



**JarvisEnroll for
Medicare Advantage
(MA) Plans
2026 User Guide**



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Introduction

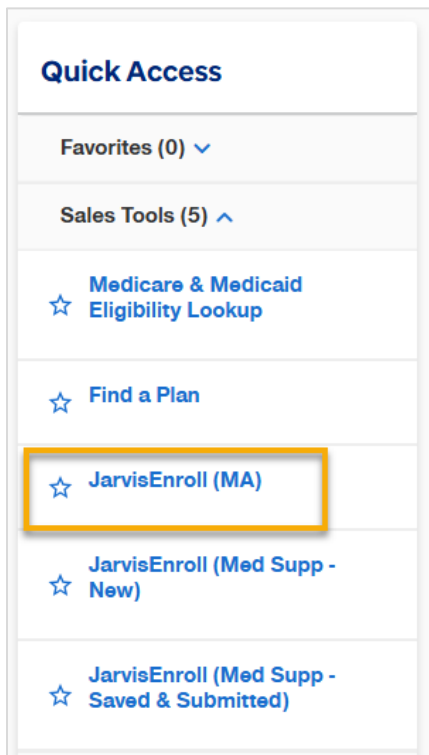
This user guide was created to help guide you through the JarvisEnroll system when enrolling a consumer or member in a Medicare Advantage plan. The guide will walk you through the **In-Person Signature** option. This option should only be used when you are conducting a face-to-face enrollment. Please reference the **JarvisEnroll Voice Signature** job aid, and the **JarvisEnroll Remote Signature Process** job aid for that enrollment process.

JarvisEnroll is UnitedHealthcare's electronic enrollment application tool. JarvisEnroll has many capabilities to make your enrollment experience faster and efficient for you and the consumer.

- There is no additional login because the tool is built inside Jarvis
- The consumer can sign the application remotely using text or email
- Applications are stored digitally and securely for 10 years
- Guardrails are set up to prevent you from missing any required information on the application

Accessing JarvisEnroll

JarvisEnroll is found inside of Jarvis. Log into Jarvis and navigate to the Quick Access panel. Select JarvisEnroll (MA).



Once selected, you will be taken to the **New Application** page.

1 New Application 2 Medicare Info 3 Applicant 4 Product/Plan 5 Questionnaire 6 Payment 7 Signature

New Application

Check eligibility for this member

Signature Type * Language

Select... English

Authorized Representative

Is there an Authorized Representative enrolling this beneficiary? * ⓘ

Yes No

Close Continue →

New Application Page

Note: If you would like to determine a consumer's Medicare and/or Medicaid eligibility, click **Check eligibility for this member** to access the Medicare & Medicaid Eligibility lookup tool. You will have the option to pull information from the Medicare eligibility results page into the application.

New Application

Check eligibility for this member

Signature Type * Language

Select... English

In the **Signature Type** field, select In-Person Signature.

New Application

Check eligibility for this member

Signature Type * Language

Select... English

In-Person Signature

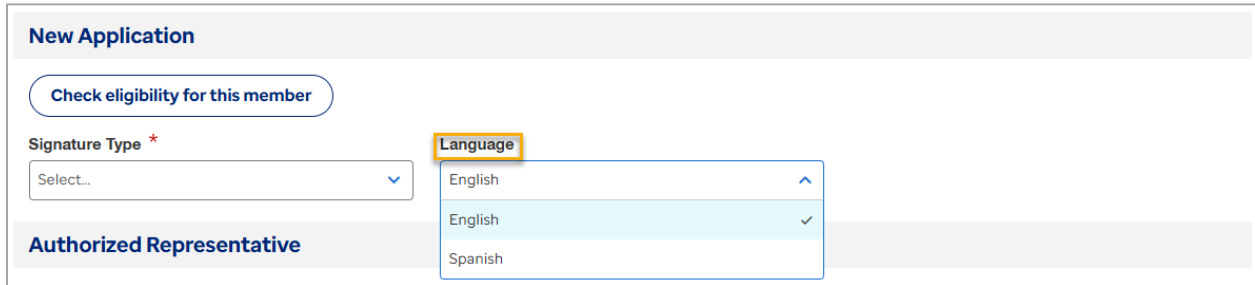
Voice Signature

Remote Signature via Email

Remote Signature via Text

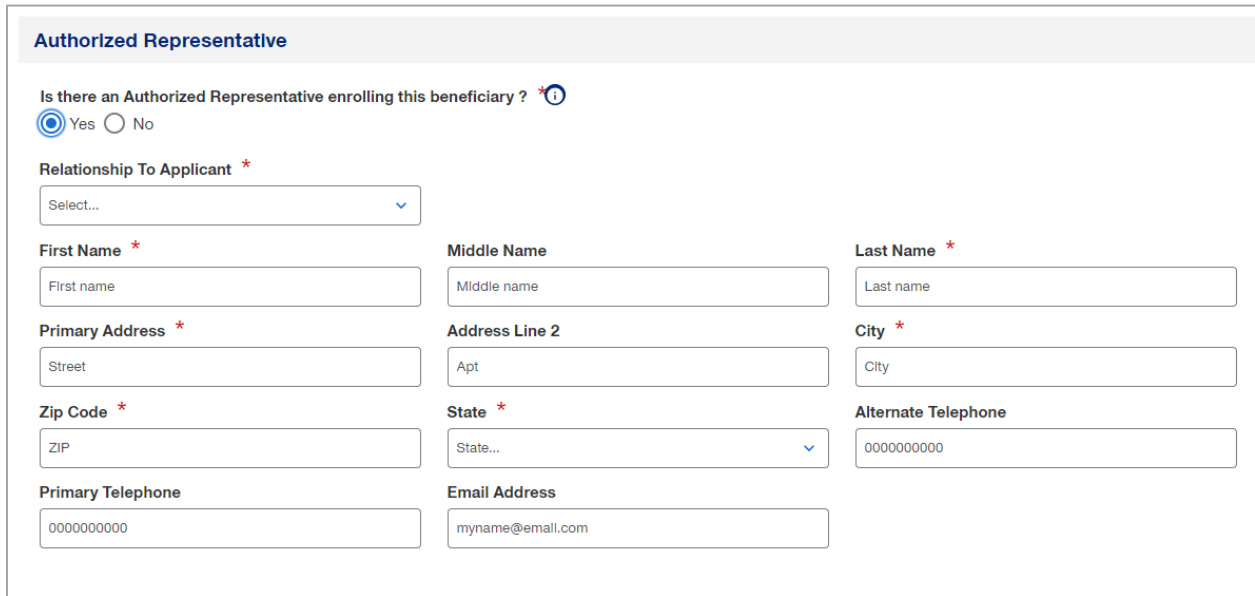
Is there an Authorized Representative enrolling this beneficiary? * ⓘ

You can select English or Spanish in the **Language** field for the application. By choosing Spanish the application will be translated into the Spanish language.



The screenshot shows the 'New Application' section of a form. At the top, there is a button labeled 'Check eligibility for this member'. Below it, there is a 'Signature Type' dropdown menu with 'Select...' as the current selection. To the right of this is the 'Language' dropdown menu, which is open and shows three options: 'English', 'English', and 'Spanish'. The 'English' option is currently selected, indicated by a checkmark and a light blue highlight. Below the 'Language' dropdown, there is a section titled 'Authorized Representative'.

If there is an **Authorized Representative**, you will be able to choose that option and enter in that individual's information.



The screenshot shows the 'Authorized Representative' section of the form. It starts with a question: 'Is there an Authorized Representative enrolling this beneficiary?' with radio buttons for 'Yes' (selected) and 'No'. Below this is a 'Relationship To Applicant' dropdown menu with 'Select...' as the current selection. The form then has several input fields arranged in a grid: 'First Name', 'Middle Name', and 'Last Name'; 'Primary Address', 'Address Line 2', and 'City'; 'Zip Code', 'State', and 'Alternate Telephone'; and 'Primary Telephone' and 'Email Address'. Each field has a placeholder text or a default value.

At the bottom, you will notice a **Close** and **Continue** option. When you select Close, the application will not be saved. Continue will take you to the next page.



The screenshot shows the bottom of the form with two buttons: a 'Close' button on the left and a 'Continue' button on the right. The 'Continue' button is dark blue with a white arrow pointing to the right.

Medicare Info Page

The Medicare Info page allows you to enter in the consumer's Medicare Card information. It is very important that you enter the consumer's name as it appears on the Medicare card, including the Middle name if applicable.

Home > Sales Tools > JarvisEnroll (MA & PDP)

1 New Application 2 Medicare Info 3 Applicant 4 Product/Plan 5 Questionnaire 6 Payment 7 Signature

Medicare Health Insurance Card Information ⓘ

First Name * First Name	Middle Name Middle Name	Last Name * Last Name
Medicare Number * Ex. 1EG4TE5MK72	Gender * Select...	Date Of Birth * mm/dd/yyyy
(Part A) Hospital effective date Month	Day	Year
---	1	---
(Part B) Medical effective date Month	Day	Year
---	1	---

Save & Close Previous Continue

Enter the **Medicare Number** without any dashes.

Medicare Number * Ex. 1EG4TE5MK72	Gender * Select...	Date Of Birth * mm/dd/yyyy
(Part A) Hospital effective date Month	Day	Year
-	1	-

Enter the **Gender**.

Medicare Number * Ex. 1EG4TE5MK72	Gender * Select... Male Female
(Part A) Hospital effective date Month	Day
	1

Enter in the **Date of Birth** as formatted in JarvisEnroll. You do not need to add the forward slashes, since JarvisEnroll will add them for you.

The screenshot shows a form with the following fields: Medicare Number (with example '1EG4TE5MK72'), Gender (dropdown menu), Date Of Birth (text input with a calendar icon and placeholder 'mm/dd/yyyy'), (Part A) Hospital effective date (Month, Day, Year dropdowns), and (Part B) Hospital effective date (Month, Day, Year dropdowns). The Date Of Birth field is highlighted with a yellow border.

Enter the **Hospital Part A and B effective dates** by using the dropdowns. Keep in mind, these fields do not have an asterisk, but need to be entered if applicable to the plan the applicant is enrolling in.

The screenshot shows two sets of dropdown menus for hospital effective dates. The first set is for (Part A) Hospital effective date, with Month, Day, and Year dropdowns. The second set is for (Part B) Hospital effective date, also with Month, Day, and Year dropdowns.

Click **Verify Medicare Eligibility**

The screenshot shows a navigation bar with four buttons: 'Save & Close', 'Verify Medicare Eligibility' (highlighted with a yellow border), 'Previous', and 'Continue'.

If nothing is identified as a mismatch with the Medicare Info, you will receive a green message.

The screenshot shows a progress bar with seven steps: New Application, Medicare Info (current step), Applicant, Product/Plan, Questionnaire, Payment, and Signature. Below the progress bar is a section titled 'Medicare Health Insurance Card Information' with a green message box stating: 'Medicare information has been successfully verified. Please proceed with the application.' Below the message are input fields for First Name, Middle Name, and Last Name.

If something is identified as mismatched with the Medicare Info, you will receive a red message stating what was identified as incorrect.

Keep in mind that if there is mismatched information, you can still proceed with the application by selecting **Continue**.

NOTE: If you launch an application from the Medicare Medicaid Eligibility Lookup tool or the Book of Business, the **Verify Medicare Eligibility** button will not be present, and you can just select **Continue**.

At the bottom, you will notice a **Save & Close** and **Previous** option.

By selecting **Save & Close**, your application can be saved where you left off and found under your Applications tab in Jarvis. The **Previous** option will allow you to go back in the application at any time.

Applicant Page

In the **Primary Address or Institution Address** section, you will need to enter the necessary address information for the consumer.

The first question will ask if the consumer resides in a nursing home or long-term care facility. If yes, you will need to enter the institution information and admission date, plus other necessary information. The **Search Address** bar allows you to find and select the institution's address.

Home > Sales Tools > JarvisEnroll (MA & PDP)

New Application
 Medicare Info
 Applicant
 Product/Plan
 Questionnaire
 Payment
 Signature

Primary Address or Institution Address

Are you a resident in a nursing home or other long-term care facility? *

Yes No

Search Address

Name of Institution *
 Admission Date *
 Primary Address or Institution Address *

 mm/dd/yyyy
 Street

Address Line 2
 City *
 Zip Code *

Apt

County
 State *

Select...

If no, then you will find and select, or fill in the consumer's **Primary Address**. Note: The **Search Address** bar functions the same way for primary addresses as it does for institution addresses.

Primary Address or Institution Address

Are you a resident in a nursing home or other long-term care facility? *

Yes No

Search Address

Primary Address *
 Address Line 2
 City *

Street
 Apt

Zip Code *
 County *
 State *

 Select...

Note: After you enter the zip code, county options will populate, and the state will autofill.

If the consumer would like mail sent to an alternate address, you can enter in the **alternate address** by choosing "yes." You must select an option to continue.

Would you like your mail sent to an alternative address? *

Yes No

Alternative or Mailing Address

Mailing Address *
 Mailing Address 2
 City *

Street

 City

Zip Code *
 State *

Zip Code
 Select...

If the consumer has a **phone number** they would like to provide, enter the phone number without any dashes or parentheses.

You must ask the ask for **autodialer and/or prerecorded voice technology** consent even if the consumer does not provide a phone number.

Contact information

Primary Telephone: 555-555-5555
Alternate or Institution Telephone: 555-555-5555

Do you give consent for UnitedHealthcare and its affiliates to call the phone number(s) you have provided using an autodialer and/or prerecorded voice technology? *

Yes No

Providing the email address below enrolls you in paperless delivery for some of your plan communications. You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

The **Email Address** field is required, but if the consumer would rather have hard copies of required materials mailed, select the box below the email address field.

Contact information

Primary Telephone: 555-555-5555
Alternate or Institution Telephone: 555-555-5555

Do you give consent for UnitedHealthcare and its affiliates to call the phone number(s) you have provided using an autodialer and/or prerecorded voice technology? *

Yes No

Providing the email address below enrolls you in paperless delivery for some of your plan communications. You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

Email address *
example@gmail.com

If you would rather have hard copies of required materials mailed to you, please check here. Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

If the consumer has a **Primary Language** other than English, select the dropdown to choose from the choices.

Language Information

Primary Spoken Language: English (dropdown menu with options: English, Albanian, Arabic, Benga, Chinese (Cantonese))

Preferred Material Format *
English (dropdown menu)

Yes, Mexican, Mexican American, Chicano/a

Yes, another Hispanic, Latino/a, or Spanish origin

If the consumer would prefer their **materials in a different language format** other than English, you could choose from Spanish or Other.

Note: Other relates to the Primary Spoken Language field.

Language Information

Primary Spoken Language: English

Preferred Material Format *
English ✓
Spanish
Other

Answering these questions is your choice. You can't b

Medicare requests we ask the next few questions, but your Race and Ethnicity? *
 Yes No

Product/Plan Page

Select the **Proposed Effective Date** from the dropdown.

Home > Sales Tools > JarvisEnroll

New Application Medicare Info Applicant **Product/Plan** Questionnaire Payment Signature

Plan details

Proposed Effective Date *
06/01/2024
07/01/2024
08/01/2024

Plan premium H-PBP-SegmentID
-- --

Are you enrolled in your state Medicaid Program? *
 Yes No

Election Period *
Election Period Worksheet

Select the **Plan Name**. Note: The plan premium and segment ID will populate when you choose the plan.

Plan details

Proposed Effective Date *
06/01/2024

Plan Name *
IND - AARP Medicare Rx Saver from UHC (PDP) (PDP)
IND - UHC Dual Complete FL-D003 (PPO D-SNP) (MAPD)

Plan premium H-PBP-SegmentID
-- --

You will need to ask the consumer the next 2 questions. If they choose “Yes” to the **Medicaid Program**, you could enter in the Medicaid Number.

Plan details

Proposed Effective Date *
06/01/2024

Plan Name *
IND - AARP Medicare Advantage from UHC FL-0031 (Regional PPO) (MAPD)

Plan premium: \$0.00
H-PBP-SegmentID: R0759 - 001 - 000

Are you a member of a State Pharmaceutical Assistance program? *
 Yes No

Are you enrolled in your state Medicaid Program? *
 Yes No

Medicaid ID Number *
[Empty field]

Select the **Election Period** for the consumer. If you are unsure of what to select, there is a built in **Election Period Worksheet** that can help.

Election Period *

ICEP
ICEP Delayed B
OEP Newly Eligible
IEP
IEP2

[Election Period Worksheet](#)

If you choose SEP as the election period, the **SEP Reason Code** area will populate.

You will be required to select an SEP Reason Code from the dropdown options.

If you are unsure of what reason code to select, there is a built in **SEP Reason Code Worksheet** that can help.

Election Period *

SEP ▼ [Election Period Worksheet](#)

SEP Reason Code *

Need assistance with SEP Reason Code?

Change In Residence

800 Series Employer

SPAP Enrollee

Institutional

Invol. Loss of Creditable Cvg

PCP Page

When you get to this page of the application, you have a few options. If you already gathered the **PCP ID** and the **PCP name**, you could enter directly in those fields.

Home > Sales Tools > JarvisEnroll

New Application
 Medicare Info
 Applicant
 Product/Plan
 PCP
 Questionnaire
 Payment
 Signature

PCP Recommendations ⓘ

Primary Care Physician (PCP)

PCP Search ⓘ

PCP Search

PCP ID *
PCP Name *

Current Patient of PCP? *

Yes No

If you do not have the PCP information, you can use the **PCP Search**. Please reference the **JarvisEnroll Primary Care Provider (PCP) Process** job aid for step-by-step information on how to work the search.

Select “Yes” or “No” for the **Current Patient of the PCP** question.

Primary Care Physician (PCP)

PCP Search ⓘ

PCP Search

PCP ID *

PCP Name *

Current Patient of PCP? *

Yes No

Questionnaire Page

Ask the consumer the next 3 questions. If they answer yes to the last 2 questions, additional information will need to be provided.

Home > Sales Tools > JarvisEnroll

New Application
 Medicare Info
 Applicant
 Product/Plan
 PCP
 Questionnaire
 Payment
 Signature

Important Questions

Please read and answer these important questions

Do you or your spouse work? *

Yes No

Are you covered under any health insurance other than Medicare, such as private insurance, Workers Compensation, Tricare or Veterans Administration (VA) benefits? *

Yes No

This information helps determine if there is a need for coordination of benefits for health coverage.

Other Insurance Information

Type of insurance (Example: Group, Private, Exchange, Veterans, etc.)

Insurance company *

Group number *

ID number *

Some individuals may have other drug coverage, including other private insurance, TRICARE, VA benefits, State Pharmaceutical Assistance Program or Federal Employee Health Benefits coverage. Will you have other prescription drug coverage in addition to the plan? *

Yes No

This information helps determine if there is a need for coordination of benefits for prescription drugs.

Name of the Plan

Member ID

Group ID

RxBin

Effective date

If the consumer is enrolling in a C-SNP, the **Chronic Conditions Verification Form** will populate.

Some individuals may have other drug coverage, including other private insurance, TRICARE, VA benefits, State Pharmaceutical Assistance Program or Federal Employee Health Benefits coverage. Will you have other prescription drug coverage in addition to the plan? *

Yes No

Chronic Questionnaire

I. Diabetes Mellitus ("Yes" to 1 or 2 pre-qualifies the candidate.)

1. Have you ever been told by a doctor or clinic that you have diabetes (too much sugar in the blood or urine)? *

Yes No Not Sure

2. Have you been prescribed or are you taking insulin or an oral medication for diabetes treatment? *

Yes No Not Sure

II. Chronic Heart Failure ("Yes" to question 1 or questions 2 and 3 pre-qualifies the candidate. "Yes" to question 2 or 3 does not qualify the consumer and the application may require further verification.)

1. Have you ever been told by a doctor or clinic that you have Congestive Heart Failure? *

Yes No Not Sure

To learn more about C-SNP, please for the Chronic Special Needs Plan (C-SNP) national webinar.

If you are enrolling a consumer or member in a D-SNP, the SSBCI qualifying conditions will populate with the addition of the provider information and Authorization to Release Information.

Additional Benefits Verification

To qualify for the Healthy Food <D-SNP: and Utilities> benefit <AZ: and additional transportation> you must have a qualifying chronic condition. I'm going to ask you some questions now to check your eligibility, then we'll need to verify your condition. Afterwards we'll send you a letter with next steps.]

Agent Note: Agent will ask the questions corresponding to the chronic condition discussed pre-enrollment, ONLY one condition is required to be selected.

Qualifying Clinical Conditions

- | | | |
|--|--|---|
| <input type="checkbox"/> Diabetes mellitus (type 1 or type 2) | <input type="checkbox"/> Cardiovascular disorders | <input type="checkbox"/> Chronic heart failure |
| <input type="checkbox"/> Chronic hypertension (chronic high blood pressure) | <input type="checkbox"/> Chronic hyperlipidemia (chronic high cholesterol) | <input type="checkbox"/> Autoimmune disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic alcohol use disorder and other substance use disorders (SUDs) | <input type="checkbox"/> Chronic gastrointestinal disease |
| <input type="checkbox"/> Chronic kidney disease (CKD) | <input type="checkbox"/> Chronic lung disorders | <input type="checkbox"/> Chronic and disabling mental health conditions |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Immunodeficiency and immunosuppressive disorders |
| <input type="checkbox"/> Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy | <input type="checkbox"/> Neurologic disorders | <input type="checkbox"/> Overweight, obesity and metabolic syndrome |
| <input type="checkbox"/> Post-organ transplantation care | <input type="checkbox"/> Severe hematologic disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Conditions associated with cognitive impairment | <input type="checkbox"/> Conditions with functional challenges and require similar services including spinal cord injuries, paralysis, limb loss, stroke and arthritis | <input type="checkbox"/> None of these conditions apply to me |
| <input type="checkbox"/> Based on your answers so far you are not eligible for the healthy food <and utilities benefit, if applicable/>and additional transportation, if applicable>. If you experience a health change, use your member card to contact us. | | |

Treating Provider Information

What provider can we contact to verify your chronic condition?

PCP ID * **PCP Name ***

OR

Name **Phone number**

Address **City** **State** **Zip Code**

Fax number **Email address**

Do we have your permission to contact this provider ? *

Yes No

Authorization to Release Information

As a reminder, the healthy food and <utilities benefit> <AZ: and additional transportation> is a special supplemental benefit only available to chronically ill enrollees with a qualifying condition, so we need your permission to release your health information so we can confirm your condition. This is called the Authorization to Release Information and it is consistent with federal law. By continuing, you acknowledge and agree to the following:

- This authorization is voluntary.
- The information shared may include sensitive health details—like medical, pharmacy, dental, vision, mental health, substance use, HIV/AIDS, reproductive, or communicable disease information.
- You cannot be denied treatment, payment for health care services or enrollment or eligibility for health care benefits if you do not agree to this authorization.
- Once shared, your information may no longer be protected under federal privacy laws if the recipient isn't a health plan or provider.
- This authorization is valid for one year. Call the number on your member card to request a copy or <write to us to> revoke it. Any revocation will take effect when we receive your written request.

By agreeing, you allow:

UnitedHealth Group and its affiliates to share your health information with each other and disclose of all your health information for the purpose of confirming eligibility for the healthy food benefits <and utilities, if applicable, additional transportation, if applicable>

Do you agree to the Authorization to Release Information ? *

Agree Disagree

To learn more about SSBCI, register for the Special Supplemental Benefits for the Chronically Ill (SSBCI) national webinar.

Payment Page

The payment page will display the Plan name and Plan Premium amount.

You must read the **Payment Disclaimer** to the consumer. Once it is communicated and they agree, select the agreement box.

Disclaimer / Payment options

Payment Disclaimer*

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

If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), Social Security (SS) will send you a letter and ask you how you want to pay it. Don't pay UnitedHealthcare the Part D-IRMAA:

- You can pay it from your SS check
- Medicare can bill you
- The Railroad Retirement Board (RRB) can bill you

This Disclaimer has been communicated to Applicant and Applicant agrees *

Premium Payment Option *

- Direct pay (Monthly Statement)
- Deduction from Social Security ⓘ
- Deduction from Railroad Retirement Board ⓘ
- Electronic Funds Transfer (EFT)

Payment Details

Plan Name	Plan Premium
IND - UHC Dual Complete FLY5 (HMO-POS D-SNP) (MAPD)	\$0.00
Total Monthly Premium	\$0.00

The **Premium Payment Options** will populate below. The consumer must select a payment option, even if the plan does not have a premium. Some of the premium options will have additional disclaimers that must be read to the consumer.

- Direct Pay is a billed monthly statement.
- Deduction for Social Security/ Deduction from Railroad Retirement Board.
- Electronic Funds Transfer is an automatic withdrawal from a checking or savings account.

Signature Page

As a reminder, this guide is for the In-Person Signature option. This option can **ONLY** be used when you are conducting a face-to-face enrollment.

When you get to the Signature page, you will see a **Statement of Understanding** that needs to be read word-for-word to your consumer, or you could have your consumer read this since you would be conducting a face-to-face enrollment.

Once your applicant agrees to the information, you can **check the agreement box**.

Enrollment in the plan depends on the plan's contract renewal with Medicare.

8. If this is a C-SNP plan, Medicare requires that your chronic condition be verified. The plan may contact your physician's office to verify your chronic condition.

9. You understand that your signature (or the signature of the person legally authorized to act on your behalf) on this application means that you have read and understand the contents of this application. If signed by an authorized representative (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 by Medicare.

10. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

11. 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.

12. You understand that by completing the online enrollment process, you will send an actual enrollment request, you will receive an acceptance or denial notice following submission of the enrollment, and you will be enrolled in the plan (if approved by CMS).

PRIVACY ACT STATEMENT
The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MAPD)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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Steps to Sign Enrollment

1. Applicant has Reviewed and Accepts Statement of Understanding *

After you check the box, you must **click on the review PDF option** and download the application to review with your consumer. This is not a receipt of enrollment.

Steps to Sign Enrollment

1. Applicant has Reviewed and Accepts Statement of Understanding *

2. **Click to review PDF with Beneficiary/Authorized Rep ***

Plan Name	Provider Name	Drug Coverage	Effective Date
AARP Medicare Advantage from UHC FL-0031 (Regional PPO)	hthtrt	Yes	06/01/2024

VERY IMPORTANT! Once you and the consumer have reviewed the application, **have the consumer check the box** once the consumer agrees. **This is step 3 and MUST be checked off by the consumer or authorized representative.**

Beneficiary/Authorized Rep Signature *

Ensure the Beneficiary/Authorized Rep is clicking the box below

3. By checking this box, I the Beneficiary/Authorized Rep, intend to sign this form electronically. I acknowledge that the information provided on this enrollment application is accurate and it is my intent to enroll in the plan indicated above. *

Applicant Name	Medicare #	Signature Date
testtest		
Agent Signature *		
Agent Name	Writing ID	Signature Date

If applicable, there is an additional field to upload proof of Medicare and/or Proof of Medicaid.

Simply Drag and Drop or select “Upload your document” to attach with the application.

The screenshot shows a web form with two main sections. The first section, titled "Plan Information", contains a table with the following data:

Plan Name	Provider Name	Drug Coverage	Effective Date
IND - AARP Medicare Advantage Plan 3 (HMO-POS) (MAPD)	Sam Kogen	Yes	06/01/2023

Below the table are three checkboxes:

- Send Applicant an Enrollment Receipt.
- Send Agent an Enrollment Receipt.
- Submit and Begin Shared Residence Application.

The second section, titled "Attach documents", is highlighted with a yellow border. It features a dashed box for file uploads with the text: "Drag and drop your file here, or upload your document. Only accepts PDF, .JPG, .JPEG, PNG format. Upload up to 5 documents, max upload cannot exceed 6MB". Below this is a checkbox: I have confirmed the document(s) I have attached are correct.

NOTE: The max capacity for uploads is 6 MB for all files. Agents can upload up to 5 files total. The accepted formats include pdf, tiff, jpeg, png, jpg.

Select **Submit Application**.

The screenshot shows a navigation bar with three buttons: "Save & Close", "Previous", and "Submit Application". The "Submit Application" button is highlighted with a yellow border.

Once you submit your application, the **Confirmation Number** will populate, and you will have the option to start the **Health Assessment** if you enrolled the consumer in a Chronic Special Needs or Dual Special Needs Plan.

The screenshot shows a confirmation message with the following text:

Home > Sales Tools > JarvisEnroll

Thank You!

The application has been submitted.✔

Confirmation # AE-16004105062024

If you wish to start a Health Assessment for the same consumer, click the "Start HA" button below. You have 3 days to complete the Health Assessment.

Start HA

Close

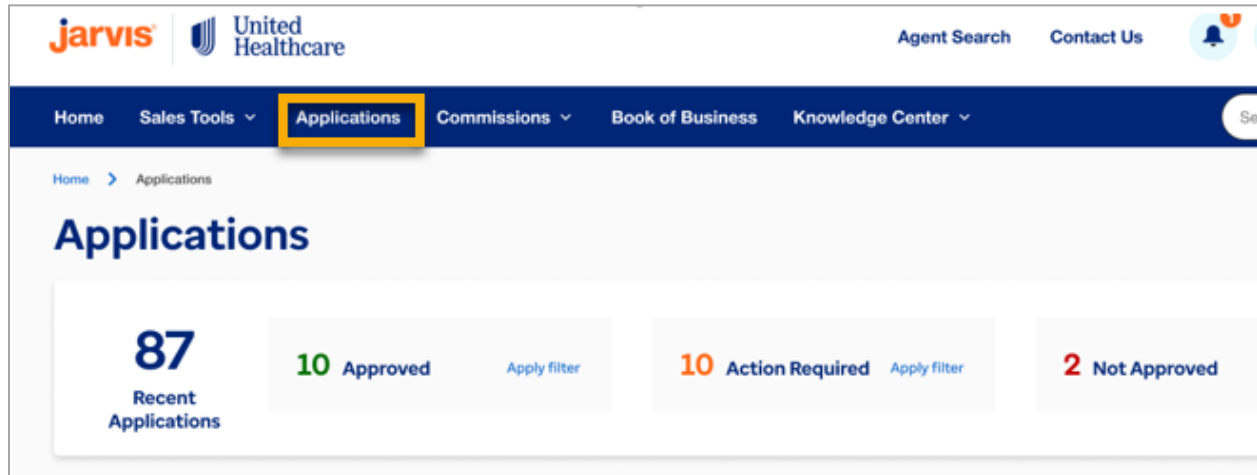
The "Start HA" button is highlighted with a yellow border.

Please reference the *Health Assessment* course in Learning Lab for steps to complete the Health Assessment.

Application Status

You can check the status of an application by going to the **Applications** tab in Jarvis.

You will be able to view your saved and submitted applications.



After the applicant’s name, you will see a dropdown arrow to view actionable fields. Depending on the status of the application, you could have several choices.

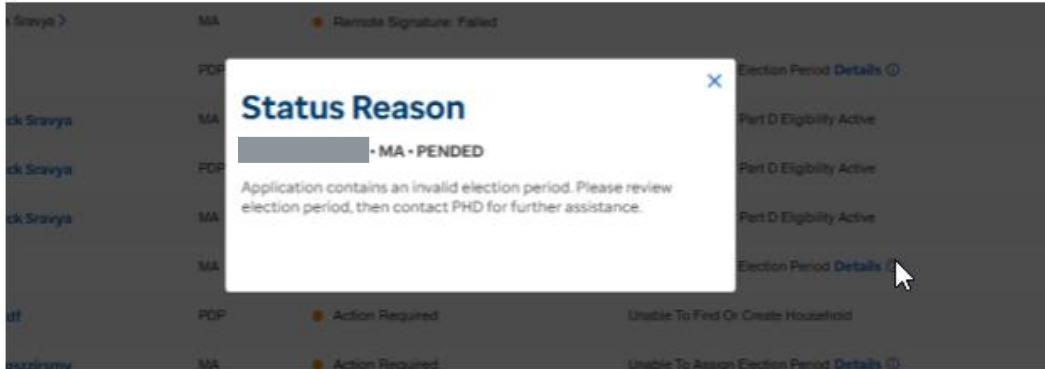
Resend App – Click to resend the application to the consumer

RS Report - Click to view the signature status (Remote Signatures only)

#	Applicant Name	Product	Status	Status Reason
1	[Redacted]	MA	Approved	Application Approved
2	[Redacted]	MA	Denied	Duplicate Application with insured plan Details
3	[Redacted]	MA	Action Needed	DUAL SNP Plan required verification Details
4	[Redacted]	MA	In-progress	Remote Signature
5	[Redacted]	MA	In-progress	Application processing
6	[Redacted]	MDSUP	Approved	Application approved

Under the Status Reason column, hover over “Details” to populate the Status Reason Information. This will explain the reason for the application status and agent action if applicable.

Applicant Name	Product	Status	Status Reason
R Test >	MA	Remote Signature: Failed	
Test >	MA	Remote Signature: In Progress	
Test >	MA	Remote Signature: In Progress	
Test	PDP	Action Required	Unable To Assign Election Period Details



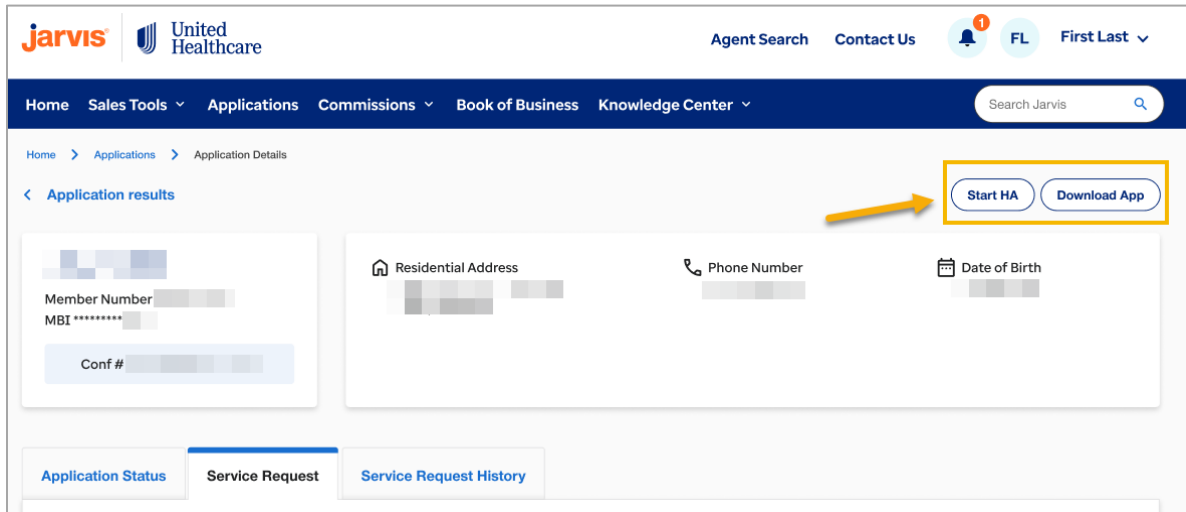
Application Details

On the **Applications** tab, click on the Applicant Name or “Details” under the Status Reason column.

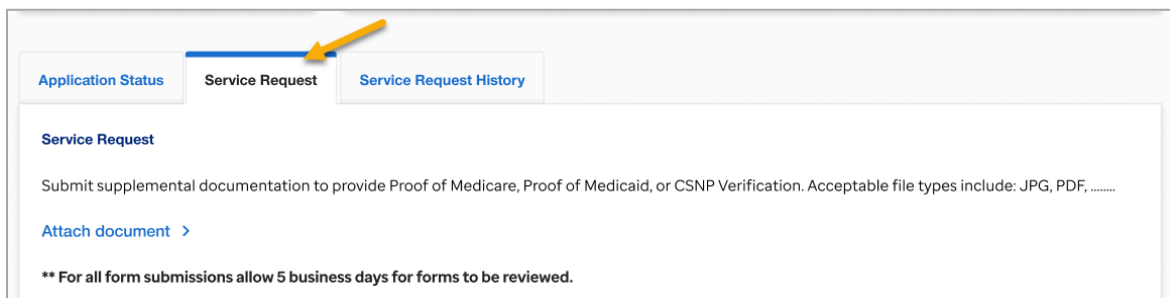
Applicant Name	Product	Status	Status Reason
R Test >	MA	Remote Signature: Failed	
Test >	MA	Remote Signature: In Progress	
Test >	MA	Remote Signature: In Progress	
Test	PDP	Action Required	Unable To Assign Election Period Details

From the Application Details page, you will be able to start the Health Assessment if you enrolled a consumer in a C-SNP or D-SNP plan by clicking “Start HA.”

You can also download the application if needed.



You can select the **Service Request** tab to upload the proof of Medicare, proof of Medicaid, and/or the Chronic Verification form.



NOTE: The max capacity for uploads is 6 MB for all files. Agents can upload up to 5 files total. The accepted formats include pdf, tiff, jpeg, png, jpg.