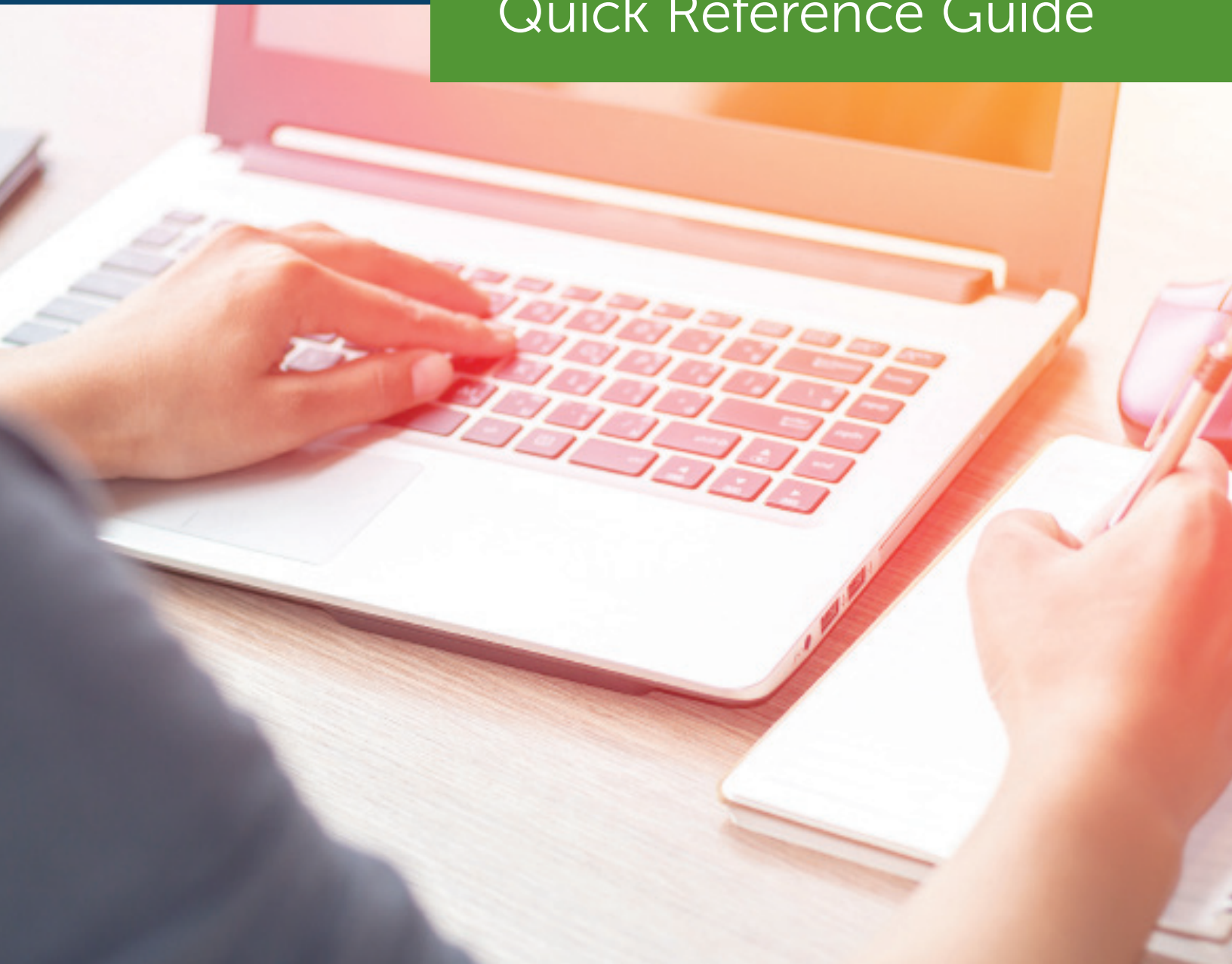




# Medicare Broker Onboarding & Recontracting

Quick Reference Guide



# Get Started

Thank you for your interest in working with Healthfirst. This quick reference guide will help you navigate the Appointment and Recontracting process with Healthfirst.

Before beginning this process, please have the following documents accessible on your computer: your **National Producer Number** (NPN), your renewed **NYS Life/Accident/Health license**, your **Errors and Omissions insurance** documents, your **Annual AHIP Certification**, and your **Banking Information**. You will need these documents to complete the onboarding and recontracting process.

If you have any questions or need additional assistance, our dedicated Broker Services unit is here for you. Please call **1-855-456-3668**, Monday to Friday, 9am–5pm.

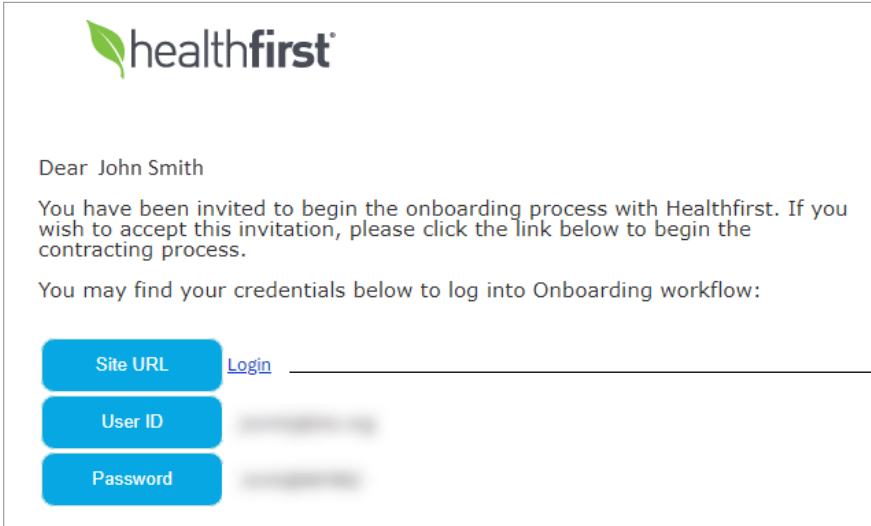
**Note:** The preferred browsers to complete these tasks are Internet Explorer and Chrome.

## Table of Contents

Click on the links below to view the associated workflow:

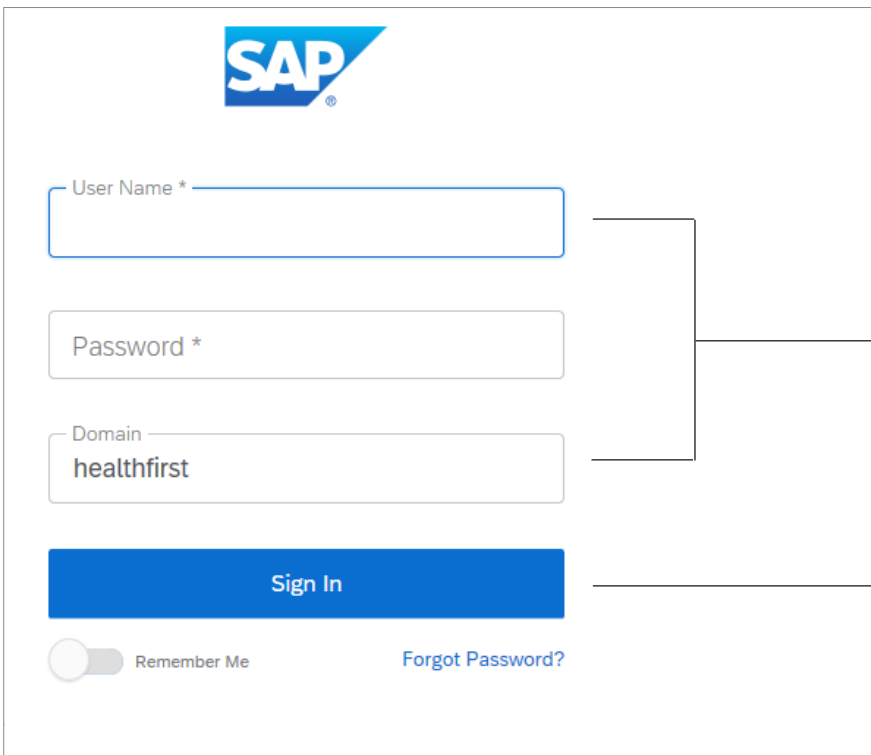
<a href="#">Initial Onboarding</a> .....	3
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# Initial Onboarding



1 The Broker will receive an email from **wpm@webcominc.com** with temporary Login Credentials.

Click **Login** to begin.



2 Enter **Temporary Credentials** provided in your invitation email to begin Onboarding.

Then click **Sign In**.

healthfirst

You are logged in

- Please set a new password. Your password must be changed to protect the integrity of your account.
- Password must contain Lowercase letters, uppercase letters, numbers and special characters
- Last four passwords may not be reused
- Password must have more than 9 characters.
- Password can not be too similar to first, last or user name
- Password must have less than 20 characters.

New Password \*

Confirm Password \*

**Change Password** Sign Out

3 Follow the instructions to create a **unique password**.

Then click **Change Password**.

healthfirst

Case ID

Home Find Cases Lists Feed More Help Sign Out

Open cases assigned to me

Case Key	Case Name	Created On	Status	Updated
Onboarding-OB-931	06/28/2019	06/28/2019 05:48:45	Retrieve NPN	06/28/2019 05:48:45

One item found.

THE BEST RUN SAP

4 Under **Open cases assigned to me**, click **Onboarding-OB**.

healthfirst

Case ID

If you have any challenges or questions during this process, please call our Broker Services team at 1-855-456-3668, Monday to Friday, 9am-5pm. We are here to help.

Please enter your SSN to continue.

SSN

Producer NPN

5 Enter **Social Security Number** to retrieve NPN.

healthfirst Case ID

If you have any challenges or questions during this process, please call our Broker Services team at 1-855-456-3668, Monday to Friday, 9am-5pm. We are here to help.

Please enter your SSN to continue.

SSN

Producer NPN 2012042

Name	Resident State	Date of Birth
	NY	

1 total rows, displaying from 1 to 1

I authorize Healthfirst to request NIPR for a PDB Report.

Submit

6 Ensure the **NPN Lookup Results** are **correct**. If they are, **check the box** "I authorize Healthfirst to request NIPR for a PDB Report".

Then click **Submit**.

healthfirst Case ID

If you have any challenges or questions during this process, please call our Broker Services team at 1-855-456-3668, Monday to Friday, 9am-5pm. We are here to help.

General Licenses Background Questionnaire Insurance Banking Information Certifications Medicare Agreement Education

Please complete all required fields.

First Name \* John

Do you have a middle name?  Yes  No

Last Name \* Smith

Suffix --select--

Date of Birth \* 06/25/1966

SSN

Producer NPN

Business Phone \* 685-687-9854

Contact Email \* jsmith@gmail.com

NIPR Email

Is this your preferred mailing address?  Yes  No

Address Line 1 \* 123 Apple Lane

Address Line 2

City \* Deer Park

State \* NY

ZIP \* 11720

Is your business address the same as your residence address?  Yes  No

Business Address Line 1 123 Apple Lane

Business Address Line 2

Business City Melville

Business State NY

Business Zip 11747

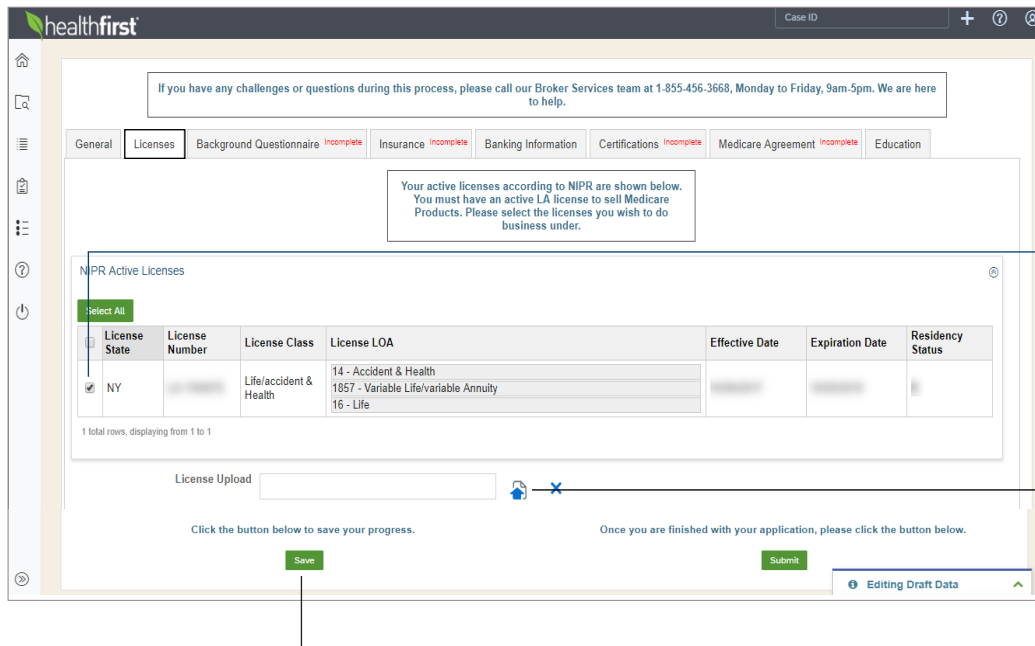
Click the button below to save your progress.

Once you are finished with your application, please click the button

7 Under the **General tab**, some details will be populated. **Enter your information in the blank fields.**

Once all fields are populated, click **Save**.

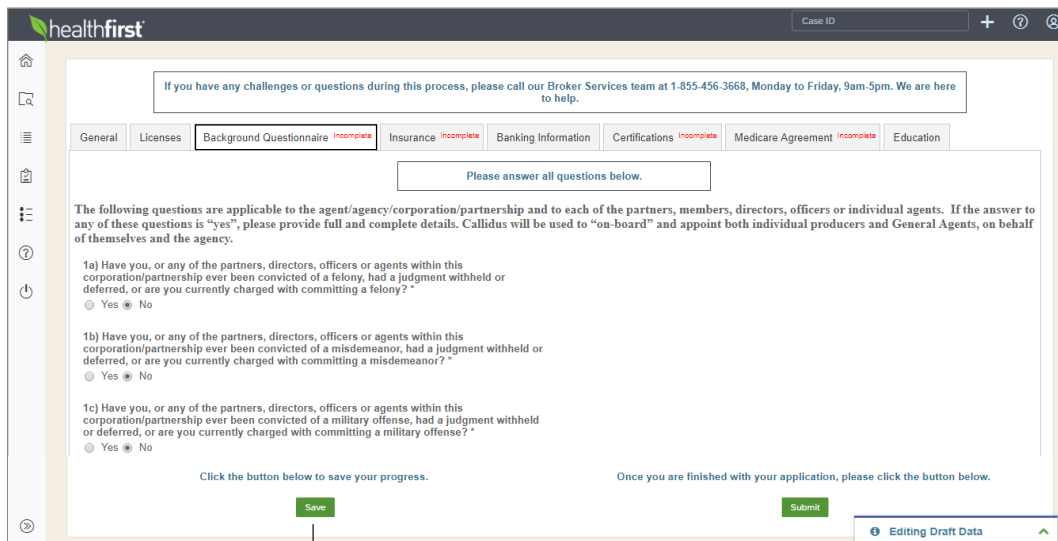
**Note: Do not click Submit** until all tabs are completed.



8 Under the **Licenses tab**, select the applicable **"NY" license (Life/Accident Only)**.

Then use the **Upward Arrow** to upload a copy of the License.

When complete, click **Save**.



9 Under the **Background Questionnaire tab**, answer the 10 questions with 'yes' or 'no'.

**Note:** Some questions may require additional comments and documents.

When all questions are complete, click **Save**.

10 Under the **Insurance tab**, complete all required fields and use the **Upward Arrow to upload a copy of your E&O Insurance**.

**Note:** An error will pop up if the given value is less than \$1,000,000.

When finished, click **Save**.

11 Under the **Banking Information tab**, enter the required fields.

For **Payment Type**, pick **one** of the two below:

1. **ACH:** Enter a **Bank Routing Number, Bank Account**, and **Bank Account Type**.
2. **Check:** Enter the **address** the check should be mailed to.

**Then upload the following:**

- Completed W-9 document
- Copy of a voided check

When finished, click **Save**.

If you have any challenges or questions during this process, please call our Broker Services team at 1-855-456-3668, Monday to Friday, 9am-5pm. We are here to help.

General Licenses Background Questionnaire Insurance Banking Information **Certifications *Incomplete*** Medicare Agreement *Incomplete* Education

Please upload your current Annual CMS certification and enter your certification date.

Annual CMS Certificate AHIP.pdf  Certification Date \* 06/25/2019

Click the button below to save your progress. Once you are finished with your application, please click the button below.

**Save** **Submit**

12 Under the **Certifications tab**, upload a copy of your **AHIP Certification** and enter the **Certification Date**.

**Note:** You **cannot** proceed with the onboarding process without uploading a copy of your CMS Certificate.

When upload is complete, click **Save**.

If you have any challenges or questions during this process, please call our Broker Services team at 1-855-456-3668, Monday to Friday, 9am-5pm. We are here to help.

General Licenses Background Questionnaire Insurance Banking Information Certifications **Medicare Agreement *Incomplete*** Education

**Errors and Omissions Insurance**  
I have and maintain Errors and Omissions Insurance coverage with minimum amounts of \$1,000,000 per incident and \$1,000,000 in aggregate, or such other amounts as determined by Healthfirst. I shall provide Healthfirst upon request the certificates of insurance evidencing such coverage. I agree to provide Healthfirst with thirty (30) days prior written notice, or as reasonably practicable, of any modification, termination, or cancellation of such coverage.

**Section 1033 of the Violent Crime and Law Enforcement Act of 1994**  
I have not been convicted of any criminal felony involving dishonesty or breach of trust or been convicted of an offense under Section 1033 of the Violent Crime and Law Enforcement Act of 1994. I agree to immediately inform Healthfirst of any conviction of the types described in the preceding sentence.

I understand that if any of the information I provided is found to be incorrect or incomplete, it may be grounds for the termination of my appointment with Healthfirst and/or the immediate termination of my Healthfirst General Agent Agreement and/or Healthfirst Producer Agreement.

**Attestation**  
I certify and attest that my electronic signature below indicates my truthfulness and accuracy of the responses to the questions in this application and my agreement with the terms and conditions outlined in the certifications herein, as well as the terms and conditions contained within the Healthfirst General Agent Agreement and/or Healthfirst Producer Agreement, as applicable.

Signature \* John Doe  
(Signature must match the name given on the General tab: Maria Ocampo)

Maria Ocampo

Click the button below to save your progress. Once you are finished with your application, please click the button below.

**Save** **Submit**

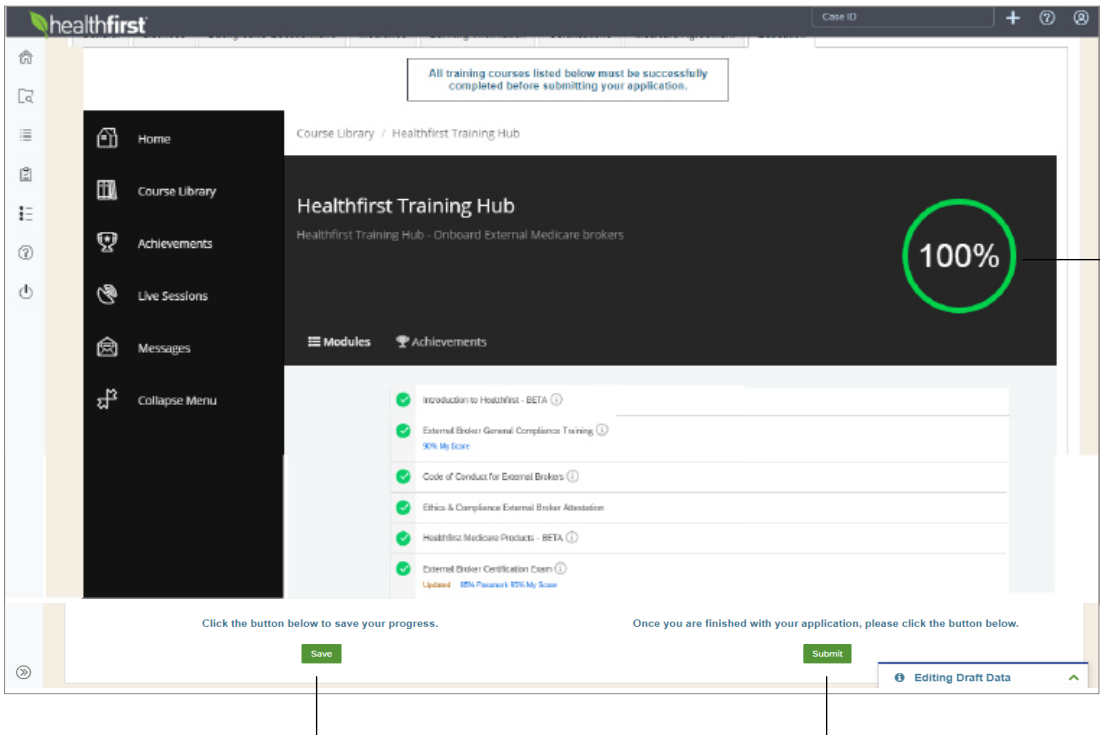
13 Under the **Medicare Agreement tab**, read and review the entire Healthfirst Medicare Advantage Producer Agreement.

Then type your name in the **Signature field**.

**Note:** The signature name must be identical to the name present in the general tab.

When finished, click **Save**.

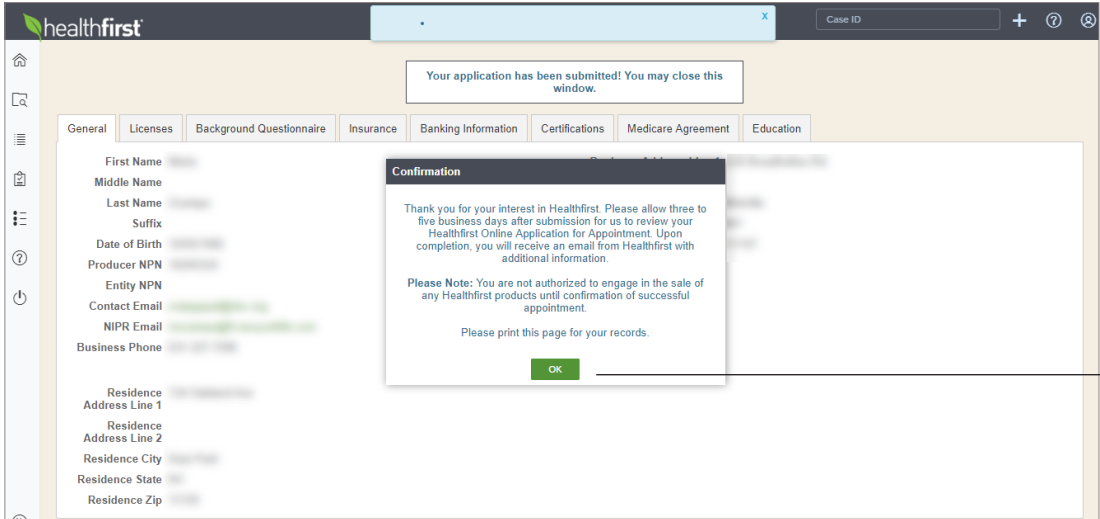




**14** Under the **Education tab**, complete six modules in LITMOS with a passing grade of 85% or higher.

**Note:** When all modules are complete, your progress bar will be 100%.

When finished, click **Save** and **Submit**.



**15** Our vendor, **Asurint**, will begin the background check once initiated. Please allow **three to five business days** for the email to appear.

Click **OK** to close the message.

If you have any additional questions regarding your onboarding application with Healthfirst, contact Broker Services, Monday to Friday, 9am-5pm, at 1-855-456-3668.

# Background Check

## Background Check Request

Dear XXXX XXXXX,

As a part of our onboarding process, you must successfully complete a background check. To make this quick and easy, Healthfirst - Sales requires that you complete an online information request. By providing this information electronically, it can be safely and securely transmitted to our background check vendor instantly, removing unnecessary delays and speeding the decision making process.

Please remember to do the following:

- Complete all fields in the online form located [here](#).
- Review your answers for accuracy and spelling.
- If you have any questions or special circumstances, you should contact Asurint at (800) 906-1674 or contact them at [support@asurint.com](mailto:support@asurint.com) before submitting the request.

Thank you,

1 You will receive an email from Asurint requesting a background check.

Click the link in the email, [here](#), to initiate background check.

Background Check Request

As part of the onboarding process, Healthfirst - Sales requests that you provide information for a background check. Please complete the following pages as accurately and completely as possible, and then submit the background check.

What We Do

How Long Will It Take

Next

2 This is the Asurint landing page. Click **Next** when ready to proceed.

**Healthfirst - Sales** healthfirst

Please enter the last four digits of your Social Security Number (SSN):

powered by  
**ASURINT**

**3** Enter the **last four digits of your Social Security Number**.  
Then click **Next**.

**Healthfirst - Sales** healthfirst

**Electronic Signature Consent - Please Read Carefully**

In connection with your background investigation for Healthfirst - Sales, you will be asked to complete online documents and receive legal notices electronically. During this process, you will be asked to electronically sign one or more of the online documents.

To provide an electronic signature, you must use the mouse to sign in the box on each form.

Once you finalize your electronic signature, click the **Accept** button. If you do not agree to sign the document electronically, click the **Decline** button.

If you need to make changes to the information previously entered regarding your electronic signature, click the **Previous** button on the bottom left of the page and resubmit the information. Once the signature process is complete, your electronic signature will be binding, as if you had physically signed the document by hand. You may print a copy of any document from your browser.

Click [here](#) for hardware/software requirements needed to access and retain the electronic records related to your application (including the documents you signed).

If at any point you would like to withdraw your electronic signature consent, update your email address, or receive a free copy of the documents you signed, please contact the Asurint Compliance Department using the information below. Proper identification will be required before such information is provided.

Contact Information:  
Asurint Compliance Department  
P.O. Box 14730  
Cleveland, OH 44114  
(800) 906-2034  
[compliance@asurint.com](mailto:compliance@asurint.com)

**NOTE:** Any withdrawal of consent will be effective as of the date the request is received.

If you consent to provide an electronic signature (rather than a wet signature) in connection with your background investigation, complete the Authorization for Electronic Signature below.

**Authorization for Electronic Signature**

I understand that by completing the required fields and selections below and clicking the **Accept** button, I agree to use an electronic mouse signature to sign documents and to receive electronic notices.

I also understand that my electronic signatures will be binding as though I had physically signed these documents by hand. I agree that any printout of a document using an electronic signature is accepted with the same authority as the original.

**First Name \***

**Last Name \***

**Date of Birth \***

**Email a Copy? \***  No  Yes

Date Completed

**4** Complete the **Electronic Signature** by entering your information and click **Accept**.  
Once this is finished, click **Next**.

**Healthfirst - Sales**

**Applicant Background Check**  
To complete the background check request, fill out the fields with accurate and complete information. Click the Next button to proceed.

**Applicant Information**

Applicant Information

First Name \*

I do not have a Middle Name

Middle Name \*

Last Name \*

Social Security Number \*

Confirm Social Security Number \*

Date of Birth \*

Gender \*

This field is required.

Phone Number

I do not have an Email Address

Email Address \*

Address History

Previous Save and Exit Next

ASURINT

5 Enter your information in the required fields.

When finished, click Next.

**Healthfirst - Sales**

**DISCLOSURE REGARDING BACKGROUND INVESTIGATION**

Healthfirst - Sales ("the Company") may obtain information about you from a third party consumer reporting agency for employment purposes. This, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report is an employment history or verification. These searches will be conducted by Asurint, P.O. Box 14730, Cleveland, OH 44114, 800-996-1674, [www.asurint.com](http://www.asurint.com). The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your employment to the extent permitted by law.

Page 1 of 1  
End of Document



Sign and click the Accept button.

- If using a mouse, place the cursor in the box and with the left mouse button held down, use your mouse like a pen to sign your name, making sure to stay in the box.
- If using a laptop, hold down the left selection button and use your finger on the trackpad to sign.
- If you are using a mobile device, you can sign in the signature block with finger or stylus.

Clear Accept Decline

Previous Save and Exit Next

ASURINT

6 Review the information, sign the Disclosure Agreement, and click Accept.

Once the signature is submitted, click Save and Exit.

**Note:** Once this is complete, you will receive a confirmation email from Asurint.



Dear John Smith,

We're pleased to inform you that your Healthfirst broker appointment application has been approved. **Congratulations, you're now appointed to sell Healthfirst health insurance plans.**

To get started, be sure to **visit the secure [Healthfirst Broker Portal](#) today to create your online account.** There you can manage or update your client list, check the status of your commissions, get more details about Healthfirst health plans, find additional sales tools, and much more.

We're committed to providing our members with what they've come to expect from us—the best in quality and service. Thank you for being a part of our important mission.

We look forward to working with you.

Sincerely,

Healthfirst Broker Services

Coverage is provided by Healthfirst Health Plan, Inc., Healthfirst PHSP, Inc., and/or Healthfirst Insurance Company, Inc. (together, "Healthfirst"). Coverage for Senior Health Partners, Managed Long-Term Care Plan, is provided by Healthfirst PHSP, Inc.

© 2019 HF Management Services, LLC 0295-19 HFIC19\_17d GEN19\_92 0295-19\_C

7 If your application was approved, you will **receive an email from Healthfirst** with more information.

To get started, **click on the link in the email.**

# Recontracting

Thank you for working with Healthfirst. We require renewal of your **License, Errors & Omissions Insurance, Annual AHIP Certification, and Annual Product Knowledge Training** to maintain your appointment.

**Note:** All renewals must be **completed online**; they will not be accepted via email.

Dear Robert,

We're writing to let you know that your broker license will **expire in 90 days**.

You must have a current and active New York State license to engage in the sale of Healthfirst insurance products, consistent with the terms of your agreement with Healthfirst.

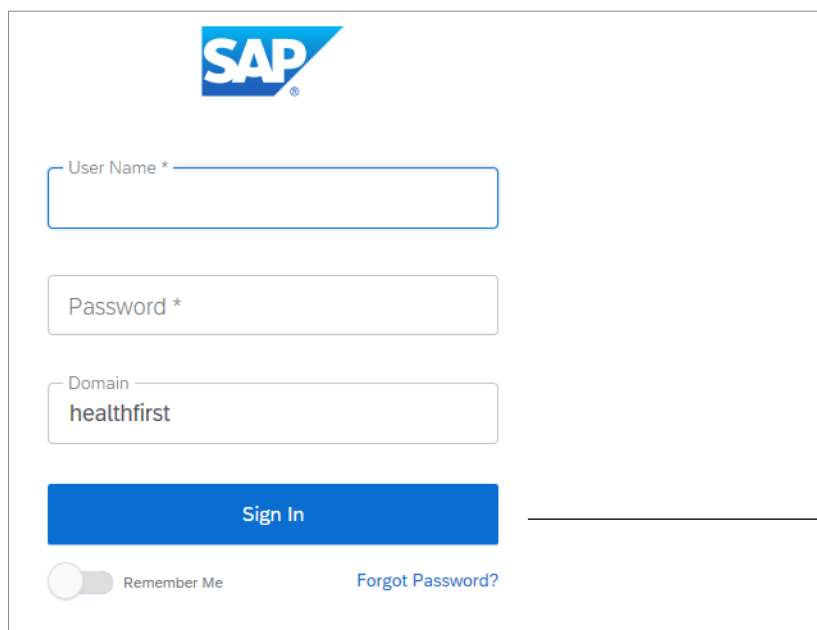
**Failure to update your license will result in the termination of your appointment with Healthfirst and possible forfeiture of your commissions.**

Please update your information as soon as possible by logging in to **your secure account**.

**Download** our step-by-step guide through the license renewal process.

If you have any questions about this information or believe you have received this message in error, please contact Broker Services at 1-855-456-3668, Monday to Friday, 9am–5pm.

1 You will receive **Automated Email Notification**. Click **Your Secure Account** link to log in to SAP.



SAP

User Name \*

Password \*

Domain  
healthfirst

Sign In

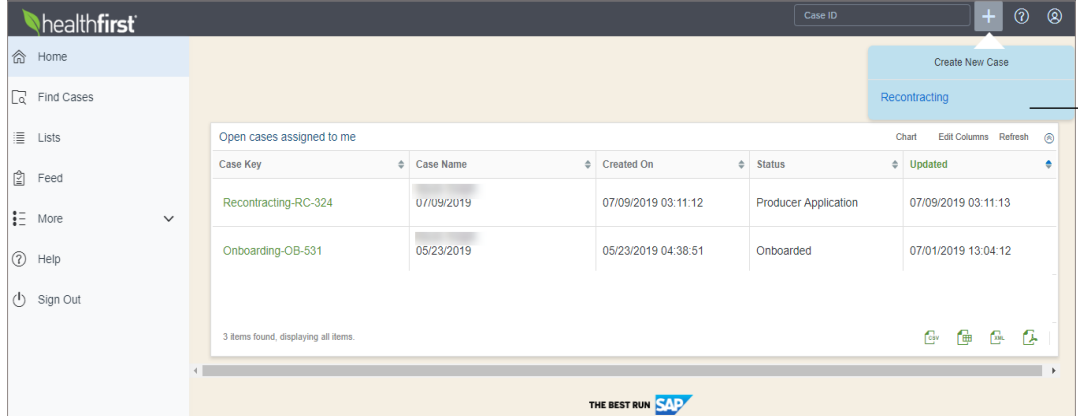
Remember Me

[Forgot Password?](#)

2 Log in to your account.

**Note:** Username is the email where the notification was received.

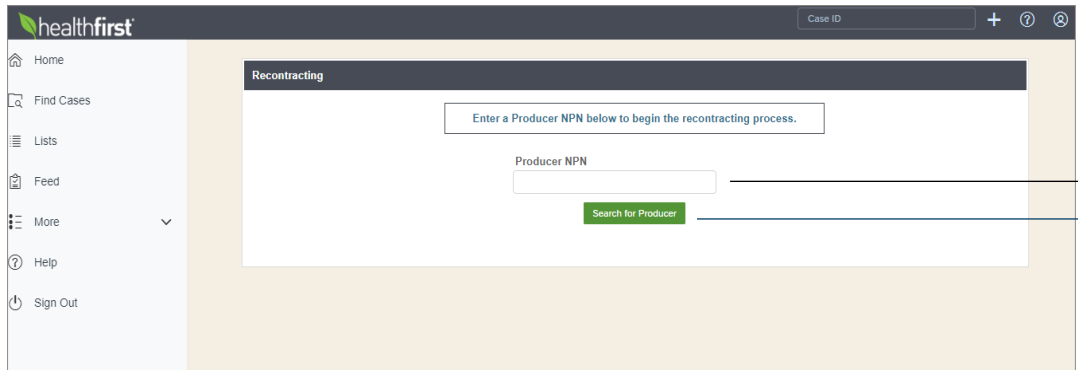
# License & Insurance



3 Click on the **plus sign symbol** on the upper right corner of the screen.

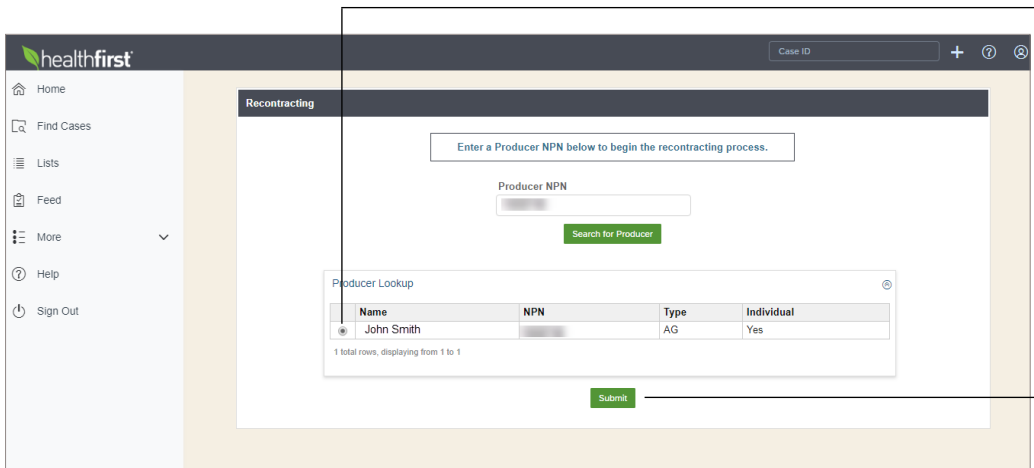
Then select **Recontracting**.

Case Key	Case Name	Created On	Status	Updated
Recontracting-RC-324	07/09/2019	07/09/2019 03:11:12	Producer Application	07/09/2019 03:11:13
Onboarding-OB-531	05/23/2019	05/23/2019 04:38:51	Onboarded	07/01/2019 13:04:12

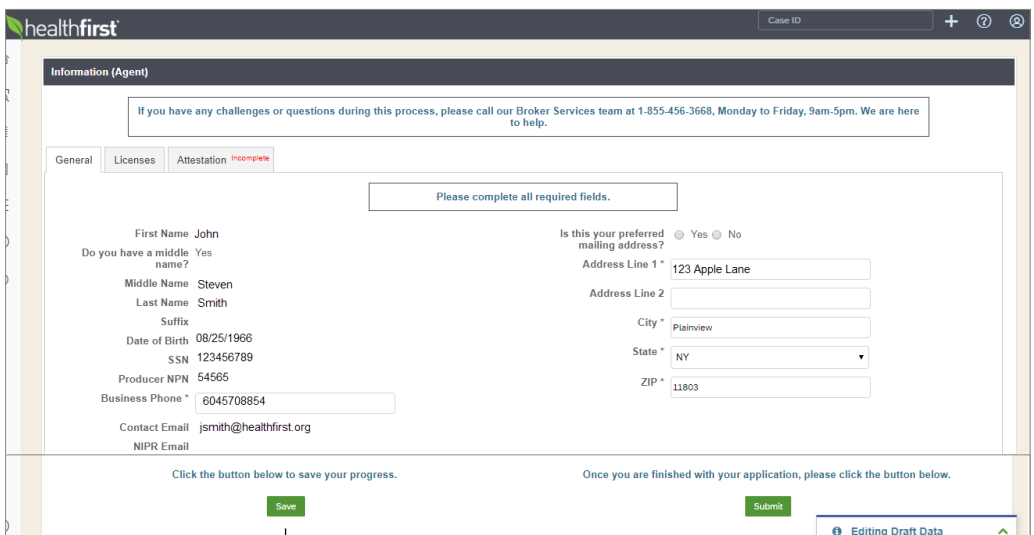


4 Enter **Agent or Agency NPN**.

Then click **Search for Producer** to retrieve the NPN details.



5 Under **Producer Lookup Information**, select the name.  
Then click **Submit**.



6 A Recontracting case has been created.  
Under the **General tab**, enter the **required fields**.  
When finished, click **Save**.



healthfirst Case ID

Information (Agent)

If you have any challenges or questions during this process, please call our Broker Services team at 1.855.456.3668, Monday to Friday, 9am-5pm. We are here to help.

General Licenses **Attestation Incomplete**

Your active licenses according to NIPR are shown below. You must select the licenses you wish to do business under.

NIPR Active Licenses

Select All

License State	License Number	License Class	License LOA	Effective Date	Expiration Date	Residency Status
<input checked="" type="checkbox"/>		Life/accident & Health	14 - Accident & Health			R

1 total rows, displaying from 1 to 1

DB Licenses

License State	License Number	Effective Date	Expiration Date	Active
NY				Yes
NY				Yes

Click the button below to save your progress. Once you are finished with your application, please click the button below.

**Save** **Submit**

Editing Draft Data

7 Under the **License tab**, select the updated License details. (License renewal)

Then **upload a copy of the license listed**.

When finished, click **Save**.

General **Insurance Incomplete**

Please provide your E&O insurance information below. Healthfirst requires that you have a \$1,000,000 per occurrence and \$1,000,000 per aggregate to be appointed with us.

Insurance Name \*  [required]

Policy Number \*  [required]

Effective Date \*  [required]

Expiration Date \*  [required]

Per Occurrence Limit \*

Aggregate Limit \*

E&O Upload

Click the button below to save your progress. Once you are finished with your application, please click the button below.

**Save** **Submit**

Editing Draft Data

8 Under the **Insurance tab**, enter **Insurance Information** (Insurance renewal).

Then **upload a copy of Errors & Omissions Insurance** with \$1,000,000 limits and other required fields.

When finished, click **Save**.

healthfirst Case ID

General Licenses **Attestation** *Incomplete*

Please sign the following agreement.

Certification

I hereby certify that I have read and understand the items on this form and that my answers are true and complete to the best of my knowledge. I have been advised that Healthfirst or any of its affiliated companies (Company), agents or subcontractors, may conduct investigations in connection with my request to represent the Company in the solicitation of Company products as described in the Healthfirst General Agent Agreement and/or Healthfirst Producer Agreement. I hereby consent to the Company requesting and obtaining all information as discussed in this application and for all such reports to be requested by and provided to the Company. I understand that a routine inquiry may be made as a requirement for state appointment and/or appointment with Company. If applicable, the Company may obtain reports from a consumer reporting agency, an investigation report or inquiries from a State Insurance Department. Any information that the Company obtains about me will be treated as confidential.

In signing this application I certify that I have not been convicted of any criminal felony involving dishonesty or breach of trust or been convicted of an offense under section 1033 of the Violent Crime and Law Enforcement Act of 1994. I further agree to immediately inform Company of any conviction of the types described in the preceding sentence. I agree to abide by the any applicable commissions disclosure requirements mandated by the State of New York. I understand and agree to follow the guidelines of Company's HIPAA Privacy Guidelines which are referenced in the Healthfirst General Agent Agreement and/or Healthfirst Producer Agreement.

I understand that if any of the information I provided is found to be incorrect or incomplete, it may be grounds for non-appointment or my immediate termination at the discretion of the Company.

My typed signature signifies my truthfulness and accuracy of the responses to the questions in this application as well as my agreement to the terms and conditions of the Healthfirst General Agent Agreement and/or Healthfirst Producer Agreement, as applicable.

Signature \* John Steven Smith

Click the button below to save your progress. Once you are finished with your application, please click the button below.

Save Submit

Auto-save not successful. Input not valid

9 Under the **Attestation tab**, type your signature.

**Note:** Signature must be identical to the signature used in the General tab (case sensitive).

When finished, click **Save**. Then click **Submit**.

healthfirst Case ID

General **Licenses** Attestation

Your application has been submitted! You may close this window.

First Name John  
Middle Name Steven  
Last Name Smith  
Suffix  
Date of Birth 08/25/1966  
Producer NPN 123456  
Entity NPN 123456  
Contact Email jsmith@healthfirst.org  
NIPR Email  
Business Phone 6045708854

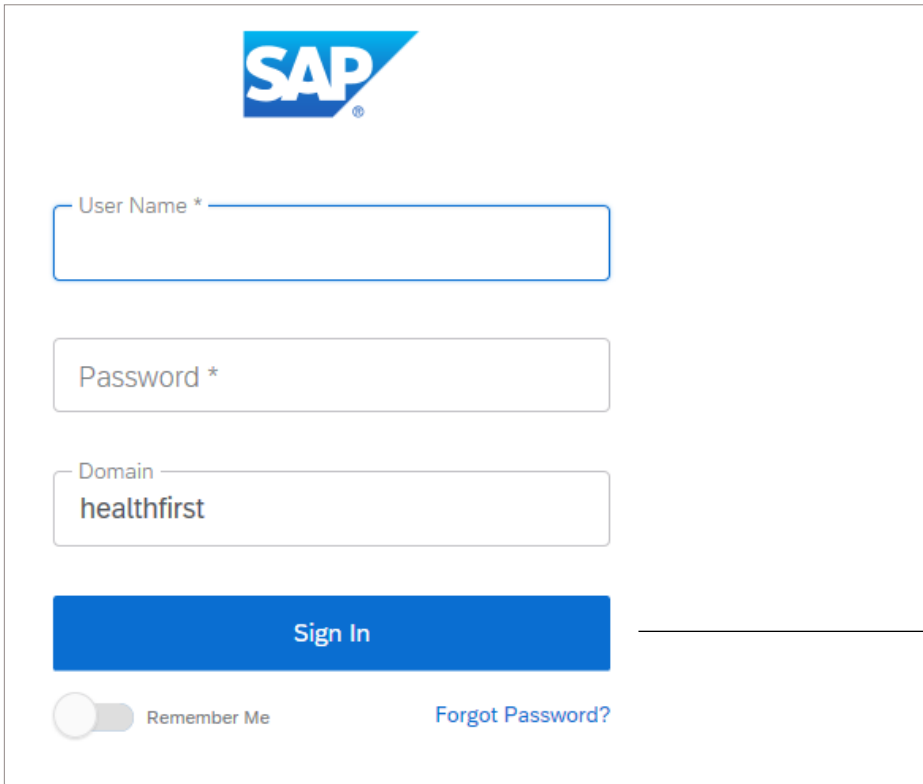
Business Address Line 1 123 Orange Lane  
Business Address Line 2  
Business City Woodbury  
Business State NY  
Business Zip 11797

Residence Address Line 1 123 Apple Lane  
Residence Address Line 2  
Residence City Plainview  
Residence State NY  
Residence Zip 11803

10 Your **Recontracting Case** was submitted successfully.

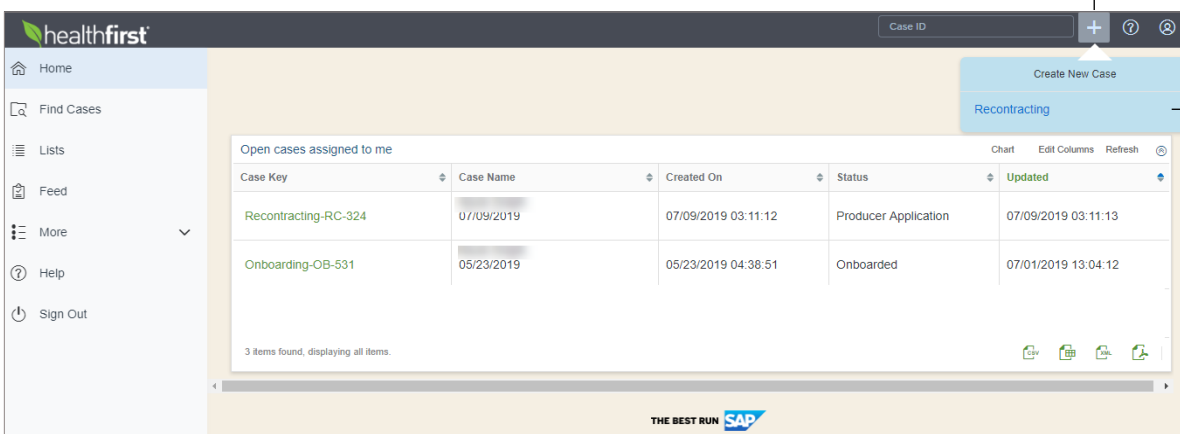
**Note:** A Commission Analyst will review your application within 1-5 business days. You may check in on your renewal anytime. Once it appears as "Closed", your renewal was successfully updated.

# AHIP Certification



The image shows the SAP login interface. At the top center is the SAP logo. Below it are three input fields: 'User Name \*', 'Password \*', and 'Domain'. The 'Domain' field contains the text 'healthfirst'. Below the input fields is a blue 'Sign In' button. At the bottom left is a 'Remember Me' toggle switch, and at the bottom right is a 'Forgot Password?' link.

1 Log in to your account.

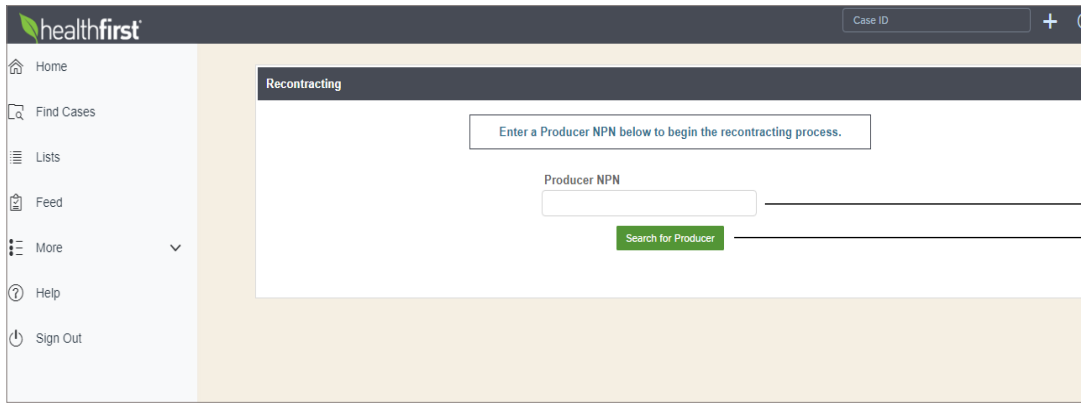


The image shows the HealthFirst dashboard. On the left is a navigation menu with options: Home, Find Cases, Lists, Feed, More, Help, and Sign Out. The main content area displays a table titled 'Open cases assigned to me'. The table has columns for Case Key, Case Name, Created On, Status, and Updated. There are two rows of data. In the top right corner of the dashboard, there is a 'Create New Case' button with a plus sign icon. A dropdown menu is open below it, showing the option 'Recontracting'.

Case Key	Case Name	Created On	Status	Updated
Recontracting-RC-324	07/09/2019	07/09/2019 03:11:12	Producer Application	07/09/2019 03:11:13
Onboarding-OB-531	05/23/2019	05/23/2019 04:38:51	Onboarded	07/01/2019 13:04:12

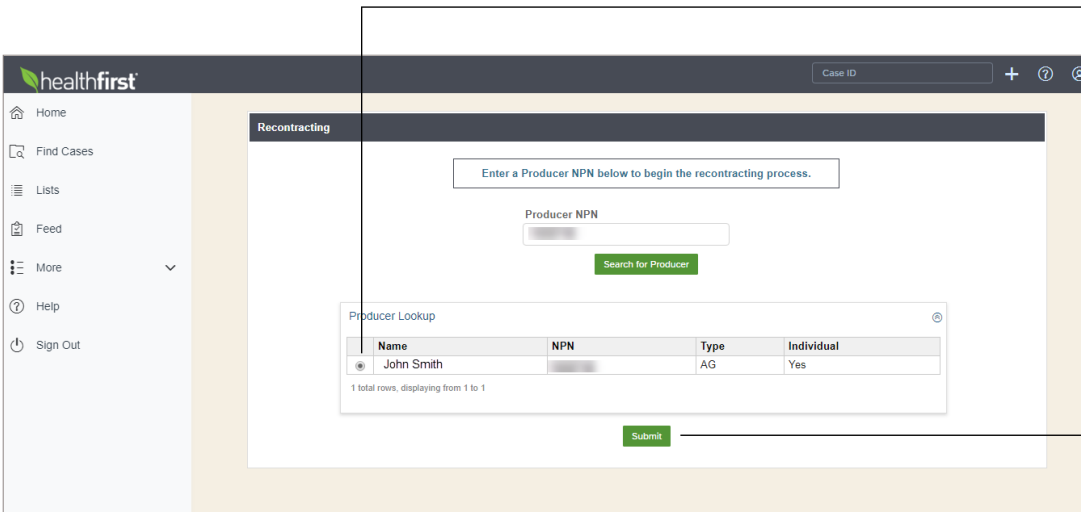
2 Click on the **plus sign symbol** on the upper right corner of the screen.

Then select **Recontracting**.



3 Enter **Agent NPN**.

Then click **Search for Producer** to retrieve the NPN details.



4 Under **Producer Lookup Information**, select the name.

Then click **Submit**.

healthfirst Case ID

Information (Agent)

If you have any challenges or questions during this process, please call our Broker Services team at 1-855-456-3668, Monday to Friday, 9am-5pm. We are here to help.

General Attestation Certifications

Please complete all required fields.

First Name  
Do you have a middle name?  
Last Name  
Suffix  
Date of Birth  
SSN  
Producer NPN  
Business Phone \*  
Contact Email  
NIPR Email

Is this your preferred mailing address?  Yes  No

Address Line 1 \*  
Address Line 2  
City \*  
State \* NY  
ZIP \*

Additional Addresses

Click the button below to save your progress. Once you are finished with your application, please click the button below.

Save

Editing Draft Data

5 Under the **General tab**, enter the **required fields**.

When finished, click **Save**.

healthfirst Case ID

Information (Agent)

If you have any challenges or questions during this process, please call our Broker Services team at 1-855-456-3668, Monday to Friday, 9am-5pm. We are here to help.

General Attestation **Incomplete** Certifications **Incomplete**

Please sign the following agreement.

Certification

I hereby certify that I have read and understand the items on this form and that my answers are true and complete to the best of my knowledge. I have been advised that Healthfirst or any of its affiliated companies (Company), agents or subcontractors, may conduct investigations in connection with my request to represent the Company in the solicitation of Company products as described in the Healthfirst General Agent Agreement and/or Healthfirst Producer Agreement. I hereby consent to the Company requesting and obtaining all information as discussed in this application and for all such reports to be requested by and provided to the Company. I understand that a routine inquiry may be made as a requirement for state appointment and/or appointment with Company. If applicable, the Company may obtain reports from a consumer reporting agency, an investigation report or inquiries from a State Insurance Department. Any information that the Company obtains about me will be treated as confidential.

In signing this application I certify that I have not been convicted of any criminal felony involving dishonesty or breach of trust or been convicted of an offense under section 1033 of the Violent Crime and Law Enforcement Act of 1994. I further agree to immediately inform Company of any conviction of the types described in the preceding sentence. I agree to abide by the any applicable commissions disclosure requirements mandated by the State of New York. I understand and agree to follow the guidelines of Company's HIPAA Privacy Guidelines which are referenced in the Healthfirst General Agent Agreement and/or Healthfirst Producer Agreement.

**I understand that if any of the information I provided is found to be incorrect or incomplete, it may be grounds for non-appointment or my immediate termination at the discretion of the Company.**

My typed signature signifies my truthfulness and accuracy of the responses to the questions in this application as well as my agreement to the terms and conditions of the Healthfirst General Agent Agreement and/or Healthfirst Producer Agreement, as applicable.

Signature \* John Smith

Click the button below to save your progress. Once you are finished with your application, please click the button below.

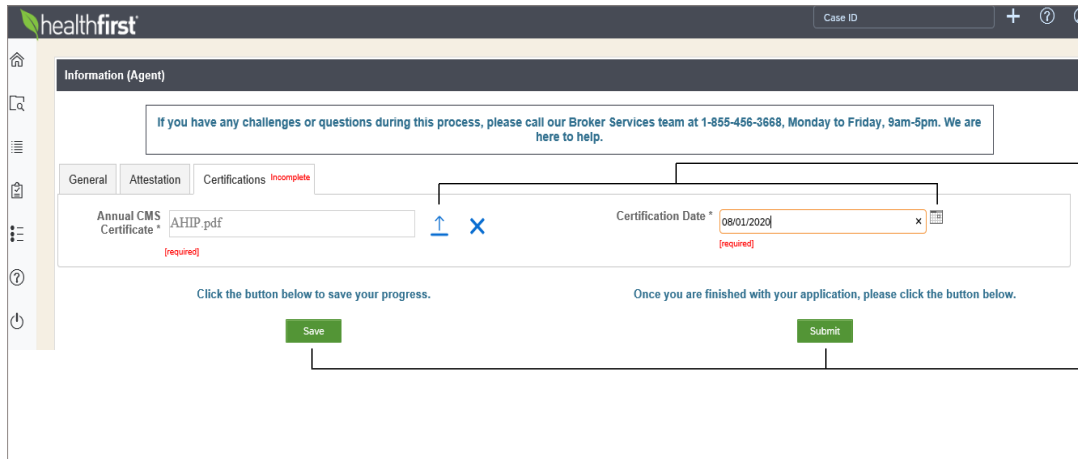
Save

Editing Draft Data

6 Under the **Attestation tab**, type your **signature**.

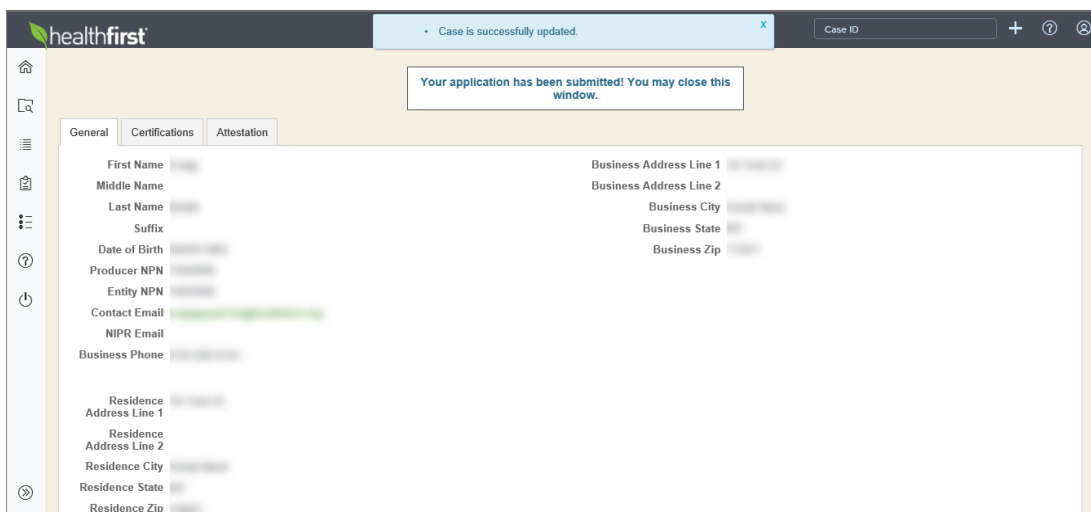
**Note:** Signature must be identical to the signature used in the General tab (case sensitive).

When finished, click **Save**.



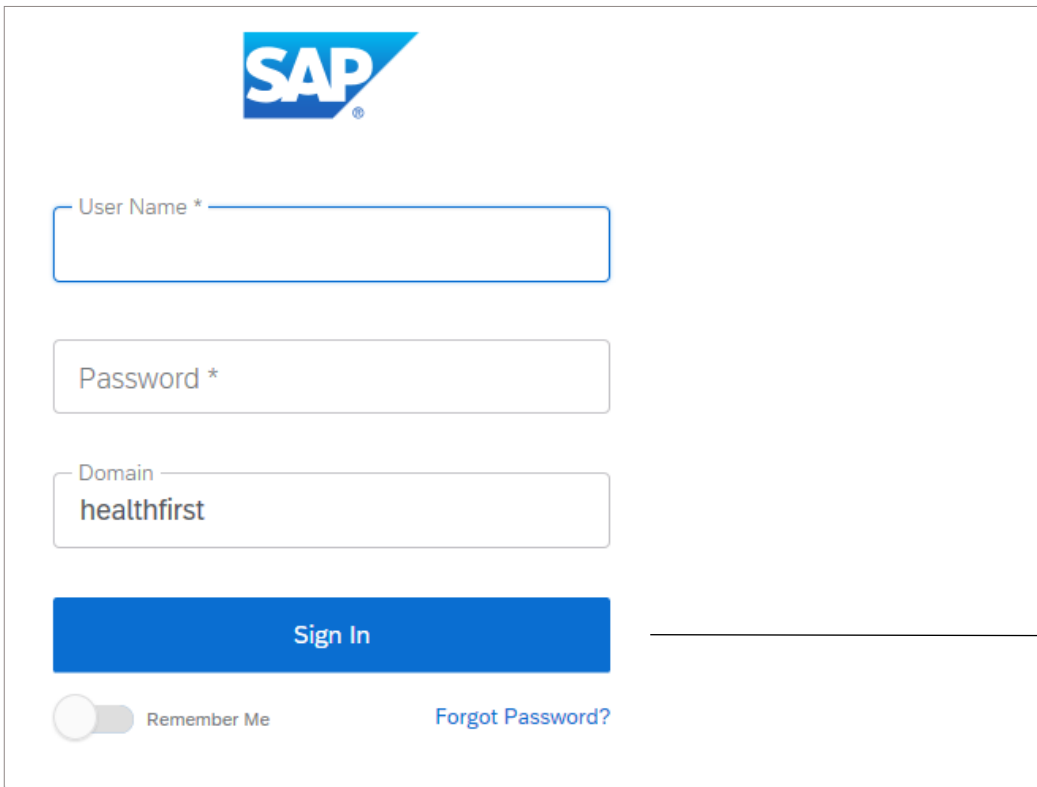
7 Under the **Certifications tab**, upload a copy of your **AHIP Certification** and enter the **Certification Date**.

When upload is complete, first click **Save**, then click **Submit**.



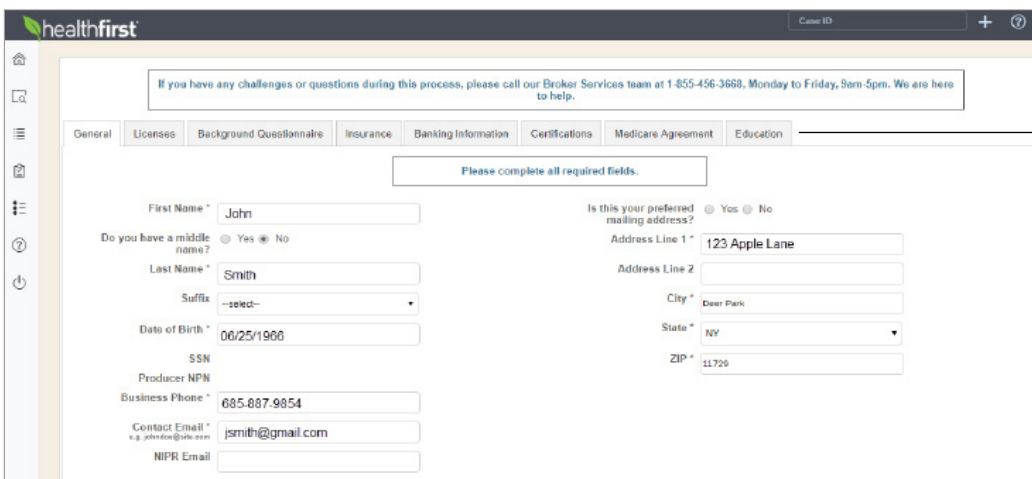
8 Your AHIP Certification has been successfully submitted.

# Healthfirst Product Training



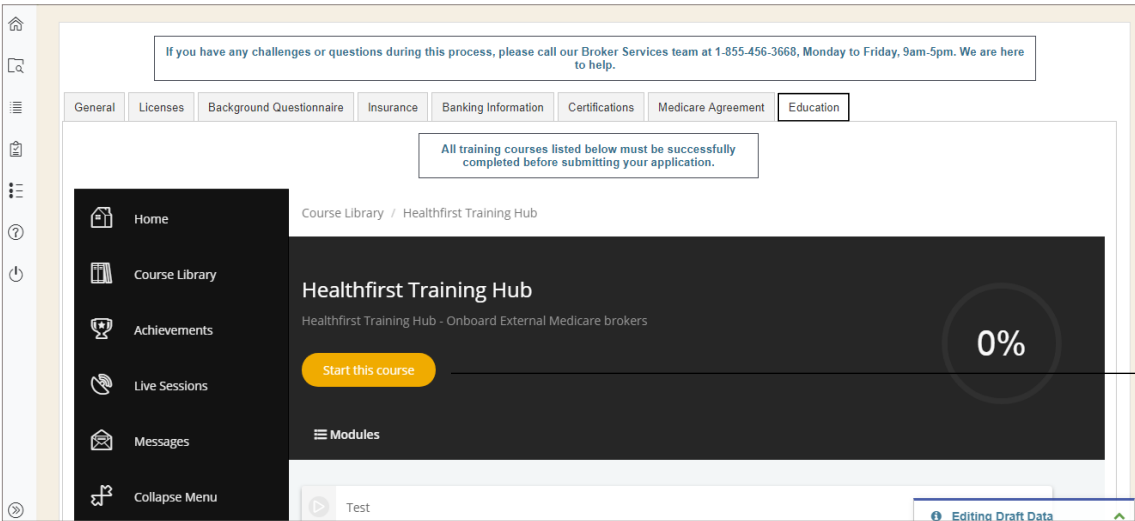
The image shows the SAP login interface. At the top center is the SAP logo. Below it are three input fields: "User Name \*" (empty), "Password \*" (empty), and "Domain" (containing "healthfirst"). A blue "Sign In" button is positioned below the password field. At the bottom left, there is a "Remember Me" toggle switch (currently off) and a "Forgot Password?" link.

1 Log in to your account and access the [Healthfirst Training Hub](#).

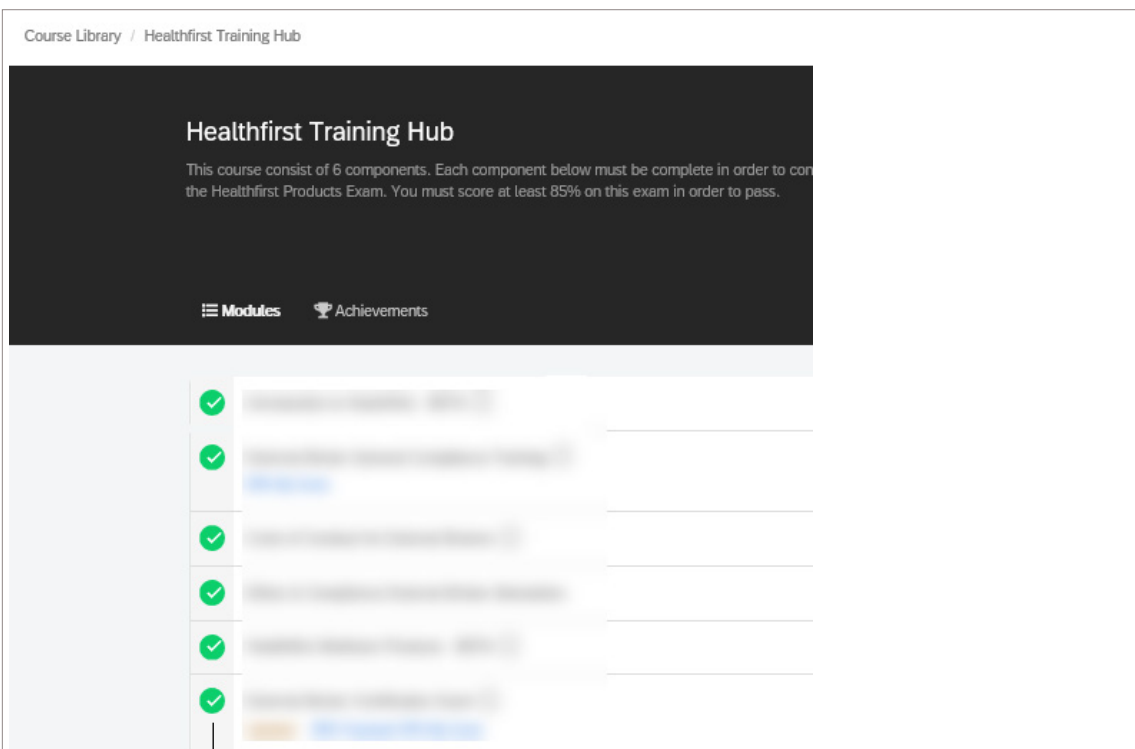


The image shows the Healthfirst profile management interface. At the top left is the "healthfirst" logo. A navigation bar contains tabs for "General", "Licenses", "Background Questionnaire", "Insurance", "Banking Information", "Certifications", "Medicare Agreement", and "Education". The "Education" tab is selected. A message box at the top reads: "If you have any challenges or questions during this process, please call our Broker Services team at 1-855-456-3668, Monday to Friday, 9am-5pm. We are here to help." Below this is a "Please complete all required fields." warning. The form contains several fields: "First Name" (John), "Last Name" (Smith), "Suffix" (dropdown), "Date of Birth" (06/25/1968), "SSN", "Producer NPN", "Business Phone" (685-887-9854), "Contact Email" (jsmith@gmail.com), "NIPR Email" (empty), "Is this your preferred mailing address?" (radio buttons), "Address Line 1" (123 Apple Lane), "Address Line 2" (empty), "City" (Deer Park), "State" (NY), and "ZIP" (11729).

2 Click on the **Education tab**.



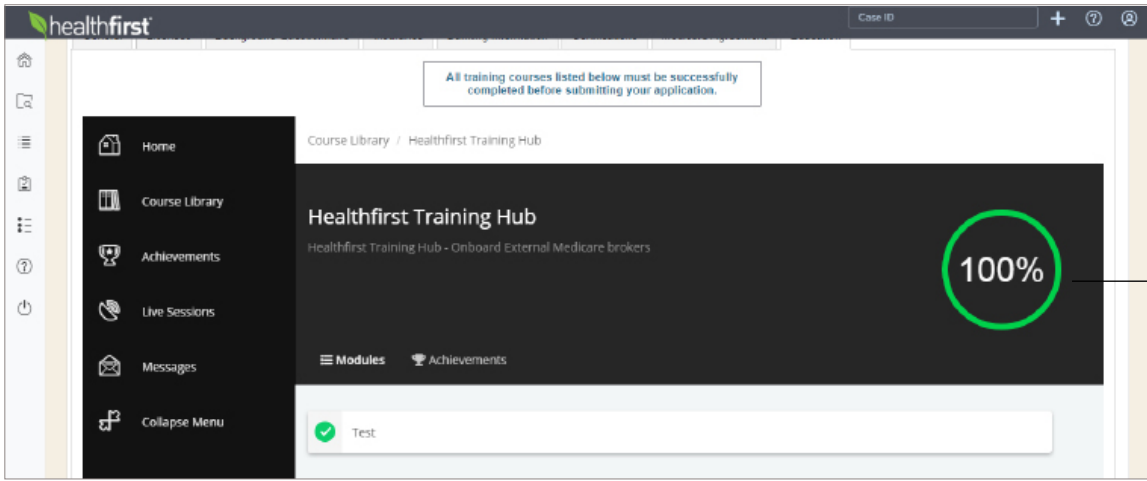
3 Under the **Education tab**, click **Start This Course** to begin.



4 Complete all six modules with a passing grade of 85% or higher.

**Note:** A module is complete when a green check mark appears next to the title.





5 When all modules are complete, your progress bar will be 100%.





This document is a representation of the Medicare broker onboarding and recontracting process and is subject to change. Healthfirst is the brand name used for products and services provided by one or more of the Healthfirst group of affiliated companies.