

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

Release of Information:

By joining this Medicare health plan, I acknowledge that SelectHealth Advantage (HMO) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that SelectHealth Advantage (HMO) 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.

I have read this information and confirm that this information is accurate.

Brokers may not click this electronic signature on the member's behalf. Only the member or the member's authorized representative, under state law may electronically sign this enrollment form on the member's behalf.

[← Back](#) [✓ Enroll Now](#)

Step 6: Agree and Submit

- To receive credit for the sale, you must complete the attestation.
- Make sure your email address is correct or enter a new address.
- Check to agree, then submit.
- Enrollment confirmation page with confirmation number will appear.
- You can print the final confirmation screen with the printer button in the upper corner.

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AGREE AND SUBMIT

READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining SelectHealth Advantage (HMO) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join SelectHealth Advantage (HMO). 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. By completing this enrollment application, I agree to the following:

SelectHealth Advantage (HMO) 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 Advantage plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in my entire year. Once I enroll, I may leave this plan or make changes only available (Example: October 15 – December 7 of every year), or under the plan's rules.

SelectHealth Advantage (HMO) serves a specific service area. If I move to a new service area, I need to notify the plan so I can disenroll and find a new Medicare Advantage (HMO). I have the right to appeal plan decisions about my enrollment. For more information, see the Handbook or Evidence of Coverage document from SelectHealth Advantage (HMO). I understand that I must follow the plan's rules to get coverage with this Medicare Advantage plan. I understand that I cannot get Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date SelectHealth Advantage (HMO) enrolls me, I will be responsible for my own health care costs. SelectHealth Advantage (HMO), except for emergency or urgent care services, does not cover the cost of health care services or supplies. I understand that I must pay my own health care costs. I understand that I must pay my own health care costs. I understand that I must pay my own health care costs.

I understand that if I am getting assistance from a sales agent, broker, or other representative to enroll in this Medicare Advantage (HMO), he/she may be paid based on my enrollment.

Release of Information:

By joining this Medicare health plan, I acknowledge that SelectHealth Advantage (HMO) will release my information including my prescription history and other information for research and other purposes which follow all applicable Federal and State laws. I understand that if I am 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.

I have read this information and confirm that this information is accurate.

Brokers may not click this electronic signature on the member's behalf. Only the member or the member's authorized representative, under state law may electronically sign this enrollment form on the member's behalf.

Agree with the above statements.

OK **Cancel**

Back **Enroll Now**

Enrollment Confirmation

- You'll receive a full record of the application. All online enrollments you submit are securely stored in your Link Message Center.
- To view a record of your online applications, access your Message Center by clicking the envelope icon next to your name in the Link homepage:




- In your Message Center, you will find a confirmation message for your enrollments.
- Click on the message to access the application records. All records are stored in a single SYSTEM NOTIFICATIONS file.



Online Enrollment Receipt

- Once the application has been submitted, use the confirmation number to **complete an enrollment receipt** and provide a copy to your client.
- It's required that agents **leave a receipt as temporary proof of enrollment** when using the online application, unless member has provided an email address for the confirmation to be sent.

 Receipt for Enrollment Request	
Application Date	Applicant's Name
Plan ID Number	Proposed Effective Date
Sales Agent Name	Sales Agent Phone Number
Enrollment Confirmation Number (if applicable)	
Agent Signature	Date
<hr/>	
Contact Information Visit us at selecthealthadvantage.org	Member Services Hours Monday through Sunday from 8:00 a.m. to 8:00 p.m.
Call toll-free: 855-442-9900 TTY Users: 800-346-4128 (Utah), 800-377-1363 (Idaho), or 711	
SelectHealth is a Medicare Advantage organization with a Medicare contract.	
H1994_10309 CMS Approved	© 2013 SelectHealth. All rights reserved. 10309 02/13