

Retail Platform – Applying for Plans

Apply and Payment - For Brokers and Agents.

Independence 

Job Aid Topics

- **Applying for plans**
 - Enrollment Selection – SEP or OEP
 - Application Checklist
 - Application Process
 - Personal Information –
 - primary and spouse/dependents
 - Authorized Representatives
 - HSA plans
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 - Provider Search
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 - Make a Payment
 - Making binder payments via ePay
 - Confirmation
- **Child Only Applications**
 - Shop and apply for child only plans

Start Application

Once all plans have been selected and the member is ready to apply, select the radio button next to the plan the member wants to apply for.

The premium amount will display in the Total Premium field. If it shows \$0, a plan has not been selected.

Click **Apply Now** to start the application.

*Refer to the Proposals job aid for how to shop for plans.

Review Proposal for Jane Doe

Created On: 07/16/2020 | Last Modified On: 07/16/2020

Individuals Included: Jane
[View details](#)

[My Prospects](#)

Select Plans

• Actions

Health Non-Qualified Dental Vision

Health Plans

• Actions

Our health plans do not require medical underwriting and are available to any individual regardless of age. When you're ready to Apply, select the button below.

• 2020 Plans

| Plan Name | Metal Levels | Monthly Premium | Actions |
|---|--------------|-----------------|------------------------|
| <input checked="" type="radio"/> Personal Choice PPO Bronze | Bronze | \$332.34 | Remove |
| <input type="radio"/> Keystone HMO Silver | Silver | \$381.89 | Remove |
| <input type="radio"/> Keystone HMO Silver Proactive | Silver | \$382.35 | Remove |
| <input type="radio"/> None | | | |

Total Premium
\$363.10
(Proposed Amount)

[Apply Now](#)

[Cancel](#)

Want To Finish Later?
[Save Changes](#)

Enrollment Selection

On the **Enrollment Selection** page, please select the Enrollment Period you wish to apply for. Screens will vary depending on the time of year. During OEP, there will be a choice of Open Enrollment or Special Enrollment for the previous year. During SEP timeframe, only the Special Enrollment option is available.

Special Enrollment

- Continue Special Enrollment, this button will link you to the Special Enrollment Selection (SEP) page.

Click either **Continue With Open Enrollment** or **Continue With Special Enrollment** to proceed.

*This page only appears when a Health Product is selected.

Open Enrollment for 2020 is available at this time. Applications may still be submitted under qualified, Special Enrollment scenarios.



Open Enrollment

Open Enrollment is the specific time period each year when you and/or your dependent(s) are eligible to enroll in a health care plan.

If you enroll today, your effective date of coverage will be **01/01/2020**.
Click the button to proceed with your enrollment.

[Continue With Open Enrollment](#)



Special Enrollment

Special enrollment is a period when you and/or your dependents may be eligible to enroll if you recently had a life-changing event, such as moving to a different county, marriage or loss of employment.

To confirm your eligibility, click the button below to answer a few questions about your qualifying event.

[Continue With Special Enrollment](#)

Open Enrollment for 2020 is not available at this time. However, you may qualify for a 2020 Special Enrollment.



Special Enrollment

Special Enrollment The Special Enrollment Period is a period of time outside of the Open Enrollment period during which you may be eligible to apply for an individual or family health plan. If you experience a Qualifying Life Event, such as getting married, having or adopting a baby, losing your coverage, or moving into a new service area, you may qualify for SEP.

To confirm your eligibility, click the button below to answer a few questions about your qualifying event.

[Continue With Special Enrollment](#)

Special Enrollment Selection

On the **Special Enrollment Selection** page, please select the qualifying event you wish to apply for.

- Choose an SEP reason radio button
 - Once the reason is selected, the reason description appears.
- Enter the event date in accordance with the rules for the SEP reason.
- Click **Continue** to proceed to the Application.

*This page only appears when a Health Product is selected.

Please tell us which qualifying event applies to you

Important Note: You must enroll within 60 days of your qualifying event to be eligible for Special Enrollment unless otherwise noted.

- Loss of Coverage
- Birth
- Marriage
- Permanent Move
- Adoption
- Court order

Recent or approaching loss of minimal essential coverage includes, but is not limited to, the loss of coverage due to:

- legal separation or divorce
- losing dependent eligibility
- death
- termination of employment
- reduction in the number of employment hours
- retirement
- exhausting COBRA coverage
- becoming Medicare eligible

Important Note: Loss of minimum essential coverage does not include loss due to gross misconduct, failure to pay premiums, fraud or misrepresentation.

*You have 60 days before and after your loss of minimal essential coverage to apply.

Please enter the date of your qualifying event:

* Event Date:

[< Back](#) [Continue >](#)

Effective Date Confirmation

This page calculates the projected effective date based on the normal effective date rules according to the SEP reason chosen.

*This page only appears when a Health Product is selected.

**Your Effective Date of Coverage will be
08/01/2020.**

Back

Continue

Confirm Your Plan Selection

After choosing Open Enrollment or an SEP reason on the previous page, you are now able to review product selections before beginning the application.

- If any changes need to be made, the agent can select the **Edit Your Plan** button to return to the Review Proposal Page and make any adjustments.

Once everything has been reviewed by the agent and client, Click **START APP-ENGLISH**

Confirm Your Plan Selection

Application Information

Please review your plan selection details below. After you have confirmed your plan selection, you can begin the application process. You may change your selected plan(s) by clicking [Edit Your Plan](#).

| Name | Relationship | Gender | Date of Birth | Zip Code | County | Used Tobacco in the Past? |
|----------|--------------|--------|---------------|----------|--------|---------------------------|
| Jane Doe | Applicant | Female | 09/01/1999 | 18039 | BUCKS | Never |

Your Selected Products

Health Plan

| | |
|----------------------------|--------------------|
| ⚠ Enrollment Period | Special Enrollment |
| Plan Year | 2020 |
| Qualifying Event | Loss of Coverage |
| Event Date | 07/15/2020 |
| Effective Date of Coverage | 08/01/2020 |

| | |
|---------------------------------------|-----------------|
| Plan Year | 2020 |
| Keystone HMO Silver Proactive Value : | \$279.81 |
| SubTotal: | \$279.81 |

Rates are based on geographic area, age, tobacco use, and family size.

Non-Qualified Dental Plan

| | |
|------------------------------|----------------|
| Plan Year | 2020 |
| Adult Preferred Dental PPO : | \$17.55 |
| SubTotal: | \$17.55 |

Product Rates are Subject to Change: The premium quoted above includes any rate modification(s) applied to your current policy. This quoted rate is subject to change based on demographics and other factors.

Vision Plan

| | |
|-----------------------------|----------------|
| Plan Year | 2020 |
| Adult IBC Vision Care 100 : | \$13.21 |
| SubTotal: | \$13.21 |

Product Rates are Subject to Change: The premium quoted above includes any rate modification(s) applied to your current policy. This quoted rate is subject to change based on demographics and other factors.

Total Premium

\$310.57

(Proposal Amount)

[Edit Your Plan](#)

[Start App-English](#)

Application Checklist

On the **Application Checklist** page, review the information to make sure the following information is available.

1. The progress menu on the left side of the page informs the agent of the steps in completing the application and can be revisited once completed.
2. The **Finish Later** button will route the agent back to the My Prospects page with the application saved.
3. The **Cancel Application** button will route the agent back to the My Prospects page with the application cancelled (this action cannot be undone).
4. **Click CONTINUE.**

*Content may vary between product lines

The screenshot shows the 'Application Checklist' interface. On the left, a progress menu lists five steps: 1. Personal Information, 2. Additional Information, 3. Signature, 4. Final Review, and 5. Complete. A blue 'Finish Later' button is positioned above the first step, and a blue 'Cancel Application' button is below the last step. On the right, the title 'Application Checklist' is followed by a list of required information items, each preceded by a green checkmark. At the bottom right, a blue 'Continue' button is visible. Four red callout boxes with white numbers (1, 2, 3, 4) point to the 'Finish Later' button, the progress menu, the 'Cancel Application' button, and the 'Continue' button, respectively.

1

Application Checklist

Have the following information at hand for a faster application:

- ✓ Birth Date for all Applicants
- ✓ Addresses for all Applicants
- ✓ Social Security Number or Individual Tax ID Number (ITIN) for all Applicants
- ✓ Information on current and past health insurance plans (if applicable)
- ✓ Payment information: for credit card payments, we accept Visa and MasterCard; For automatic bank withdrawal, please have your bank account number and bank routing number.
- ✓ Documentation showing the date of the event that qualifies you for Special Enrollment (if applicable).

2

3

4

Continue

HSA information

For plans that offer an HSA (Health Savings Account) option, there will be additional marketing content on the Application Checklist page.

Review this information with the Consumer so they are aware of next steps if they would like to opt-in to this type of account.

No preference will be collected as part of the application.

Application Checklist

Have the following information at hand for a faster application:

- ✓ Birth Date for all Applicants
- ✓ Addresses for all Applicants
- ✓ Social Security Number or Individual Tax ID Number (ITIN) for all Applicants
- ✓ Information on current and past health insurance plans (if applicable)
- ✓ Payment information: for credit card payments, we accept Visa and MasterCard; For automatic bank withdrawal, please have your bank account number and bank routing number.
- ✓ Documentation showing the date of the event that qualifies you for Special Enrollment (if applicable).

Health Savings Account (HSA) - Qualified Plan

Since you are enrolling in an HSA-qualified plan, you may be eligible to open an HSA.

An HSA provides tax-advantaged funds that you can use to pay for copays, deductibles, coinsurance and more. And you don't need to worry about using all of your HSA dollars during the plan year. Any leftover money rolls over each year to pay for future qualified medical expenses, even if you change coverage.

Although you can work with any HSA custodian, Independence offers a PNC HSA that includes enhanced integration and no monthly account fee.

To open an HSA, register at ibx.com/login after your coverage starts.

Learn more

Refer to [IRS Publication 969](#) for more information about HSA eligibility.

Independence does not provide tax or legal advice. Please consult with your own tax or legal advisor regarding the tax and legal implications of a Health Savings Account.

Continue

Personal Information

On the **Personal Details** page, provide the necessary information regarding the Applicant's demographics.

*Note: There are questions included for state residency, citizenship and Medicare eligibility that contribute to the applicant's ability to qualify for enrollment.

The Applicant may also choose to designate an Authorized Representative, if Yes is selected, you will proceed to the Authorized Representative page to complete this selection.

*The Authorized Representative option is only available for Health applications.

Click SAVE AND CONTINUE.

*Content may vary between product lines

[Finish Later](#)

Personal Details for Jane
Please answer all sections of this application truthfully and accurately.

Personal Details

1 Personal Information
2 Additional Information
3 Signature
4 Final Review
5 Complete

[Cancel Application](#)

First Name:

M.I.: (optional)

Last Name:

Suffix: - (optional)

Date of Birth: (mm/dd/yyyy)

Social Security Number / ITIN: - -

(Individual Tax ID Number may only be used if you do not qualify for a Social Security Number)

Re-enter Social Security Number / ITIN: - -

Gender: -

Used Tobacco in the Past?: - ?

Marital Status: Married Single

Are you a permanent Pennsylvania resident? Yes No

Are you a US Citizen? Yes No

Are you entitled to benefits under Medicare Part A or enrolled under Medicare Part B? Yes No

Note: If you answered yes, you are not eligible to apply for this plan.

Authorized Representative

You can choose an authorized representative. You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an authorized representative. If you ever need to change your authorized representative, contact Independence Blue Cross.

Do you wish to specify an authorized representative? Yes No

[Back](#) [Save and Continue](#)

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Authorized Representative

If Add an authorized representative is selected, on the **Authorized Representative** page, provide the necessary information regarding the Representative's demographics.

Complete the Signature section to complete the Authorized Representative designation.

Click SAVE AND CONTINUE.

[Finish Later](#)

Authorized Representative Jane

You can choose an authorized representative. You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an 'authorized representative'. If you ever need to change your authorized representative, contact Independence Blue Cross.

Contact Details

I am authorized under pertinent law to act on the behalf of the person named on this application.

Relationship to Applicant:

First Name:

MI: (optional)

Last Name:

Suffix: (optional)

Company Name: (optional)

Street Address:

(no P.O. boxes please):

City:

State:

Zip Code:

Signature

By signing, you, **Jane** allow this person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf.

First Name:

MI: (optional)

Last Name:

Suffix: (optional)

Signature Date: (mm/dd/yyyy)

[Back](#) [Save and Continue](#)

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Address for Primary Applicant

On the **Address** page, please provide the necessary information regarding Applicant's Home address.

- Address Verification services will check the address entered and either suggest an alternate address if a partial match is found or allow for the agent to select to continue with the entered address if it is not able to be verified.

Click SAVE AND CONTINUE.

*Content may vary between product lines

The screenshot shows a web form titled "Address for Jane" with a sub-section "Home Address". On the left, a progress bar has five steps: 1. Personal Information (active), 2. Additional Information, 3. Signature, 4. Final Review, and 5. Complete. A "Finish Later" button is at the top left, and a "Cancel Application" button is below the progress bar. The "Home Address" section contains the following fields: "Street Address:" (text input), "(no P.O. boxes please):" (text input), "City:" (text input with "Pennsylvania" selected in a dropdown), and "Zip Code:" (text input with "18039" selected in a dropdown). A "Back" button is at the bottom left, and a "Save and Continue" button is at the bottom right, highlighted with an orange border.

A warning message with a yellow triangle icon: "NOTE: We found a partial match based on the address entered. Please select an address from the suggested list or select the option to use the address as you originally entered it. You can still go back and edit your address above if needed." Below the message are two radio button options: "100 Main St, Pottsville, PA 17901" and "100 main st, bucks, PA 18039", separated by the word "or".

A warning message with a yellow triangle icon: "NOTE: We were unable to locate a match based on the address entered. Please check your entry above and edit if necessary or select the option below to use the address as you originally entered it." Below the message is one radio button option: "100 main st, Philly, PA 18039".

Personal Information - Spouse/Domestic Partner

On the **Personal Details for Spouse/Domestic Partner** page, please provide the necessary demographic and address information.

- If address is different than the Primary Applicant, the Consumer can answer Yes and input their address information.
- Address Verification services will check the address entered and either suggest an alternate address if a partial match is found or allow for the agent to select to continue with the entered address if it is not able to be verified.

*Note: There are questions included for state residency, citizenship and Medicare eligibility that contribute to the applicant's ability to qualify for enrollment.

Click SAVE AND CONTINUE.

*Content may vary between product lines

[Finish Later](#)

1 Personal Information

2 Additional Information

3 Signature

4 Final Review

5 Complete

[Cancel Application](#)

Personal Details for Spouse/Domestic Partner

First Name:

M.I.: (optional)

Last Name:

Suffix: (optional)

Date of Birth: (mm/dd/yyyy)

Social Security Number / ITIN: - -

(Individual Tax ID Number may only be used if you do not qualify for a Social Security Number)

Re-enter Social Security Number / ITIN: - -

Gender:

Used Tobacco in the Past? : ⓘ

Relationship to Applicant:

Are you a permanent Pennsylvania resident? Yes No

Are you a US Citizen? Yes No

Are you entitled to benefits under Medicare Part A or enrolled under Medicare Part B? Yes No

Note: if you answered yes, you are not eligible to apply for this plan.

Address

Same address as Primary Applicant? Yes No

[Back](#) [Save and Continue](#)

Personal Information -Dependent

On the **Personal Details for Dependent** page, please provide the necessary demographic and address information.

- If address is different than the Primary Applicant, the Consumer can answer Yes and input their address information.
- Address Verification services will check the address entered and either suggest an alternate address if a partial match is found or allow for the agent to select to continue with the entered address if it is not able to be verified.

***Note:** There are questions included for state residency, citizenship and Medicare eligibility that contribute to the applicant's ability to qualify for enrollment.

Click SAVE AND CONTINUE.

*Content may vary between product lines

Personal Details for Dependent

1 Personal Information

2 Additional Information

3 Signature

4 Final Review

5 Complete

Cancel Application

Finish Later

First Name:

M.I.: (optional)

Last Name:

Suffix: (optional)

Date of Birth: (mm/dd/yyyy)

Social Security Number / ITIN: - -

(Individual Tax ID Number may only be used if you do not qualify for a Social Security Number)

Re-enter Social Security Number / ITIN: - -

Gender:

Relationship to Applicant:

Are you a permanent Pennsylvania resident? Yes No

Are you a US Citizen? Yes No

Are you entitled to benefits under Medicare Part A or enrolled under Medicare Part B? Yes No

Note: If you answered yes, you are not eligible to apply for this plan.

Address

Same address as Primary Applicant? Yes No

Back

Save and Continue

Contact Information

On the **Contact Information** page, please provide the necessary information regarding Applicant's phone number, best time to call, email address and communication preferences.

Click SAVE AND CONTINUE.

*Content may vary between product lines

[Finish Later](#)

Contact Information for Jane

- 1 Personal Information
- 2 Additional Information
- 3 Signature
- 4 Final Review
- 5 Complete

[Cancel Application](#)

Contact Details

Note: By providing my phone number and/ or email address, I authorize Independence Blue Cross, LLC, and its subsidiaries and affiliates (collectively "Independence"), and my employer to contact me via email, automated text and/or phone call. I understand that my consent is not a condition of any benefit or purchase. Message and data rates may apply.

Primary Phone Number Select Type

Secondary Phone Number Select Type (optional)

Best time to call?: Select

Your email address is required because you are applying online. We may email you about your application. If you prefer not to provide an email address, please call 1-888-475-6206 (TTY: 711) to speak to a licensed agent to apply over the phone.

Applicant Email Address:

Re-enter Applicant Email Address:

Preferences

I prefer electronic communications.

By checking this box, you authorize Independence Blue Cross communicate with you electronically at the email address you provided above. This may include documents related to your application, enrollment, billing, benefits, health statements, legal documents and proxy statements. Most documents will be available through your online Member account. Note that not all documents are available electronically. You may still receive some documents in the mail.

You have the right to stop receiving documents electronically at any time. You may also request a free paper copy of any communication by calling us. Just log on to your online Member account or call us.

Some of the information we send to you may be Protected Health Information ("PHI") under the Health Insurance Portability and Accountability Act ("HIPAA"). By choosing electronic communication:

- You allow us to send PHI to you electronically, including by email and text message.
- You agree that you are solely responsible for the security of the email address and phone number you provide, the security of the computing device used to view the communication, and the risks of electronic communication.
- You understand that you should keep your email address and cell number updated to receive timely information and prevent delivery of PHI to an unintended recipient.
- You have provided a working and private email address and/or cell number.
- You confirm that you have internet access, a current web browser, and can open PDF files using Adobe Acrobat Reader or its equivalent.

I prefer to receive SMS alerts and communications.

By providing my cell phone number and/ or email address, I authorize Independence Blue Cross, its subsidiaries and affiliates (collectively "Independence"), to contact me via email, automated text and/or cell phone call. I understand that my consent is not a condition of any benefit or purchase and that I can opt out at any time. Message and data rates may apply.

[Back](#) [Save and Continue](#)

PCP Selection

If the member is applying for a plan that requires a PCP, the Doctor Selection screen will appear. It is not required to select a PCP at this time.

Click **Select Doctor/Facility** to select a PCP, or click **Continue** to leave blank.

- Select the PCP for each member of the application, one at a time.
- The user will be presented with a list of providers within the default radius (10 mi) of the applicant's zip code.
- The user can then refine the results by selecting the advanced filters link to search by additional parameters.
- Only doctors within the accepted network and search parameters will be shown in the search results.
- The user can attest if the Provider is their current PCP (optional if provider is accepting new patients, required if provider is only accepting current patients).
- Select the desired PCP and proceed to repeat this process for all members on the application.

Finish Later

Select a Primary Care Doctor

Doctor Selection

Please select a Primary Care Physician (PCP) for each person who will be covered by the plan. Remember to call your PCP first when you need care. They'll help coordinate prior authorizations or referrals if you need them.

Important Note: You will not be required to make a PCP selection at this time but will be asked at a later date to choose your PCP.

| Name | Date of Birth | Doctor/Facility Details |
|----------|---------------|-------------------------|
| Test One | 09/26/1979 | |

Select Doctor/Facility

Continue

Back

Cancel Application

* By checking this box, I authorize Personal Health Information to be shared with this doctor to validate that either I or my dependent am/is a current patient, and to assign me or my dependent to this doctor.

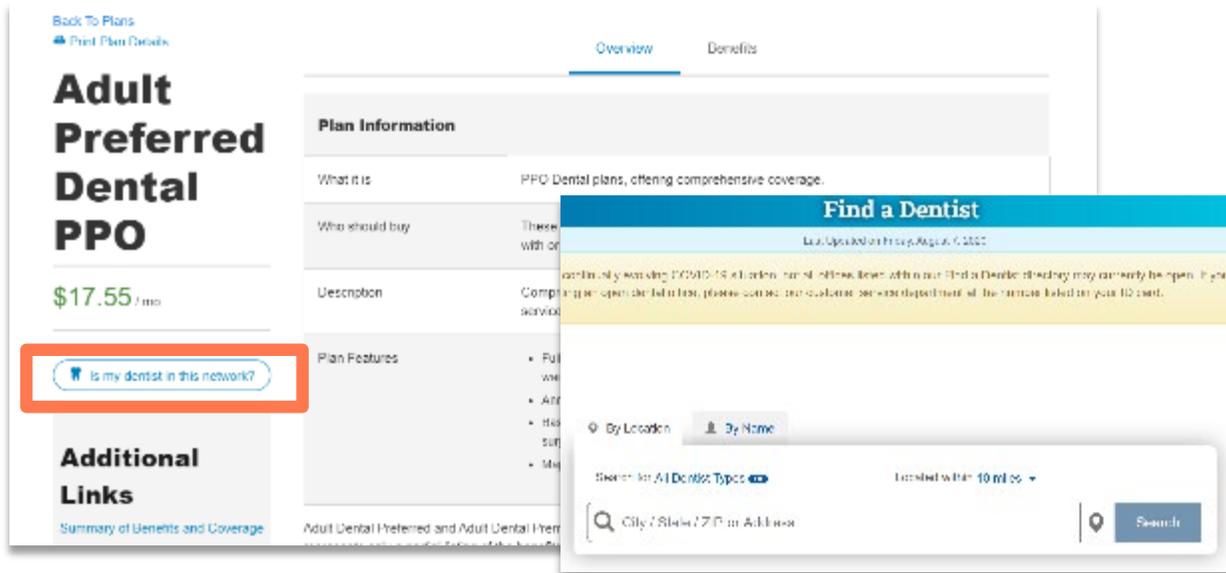
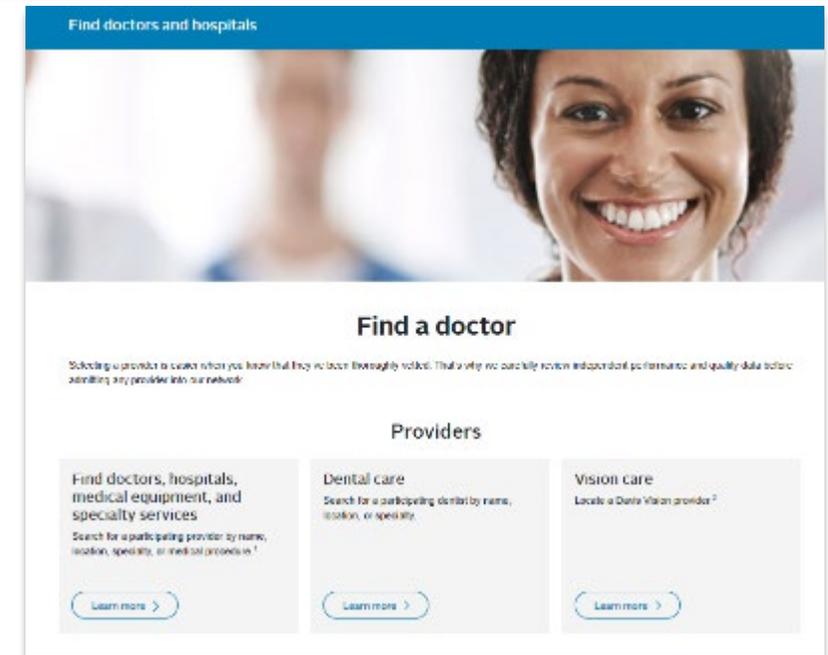
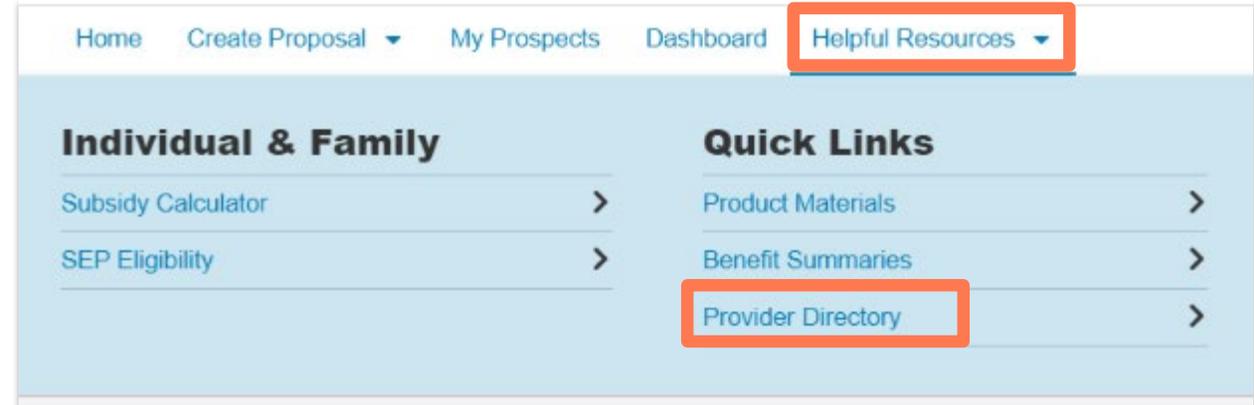
Provider Search

If the consumer is in need of searching a provider, there is a Provider Directory link located in the header.

Select the **Helpful Resources** dropdown and there will be a label for 'Provider Directory'.

Select the 'Provider Directory' label and the user will be redirected to the website to search providers

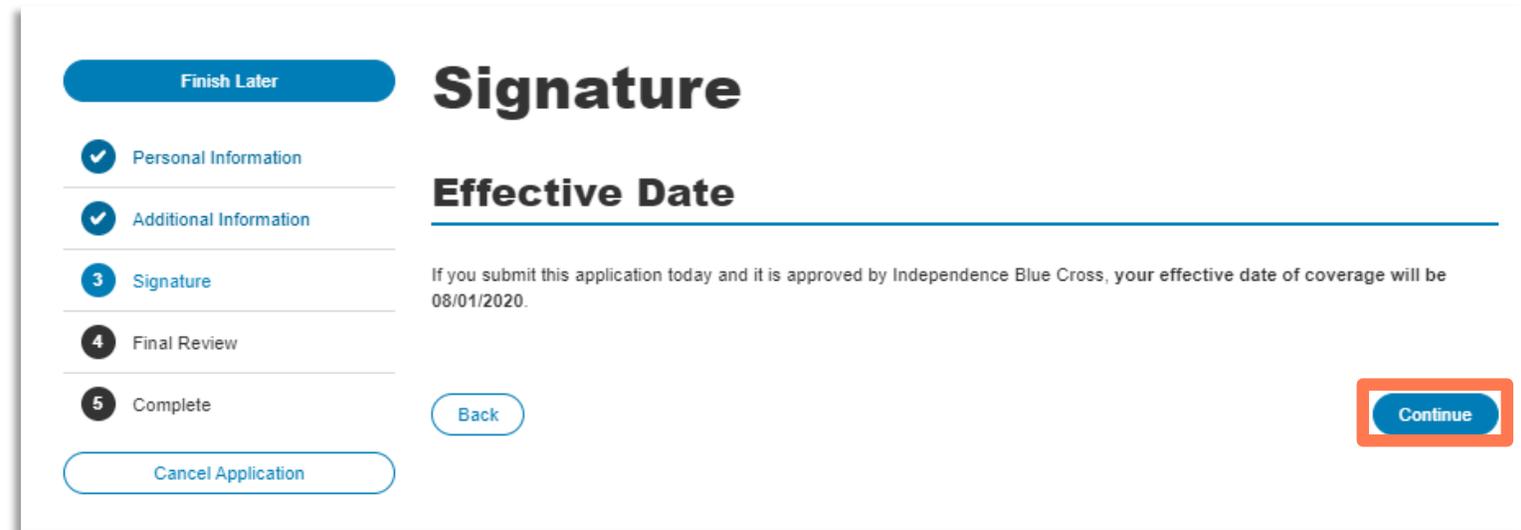
For Dental/Vision products, the provider directory link is located on **the Plan Detail and Plan Compare Pages**.



Effective Date

On the **Effective Date** page, Agents will need to review the effective date information.

Click **CONTINUE**.



The screenshot shows a multi-step application process. On the left, a vertical progress bar lists five steps: 'Personal Information' (checked), 'Additional Information' (checked), 'Signature' (active), 'Final Review', and 'Complete'. At the top left of the main content area is a blue button labeled 'Finish Later'. Below the progress bar is a 'Cancel Application' button. The main content area is titled 'Signature Effective Date' and contains the text: 'If you submit this application today and it is approved by Independence Blue Cross, your effective date of coverage will be 08/01/2020.' There are two buttons at the bottom: a 'Back' button and a 'Continue' button, which is highlighted with a red border.

Submission Type

The following submission types will display based on the Agent's agency type. There is a description that displays under each submission type for reference when selected.

- **Telesales Agents** will have all submission types displayed.

- **Brokers/Retail agents** will have only have In-person and Email submission types displayed.

- In-Person (*Face to face interaction with the consumer*)
- Email (*Phone interaction where agent fills in the application and sends to the consumer to sign and submit payment*)
- Web Conferencing (*Interaction via web conferencing software to share screens with consumer and collect information over the phone*)
 - Enter Vender Name and Call Session ID
- Voice Signature (*Recorded phone interaction to collect information from consumer over the phone*)
 - Call Session ID (copied from CRM or Screen when entering recording software)
 - Outbound Call Default
- In-Person and Email selections require no additional information to be supplied on this page.

Click **CONTINUE**

Finish Later

- ✓ Personal Information
- ✓ Additional Information
- 3** Signature
- 4 Final Review
- 5 Complete

Signature Submission Type

Please click on a submission type below to select it and provide the necessary details to submit a signature.

In-Person | Email | Web Conferencing | Voice Signature

Cancel Application | Back | Continue

Web Conferencing

Use this submission type when some form of web conferencing software is used to facilitate the conversation between Agent and Applicant.

Session ID:

Vendor Name:

Voice Signature

Use this submission type in Telesales when there is a recorded call and the Agent is both selling and completing the enrollment with the Applicant.

Session ID:

Outbound Call Default:

Submission Type - Email

This submission type is used when the agent needs to collect responses over the phone and emails a link for the consumer to review, sign and submit the application along with payment.

Agent chooses the Email submission type, completes the Agent Acknowledgement questions and adds any remarks if needed.

Click **CONTINUE**.

Signature

Personal Information
Additional Information
Signature
Final Review
Complete

Cancel Application

Signature

Submission Type

Please click on a submission type below to select it and provide the necessary details to submit a signature.

In Person **Email** Web Conferencing Voice Signature

When the Agent completes the application up to the Agent Acknowledgements and then sends the via email to finish their acknowledgements and pay (if applicable).

Continue

Agent Acknowledgements [View/Print Application \(PDF\)](#)

Are you related to the applicant? Yes No

Current Agent Email: pujitha.raya@bcbsfl.com
Applicant Email: amanda.padgett@guidewellconnect.com

I hereby certify that I have spoken with the applicant over the telephone to record all of his or her answers to the questions included in this application. I further certify that I have explained the key benefits of the health plan for which they are applying.

I certify that I have reviewed the applicant's eligibility criteria for a special enrollment period. I will retain a copy of their documentation and understand that I will be required to forward this documentation to Independence Blue Cross upon request.

I have explained the application acknowledgement process and payment options to the applicant.

I, agent@BC One Agree Disagree

State License Number: AAL1
Date: 07/16/2020
Agency/Agent Code: Z113-Z113
Agency Code: Z113
Agency Email:

Add Your Remarks

Back **Continue**

Submission Type - Email

Agent receives a confirmation page with all the application details. A link is available to view/print the application output.

Agent returns to the Prospects to view the application status. An email is simultaneously sent to the consumer to review and complete the application.

Agent needs to inform the consumer of the **'Passcode'** listed on this page so they can access their application.

Once the Consumer reviews the application and confirms its accuracy, the Consumer completes the initial payment and submits the application. The Prospect record details will be updated with the Application status.

The agent will receive an email communication if the Consumer requests any changes after reviewing the application details. The agent can then revise the application and send back to the Consumer for review again.

Click **RETURN TO MY PROSPECTS**.

Agent Confirmation

An email containing a link to review the application online has been sent to the applicant's email address. Please communicate the pass code and instruct the applicant to review the application online.

Application Information [View/Print Application \(PDF\)](#)

Please use the View/Print Application link above to print or save a copy of your application for your personal record.

Application ID: IBA-1092899882
Application URL Sent Date: Thursday, July 16, 2020
Requested Effective Date: 08/01/2020
Plan Name: Keystone HMO Silver

Telephonic Information

Passcode for Applicant: 720870

Customer URL: <https://consumerapply.websales.qa.ibm.com/iss/sc/telephonic/off/index.do?teleToken=8JHfVXkwt3qwQ54VQ8VEmXyUJhx3zTMJID8mbny9P1yrtwbVWZsD8CKXxYY4pbKdtQIR51ZyjuaeGydDU1D00%2BQ%3D%3D>

Eligible Applicant(s):

| Name | Age | Gender | Relationship | Used Tobacco in the Past? | Premium |
|------------------------|-----|--------|--------------|---------------------------|----------|
| Jane Doe | 20 | F | Self | Never | \$370.43 |
| Jan Doe | 20 | M | Spouse | Never | \$370.43 |
| Subtotal: | | | | | \$740.86 |
| Total Monthly Premium: | | | | | \$740.86 |

Agent/Agency Information

Agent: agentIBC One
Agent Phone:
Agent Email: pujitha.raya@bcbsfl.com

Agency: GuideWell Connect
Agency Phone:
Agency Email:

[Return to My Prospects](#)

Agent Acknowledgements (All submission types)

Complete the **Agent Acknowledgements** page.

- Agent relationship question is included on this page.
- Review the agent information displayed and click **Agree** or **Disagree**.
 - ***Note: If the agent disagrees, the application will not proceed.**

*Note: Each submission type has varied language/acknowledgements.

Click CONTINUE.

Finish Later

✔ Personal Information

✔ Additional Information

3 **Signature**

4 Final Review

5 Complete

Cancel Application

Signature

Agent Agreements/Acknowledgements [View/Print Application \(PDF\)](#)

Are you related to the applicant? Yes No

I hereby certify that I have spoken with the applicant in person to record all of his or her answers to the questions included in this application. I further certify that I have explained the key benefits of the health plan for which they are applying.

I certify that I have reviewed the applicant's eligibility criteria for a special enrollment period, if applicable, and verified that the information provided is accurate and complete. I will retain a copy of the documentation in accordance with the record retention requirements of applicable law and regulation, and understand that I will be required to forward this documentation to Independence Blue Cross upon request.

I have explained the application acknowledgement process and payment options to the applicant.

I, agentIBC One Agree Disagree

| | |
|-----------------------|------------|
| State License Number: | AAL1 |
| Date: | 07/16/2020 |
| Agency/Agent Code: | Z113-Z113 |
| Agency Code: | Z113 |
| Agency Email: | |

Add Your Remarks

Back **Continue**

Consumer Acknowledgements

Explain the **Consumer Acknowledgments** page to the applicant.

Ask the applicant to review the **Consent to Electronic Contract** and acknowledge the information is displayed.

Only the Primary Applicant is required to e-sign the application:

- Enter **Date of Birth**
- Click **Agree** or **Disagree**.
***Note: If the consumer disagrees, the application will not proceed.**

The checkboxes and content on this page may differ depending on the product type that was selected.

Click **CONTINUE**.

Note: For Voice Signature submission type, TeleSales agents will need to read the entire **Consent to Electronic Contract**, checkboxes and content on the page directly to the applicant.

*Content may vary between product lines

The screenshot shows a web application interface for signing an application. On the left is a progress bar with steps: Personal Information, Additional Information, Signature (current), Final Review, and Complete. A 'Cancel Application' button is below the progress bar. The main content area is titled 'Signature' and 'Consumer Acknowledgements'. It includes 'Application Information' with details like Enrollment Period, Plan Year, Qualifying Event, Event Date, Effective Date of Coverage, and County. Below this is a 'Consent to Electronic Contract - Application' section with a scrollable text area containing terms and conditions. At the bottom, there are checkboxes for accepting terms, a date of birth input field, radio buttons for 'Agree' and 'Disagree', and 'Back' and 'Continue' buttons. A blue arrow points from the text 'acknowledge the information is displayed' to the scrollable consent text area. An orange box highlights the bottom section containing the checkboxes, date field, and radio buttons.

Signature
Consumer Acknowledgements

Application Information [View/Print Application \(PDF\)](#)

Enrollment Period: Special Enrollment
Plan Year: 2020
Qualifying Event: Loss of Coverage
Event Date: 07/01/2020
Effective Date of Coverage: 08/01/2020
County: BUCKS

Please review the following Terms and Conditions and select 'Agree' to continue. Please note that all functions of this site are based on Eastern Time.

Consumer Acknowledgements

Consent to Electronic Contract - Application

By applying to Keystone Health Plan East or OCC Insurance Company ("the companies") for coverage for myself and the dependents listed on this application, I understand and agree as follows:

a) Effective date of coverage will be the 1st day of each month.
b) Coverage does not begin until this application is processed by the companies with an effective date of coverage assigned and payment has been received.
c) Credit card/debit card payments are acceptable for the first month's premium payment only. Pre-paid debit card payments are accepted for ongoing payments.

By checking the box, I (We) accept the Declarations and Conditions of Enrollment.

Summary of Benefits and Coverage Acknowledgement

By checking the box, I indicate that Summary of Benefits and Coverage PDF is provided for the medical coverage selected on this application. If you need another copy, visit [iba.com/sbc](#).

Electronic Signature

I acknowledge that I have read, understand all statements in this application, and have supplied the requested information. The information supplied on the application and any signed addendum is accurate and complete to the best of my knowledge. No material information has been withheld or omitted on any person applying. I understand that if my signature and date do not appear and/or my answers are incomplete, the application will either be rejected or returned for completion.

You must accept the Declarations and Conditions of Enrollment to submit your application to the companies. If you choose not to accept the Declarations and Conditions of Enrollment, you may Save & Exit the application. Your application will remain active until the end of the open enrollment period after it was started. During this time, you can log back into your account and update any of your selections and/or submit your application. After the end of the open enrollment period, your application will be deactivated and you will be required to start a new application if you choose to apply.

*I understand that my information will be retained for transaction tracking purposes.

I, Jane Doe, have read and understand the above statements.

Enter Date of Birth:

Agree Disagree

[Back](#) [Continue](#)

Final Review

On the **Final Review** page, you can review all Application Information and View/Print the application for the consumer.

Click PAY AND SUBMIT APPLICATION.

*Content may vary between product lines

Final Review

[View/Print Application \(PDF\)](#)

Please review your application by clicking on the View/Print Application (PDF) link above. Please click the back button to return to the previous page to submit your application.

Enrollment Period: Special Enrollment
Effective Date of Coverage: 01/01/2020
Primary phone number: (904) 998-9898
Secondary Phone Number:
Email Address: amanda.padgett@guidewellconnect.com
County: BUCKS
Home Address: 100 main st , bucks, PA 18039

Eligible Applicants

| Name | Relationship | Gender | Age | Smoker |
|----------|--------------|--------|-----|--------|
| Jane Doe | Self | Female | 20 | Never |
| jon Doe | Spouse | Male | 20 | Never |

*Note: Total premium rate includes all applicants listed above.

Payment Information

*Note: Your Initial Payment Must be made before the effective date of your coverage. Please submit your application and continue to Make A Payment.

[Back](#) [Pay and Submit Application](#)

Personal Details

Please answer all sections of this application truthfully and accurately.

Applicant Information

| First, M.I., Last | Social Security Number | Age | Date of Birth | Gender | Relationship to Applicant | Zip Code | Used Tobacco in the Past?* |
|-------------------|------------------------|-----|---------------|--------|---------------------------|----------|----------------------------|
| pay error | XXX-XX-5678 | 30 | 09/09/1989 | Male | Self | 19081 | Never |

* Have you used a tobacco product on average four or more times per week within the past 6 months, other than for religious or ceremonial use?

Applicant Details - pay error

First Name: pay
Last Name: error
Social Security Number / ITIN: XXX-XX-5678
Date of Birth: 09/09/1989
Gender: Male
Used Tobacco in the Past?: Never

Are you entitled to benefits under Medicare Part A or enrolled under Medicare Part B?
No

Note: If you answered yes, you are not eligible to apply for this plan.

Marital status: Single
Are you a permanent Pennsylvania resident? Yes
Are you a U.S. Citizen? Yes
Do you wish to specify an authorized No representative?

Make a Payment

On the **Make a Payment** page, you can review the initial amount due to submit the application.

Click MAKE A PAYMENT

Agent will be redirected to the Epay payment vendor to complete the binder payment.

The screenshot displays the 'Make a Payment' interface. On the left, a progress bar shows five steps: 'Personal Information', 'Additional Information', 'Signature', 'Final Review', and 'Complete'. The 'Final Review' step is currently active. Above the progress bar is a 'Finish Later' button, and below it is a 'Cancel Application' button. The main content area features the heading 'Make a Payment' and a message: 'You still need to make your binder payment. The first month's premium, otherwise known as your binder payment, must be paid in full in order to process your application. Your application will remain pending until you make your binder payment.' To the right of this message are two buttons: 'Print Your Application' and 'Return to My Prospects'. A large white box in the center displays 'Initial Amount Due: \$740.86'. Below this box is a note: 'Please note that by clicking the Make a Payment button, you will be taken to our ePay site to complete your binder payment.' At the bottom right, a 'Make a Payment' button is highlighted with a red border.

Make a Payment – Payment Options

The Payment Options screen displays.

Select a payment option from the dropdown.

Click **Next**.

The screenshot displays the 'Payment Options' screen. At the top, it says 'Payment Options' and 'Complete the following to pay for your first month of coverage.' Below this is a progress indicator with three steps, where the first step is active. The main question is 'How would you like to pay for your coverage?'. Underneath is a 'Security & Privacy' section with a paragraph of text. A 'Select payment method' label is positioned above a dropdown menu. The dropdown menu is open, showing options: 'Select one...', 'Bank Account', 'Prepaid Debit Card', 'Debit Card', and 'Credit Card'. To the right of the main form is a 'Selected Coverage' section showing 'HEALTH' with 'Personal Choice EPO' and 'Silver Reserve' options, and a 'Your Monthly Rate' of '\$1280.29'. At the bottom right, there is a 'Need help?' section with the text 'Contact a licensed agent' and the phone number '1 - 888 - 475 - 6206'.

Payment Options

Complete the following to pay for your first month of coverage.

1 2 3

How would you like to pay for your coverage?

Security & Privacy

We value your security and privacy. During this application process, all of your personal and financial information is kept secure with industry-standard certificates and information privacy standards.

Select payment method

- Select one...
- Bank Account
- Prepaid Debit Card
- Debit Card
- Credit Card

Selected Coverage

HEALTH

Personal Choice EPO \$1280.29
Silver Reserve

Your Monthly Rate
\$1280.29

Need help?

Contact a licensed agent
1 - 888 - 475 - 6206

Make a Payment – Payment Information

Enter the information for the type of payment selected. Bank account was selected for this example.

Click **Verify**.

The screenshot shows a web form titled "Payment Options" with a dark blue header. Below the header, a line of text reads "Complete the following to pay for your first month of coverage." Above the main form area, there are three numbered steps: 1, 2, and 3. Step 1 is highlighted with a blue circle and a red border around the form content. The form content is titled "Payment Information: Bank Account" and contains the following fields:

- Account Holder First Name:
- Account Holder Last Name:
- Account Type:
- Routing Number:
- Account Number:
- Account Number Confirmation:

At the bottom right of the form, there are two buttons: "Back" (dark blue) and "Verify" (grey).

Make a Payment – Payment Information Verification

You will be required to scroll and read the terms and conditions text in order to continue.

Click the Acknowledge check box, and click **Submit**.

| | |
|---------------------|-----------|
| Account Holder Name | John Doe |
| Account Type | Checking |
| Routing Number | 062001186 |
| Account Number | 72343078 |

Please read the document below in its entirety and check the consent checkbox to enable the submit button and proceed.

HELD UNENFORCEABLE OR INAPPLICABLE, YOU AGREE THAT YOUR HEALTH PLAN AND ITS AFFILIATES' AGGREGATE LIABILITY SHALL NOT EXCEED ONE HUNDRED (\$100) DOLLARS. THE MATERIALS, INFORMATION, AND EBILL SERVICES ARE PROVIDED 'AS IS' WITHOUT WARRANTY OF ANY KIND, EITHER EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, THE IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE.

Indemnification

Upon a request by your Health Plan, you agree to defend, indemnify, and hold harmless your Health Plan and its affiliates, and their employees, contractors, leadership team, and directors, from all liabilities, claims, and expenses, including attorneys' fees and disbursements, that arise from your use or misuse of the eBill Services. Your Health Plan reserves the right, at its own expense, to assume the exclusive defense and control of any matter otherwise subject to indemnification by you, in which event you will cooperate with your Health Plan in asserting any available defenses.

I acknowledge that coverage does not begin until the effective date of the application and the premium for the first month of coverage is received. I authorize this payment.

[Back](#) [Submit](#)

Make a Payment – Payment Information Verification

You will be required to scroll and read the terms and conditions text in order to continue.

Click the Acknowledge check box, and click **Submit**.

| | |
|---------------------|-----------|
| Account Holder Name | John Doe |
| Account Type | Checking |
| Routing Number | 062001186 |
| Account Number | 72343078 |

Please read the document below in its entirety and check the consent checkbox to enable the submit button and proceed.

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Indemnification

Upon a request by your Health Plan, you agree to defend, indemnify, and hold harmless your Health Plan and its affiliates, and their employees, contractors, leadership team, and directors, from all liabilities, claims, and expenses, including attorneys' fees and disbursements, that arise from your use or misuse of the eBill Services. Your Health Plan reserves the right, at its own expense, to assume the exclusive defense and control of any matter otherwise subject to indemnification by you, in which event you will cooperate with your Health Plan in asserting any available defenses.

I acknowledge that coverage does not begin until the effective date of the application and the premium for the first month of coverage is received. I authorize this payment.

[Back](#) [Submit](#)

Confirmation

On the **Confirmation** page, you can View and/or Print the application for the consumer.

Click RETURN TO MY PROSPECTS

***If Consumer also purchased Dental or Vision, you can continue to the next application.**

After submission, you can view the Prospect's details from the My Prospects page:

- Prospect name
- Primary phone number
- Secondary phone number
- Email Address
- Application Submission Date
- Application ID
- Primary Applicant Name
- Premium Amount
- Product/ Plan Name
- Application Status / Enrollment Status



A confirmation card for a prospect named Tyler. It features a blue circular logo with a caduceus on the left. To the right of the logo, the date "06/16/2020" is displayed above the text "App ID: IBA-1092883742" and "Tyler". Further right, the amount "\$292.15" is shown above a green progress bar labeled "Application Submitted". To the right of the progress bar is a blue "Action" button with a dropdown arrow. Below the progress bar is a "View PDF" button.

Confirmation

Application Information

[View/Print Application \(PDF\)](#)

Please review your application by clicking on the View/Print Application (PDF) link above. If you do not print a copy of your application now, you will need to contact 1-800-xxx-xxxx to obtain a copy.

Application ID: 01/01/2020
Application Submit Date: test@test.com
Home Address: 1234 Somewhere Dr, Philadelphia, PA 19019

Eligible Applicants

| Name | Relationship | Gender | Age |
|----------|-------------------------|--------|-----|
| John Doe | Self | Male | 37 |
| Jane Doe | Spouse/Domestic Partner | Female | 32 |
| Jill Doe | Dependent | Female | 11 |

Payment Information

Thank you. We've received your payment and your application is being processed. If you have any questions, please call 1-800-xxx-xxxx.

Initial Payment Information

ACH

Payment Transaction ID: 1234
Account Number: ****6789
Payment Submitted Date: 02/11/2020

Amount Paid
\$351.00

[Return to My Prospects](#)

Confirmation – Error Messages

If there are errors in capturing the payment from Epay, an error message will display on the Confirmation page.

- If there is a connection error and the payment is not able to be communicated, a **Connectivity Error** message will appear and the application will be submitted and payment will be invoiced.
 - *If the error is on the Epay server, the message will appear while in Epay, if the error is on the SalesConnect server, the error will appear on the Confirmation page.
- If there is an issue with submitting the proper payment details after three tries, Epay will redirect the agent to the Confirmation page and display the **Payment Error** message. The application will be submitted and payment will be invoiced.

Payment Information

Connectivity Error! We are unable to accept payment at this time due to connectivity issues. Your application has been submitted and will be processed. You will not get charged at this time and will receive an invoice in the mail.

[Return to My Prospects](#)

Payment Information

Payment Error! We are not able to accept your payment at this time. Your application has been submitted and will be processed. You will not get charged at this time and will receive an invoice in the mail.

[Return to My Prospects](#)

Connectivity Error! We are unable to accept payment at this time due to connectivity issues. Your application has been submitted and will be processed. You will not get charged at this time and will receive an invoice in the mail.

[Return to Shopping](#)

Child Only Shop and Apply

The sales tool has business rules in place that allow for child only applicants to purchase available plans that meet this criteria. The system automatically checks the age of the primary applicant and presents the applicable plans to be displayed on the View/Add plans page.

Shopping works as normal for these types of plans, if a Health plan is chosen during SEP, an SEP reason will be required.

Individuals on this Proposal
X

| Name | Relationship | Gender | Date of Birth | Zip Code | County |
|------|--------------|--------|---------------|----------|--------|
| Jane | Applicant | Female | 09/01/2019 | 15039 | BUCKS |

Note: Editing Demographic Information requires that you create a new proposal with the updated information.

[Edit Demographic Information](#)

Individuals Included: Jane
My Prospects

View / Add 2020 Health Plans

My Favorite 2020 Plans

[Favorite plans help](#)

| Favorite Plans | Select | Plan Name | ↕ CSR | ↕ Annual Deductible | ↕ Annual Maximum Out of Pocket | ↕ Metal Levels | ^ Monthly Premium |
|----------------|--------------------------|--------------------------------------|-------|---|---|----------------|-------------------|
| ★ | <input type="checkbox"/> | Keystone HMO Silver Proactive Select | 01 | Tier 1: \$0 Tier 2: \$6,000 Tier 3: \$6,000 | Tier 1: \$0 Tier 2: \$6,000 Tier 3: \$6,000 | Silver | \$244.49 |
| ★ | <input type="checkbox"/> | Keystone HMO Silver Proactive | 01 | Tier 1: \$0 Tier 2: \$6,000 Tier 3: \$6,000 | Tier 1: \$0 Tier 2: \$6,000 Tier 3: \$6,000 | Silver | \$292.50 |
| ★ | <input type="checkbox"/> | Keystone HMO Gold Proactive | 01 | Tier 1: \$0 Tier 2: \$0 Tier 3: \$0 | Tier 1: \$0 Tier 2: \$0 Tier 3: \$0 | Gold | \$327.89 |
| ★ | <input type="checkbox"/> | Keystone HMO Gold | 01 | \$0 | \$0 | Gold | \$388.79 |

Child Only Shop and Apply cont.

Child-only applications will list the child as the primary subscriber and will also include a Parent/Legal Guardian page to complete in the application flow. The rest of the application follows the normal workflow.

*Authorized Representative will not show as an option for Child-only applications as the Parent/Legal Guardian services this purpose.

Parent or Legal Guardian Information

Relationship to child Father
 Mother
 Legal Guardian

First Name:

M.I.: (optional)

Last Name:

Suffix: (optional)

Social Security Number / ITIN : - -

(Individual Tax ID Number may only be used if you do not qualify for a Social Security Number)

Re-enter Social Security Number / ITIN : - -

Date of Birth: (mm/dd/yyyy)

Is the address of the Parent or Legal Guardian the same as the home address? Yes No

Back

Save and Continue