NA CCP/PDP 2021 <Centene> Teledigital Inbound Enrollment Script

Text Color Key
Blue Text = Representative to Customer
Black Bold Italics = Representative Conditional Statements ("If Statements")
Black Italics = Representative Actions
Red Text and/or < > = Variable Information
<< >> = Content that may be removed, depending on version

Purpose:
This script is intended to be used when an inbound caller requests to complete a telephonic enrollment into a <Centene> <Medicare Advantage> <Medicare Prescription Drug> Plan. This script is initiated if the caller has identified the plan in which they want to enroll, and is for the purpose of completing the telephonic application.

ENROLLMENT INSTRUCTIONS

Late Enrollment Penalty Reminder

If beneficiary is leaving an MA-only plan or enrolling into an MA-only plan with no credible prescription drug coverage, explain to the beneficiary the late enrollment penalty for not having prescription drug coverage.

Buy Up Option Reminder

If a plan offers optional benefit buy up package(s), review the buy up package(s) and premium amount(s) and ask if he/she would like to add the buy-up package.

INTRODUCTION REQUIRED STATEMENTS

Are you continuing from the inbound sales presentation?

IF YES:	*IF NO:*
As we move to the enrollment portion of this call, I'd like to remind you that this call is being monitored and recorded for quality assurance do I have your permission to continue recording? ***If No,*** *end enrollment. State:* I'm sorry, however CMS requires that all calls are recorded and monitored and without your consent I will not be able to continue. You may complete a self-enrollment through **<<**the <Plan Name>'s website or**>>** Medicare's website at www.medicare.gov.	*Continue*

Was call transferred from a different agent? (If warm transfer make note of plan selected and SEP to be used.)

IF YES:	*IF NO:*
Hello, my name is <agents name> with Diversified Health and I am a licensed agent in the state of <applicant's state> and appointed by <plan name>. This call is being monitored and recorded for quality assurance, may I have your permission to continue? ***If No,*** *end enrollment. State:* I'm sorry, however CMS requires that all calls are recorded and monitored and without your consent I will not be able to continue. You may complete a self-enrollment through **<<**the <Plan Name>'s website or**>>** Medicare's website at www.medicare.gov.	*Continue*

Has selected plan name been provided?

IF YES:	*IF NO:*
Continue	*Request plan name and zip code.*

We can only have one sales agent present. Is there another sales agent with you right now?

IF YES:	*IF NO:*
The rules that govern the Medicare program do not allow me to complete an application when a sales agent is physically present or on the phone. If you would like to proceed, please call me back at <1-800-662-2901> (TTY 711), <Monday-Thursday 9-6, Friday 9-3:30 Eastern Standard Time when the licensed sales agent is no longer present if you'd like to enroll. Thank you for calling. *End call*	*Continue*

You are not required to provide health related information unless this information is needed to determine your eligibility to enroll in the plan. If you choose not to provide the requested health information, you may not be able to enroll in the plan. Do I have your permission to submit your enrollment to CMS?

IF YES:	*IF NO:*
Continue	*Advise the caller that it is a requirement to complete the enrollment. If the caller refuses to provide permission to submit the enrollment, end the enrollment.*

Do you, < Enrollee first, <<middle initial>>, and last name > understand you are requesting enrollment into < Plan Name >, <<with additional buy-up option >>, a Medicare Advantage <HMO, HMO-POS, PPO, PFFS, DSNP, PDP > plan?

IF YES:	*IF NO:*
Continue	*Offer explanation of the telephonic enrollment process. If the caller continues to not understand, advise that you cannot complete the telephonic enrollment and provide information for alternate methods of enrollment. End call.*

Diversified Health is a licensed and certified representative of < plan name > and may be compensated when enrolling you into this plan.

P.O.A OR AUTHORIZED REPRESENTATIVE

Are you completing this application for yourself?

IF YES:	*IF NO:*
Skip to Demographic Information	*Continue*

Can you confirm that you are authorized under state law to complete the enrollment request for <beneficiary name>? This means that you have Durable Power of Attorney for health care decisions, or are a Court Ordered Legal Guardian, authorized to make health care decisions under State Surrogate Consent Laws, and you can provide proof of authorization upon Medicare's request.

IF YES:	*IF NO:*

<table>
<tr><td></td><td>
<table>
<tr><td>Continue</td><td>Advise that we cannot complete the telephonic enrollment at this time and provide information for alternate methods of enrollment. End call.</td></tr>
</table>

Please provide your Name, address, phone number and relationship to the beneficiary for our records.

Once provided, thank them and continue the script (for POA substitute Member's Name in all places where applicable).</td></tr>
<tr><td>DEMOGRAPHIC INFORMATION</td><td>Obtain or confirm Medicare and demographic information. Confirmation of data already provided is acceptable as along as HIPAA has been verified.

Please state your full name as it appears on your red, white and blue Medicare card.

Please state your sex.

What is your date of birth?

Would you like to provide an email address? Please know that by providing your email address, you are agreeing to receive emails from <plan name>. They will give you the opportunity to opt in and you may opt out of future email communications. If Yes, state. May I have your email address please?

What is your telephone number?

May I have your complete permanent home address including your city, state, zip code, and county?
PO box not permitted) If homeless, a Post Office Box, an address of a shelter or clinic, or the address where the individual receives mail (e.g. social security checks) may be considered the place of permanent residence.

Do you have a mailing address that is different from your permanent home address?
If Yes, state: May I have the alternate address including your city, state, zip code, County?

Would you like to provide an emergency contact? If yes, capture name, phone and relationship

<<Skip if PDP only plan>> Would you like to provide me with the name of your Primary Care Physician?</td></tr>
</table>

IF YES:	*IF NO:*
State: Please state the name of your PCP. *Look up the requested physician to capture the PCP ID.* *Ask:* Are you a current patient? ***If the requested PCP is not available,*** *state:* The PCP you selected is not part of this plan. Would you like me to help you select another or would you like the plan to select one for you?	*State:* If you need a PCP and do not choose one now, the plan may select one for you, but you can change doctors at any time by calling the plan.

May I have your Medicare number as shown on your red, white and blue Medicare card? *Repeat Medicare number back to beneficiary to confirm accuracy of data entered.*

If MA/MAPD plan*, state:* You need to be entitled to Medicare Part A **and** be enrolled in Medicare Part B to enroll in this plan. May I please have the Part A and Part B effective dates as they appear on your card?
Were Part A and B dates provided?

IF YES:	*IF NO:*
Continue	*State:* I'm sorry, but you cannot enroll in this plan since you must have Medicare Part A and Part B.

<<If PDP plan, *state:* You must have Medicare Part A **or** Part B or both to enroll in this plan. May I please have the Part A and/or Part B effective dates as they appear on your card?**>>**
<<*Was Part A or B date provided?****>>***

IF YES:	*IF NO:*
Continue	***<<****State:* I'm sorry, but you cannot enroll in this plan since you must have Medicare Part A or Part B.**>>**

ELECTION PERIOD

If outside of Annual Election Period (AEP), has SEP already been determined?

IF YES:	*IF NO:*
Continue to Late Enrollment Penalty section.	Typically, you may enroll in a <Medicare Advantage Plan / Prescription Drug Plan> only during the Annual Enrollment Period from

	October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. I will ask you some questions to see if we can establish an enrollment period for you. Please respond with 'Yes' or 'No' if any apply to you. By stating 'Yes' to any of the following you are certifying that, to the best of your knowledge, you are eligible for that enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

Start at the top of the following list, and continue asking questions until a SEP is determined. Once determined continue.

Are you new to Medicare?

Are you enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP)?

Have you recently moved outside of your plan's service area or have you moved and this plan is a new option? ***If yes***, what was the date?

Have you recently been released from incarceration? ***If yes***, what was the date?

Have you recently returned to the United States after living permanently outside of the United States? ***If yes***, what was the date?

Have you recently obtained lawful presence status in the United States? ***If yes,*** what date did you obtain this status?

Have you recently had a change in your Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid)? ***If yes,*** what date was this change?

Have you recently had a change in your Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help)? ***If yes,*** what date was this change?

	Do you have both Medicare and Medicaid or is your state helping to pay for Medicare premiums or do you get Extra Help paying for your Medicare prescription drug coverage, but you haven't had a change ? Are you moving into, live in, or recently moved out of a Long Term Care Facility (example, nursing home)? ***If yes***, as of what date? Have you recently left a Program of All-Inclusive Care for the Elderly (PACE)? ***If yes,*** when did you leave? Have you recently involuntarily lost creditable prescription drug coverage (as good as Medicare's)? ***If yes,*** what was the date? Are you losing or leaving coverage you had from an employer or union? ***If yes,*** What was the date? Do you belong to a pharmacy assistance program provided by your state? Were you enrolled in a plan by Medicare (or your state) and you want to choose a different plan? ***If yes,*** what date did your enrollment in that plan start on? Is your plan ending its contract with Medicare or is Medicare ending its contract with your plan? Were you affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to you, but you were unable to make my enrollment because of the natural disaster. Did you have Medicare prior to now, but are now turning 65? In the last 12 months, did you join a Medicare Advantage plan with prescription drug coverage when you turned 65? Are you enrolling in a 5-star Medicare plan? Were you enrolled in a plan placed in receivership? Were you in a plan identified by CMS as a Consistent Poor Performer?

<table>
<tr><td></td><td>If MA/MAPD only, ask: Were you enrolled in a Special Needs Plan but have lost the Special Needs qualification requirement to be in that plan? If yes, when?

Is there another reason not mentioned above that makes you eligible to enroll at this time? If yes, What is the other reason?</td></tr>
<tr><td>REQUIRED QUESTIONS</td><td>Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits or State Pharmaceutical Assistance Programs. Will you have other prescription drug coverage in addition to <plan name>?
<table>
<tr><th>IF YES:</th><th>IF NO:</th></tr>
<tr><td>What is the name of the other coverage?
What is your identification (ID) number for this coverage?
What is your policy group number for this coverage?</td><td>Continue</td></tr>
</table>
Do you live in a long-term care facility, such as a nursing home, but not an assisted living facility?
<table>
<tr><th>IF YES:</th><th>IF NO:</th></tr>
<tr><td>What is the institution name?
What is the address of the institution?
What are the city, state and zip code?
What is the facility phone number?</td><td>Continue</td></tr>
</table>
Are you currently enrolled in a State Medicaid Program?
<table>
<tr><th>IF YES:</th><th>IF NO:</th></tr>
<tr><td>What is your Medicaid identification number?</td><td>And the prospect is attempting to enroll in the DSNP Plan for Dual Eligible beneficiaries, please inform the beneficiary that he/she is not eligible to join the <Plan Name>'s Special Needs plan for Dual Eligibles. If <Plan Name> has other Medicare Advantage plans that he/she may be eligible for, review available plans. If prospect is not enrolling into a DSNP plan, continue.</td></tr>
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Do you work? Capture reponse.
Does your spouse work? Capture reponse.

If available, would you like to receive your plan information in a language other than English or in an accessible format?
<table>
<tr><th>IF YES:</th><th>IF NO:</th></tr>
<tr><td>Which language would you prefer?
Refer to the plan's list of alternative languages and format.
If included, continue
If not included, state:
Please contact <plan name> directly to check the availability of that <format/language> in your area at <XXX-XXX-XXXX, Day – Day from X a.m. – X p.m.> TTY users should call <TTY number>.</td><td>Continue</td></tr>
</table>

Would you like to receive your plan materials in large print? Capture response
</td></tr>
<tr><td>STATEMENTS OF UNDERSTANDING</td><td>
If you have health coverage from an employer or union, joining <plan name> could affect your employer or union health benefits. You could lose your employer or union health coverage if you join <plan name>. Please read the communications your employer or union sends you. If you have questions, visit the employer or union website, or contact the office listed in the employer or union communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your employer or union coverage can help.
<table>
<tr><th>IF PFFS:</th><th><<IF PDP>>:</th></tr>
<tr><td><Plan name> PFFS, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare Supplement plan as well as other Medicare Advantage plans. <Plan name> has network providers (that is, providers who have signed contracts with their plan) for all services covered under Original Medicare. These providers have already agreed to see members of their plan. If your provider is not one</td><td><<If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining <plan name>, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare</td></tr>
</table>
</td></tr>
</table>

of their network providers, then the provider is not required to agree to accept to the plan's terms and conditions of payment, they may choose not to provide healthcare services to you, except in emergencies. If this happens, you will need to find another provider that will accept the plan's terms and conditions of payment. You should verify that your provider(s) will accept <plan name> PFFS before each visit. Providers can find the plan's terms and conditions of payment on their website at: <www.wellcare.com/medicare or other plan websites>. Once <plan name> PFFS has your enrollment form, you will get a call from a plan representative. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in <plan name> PFFS. If <plan name> PFFS is not able to reach you by telephone, then you will get a letter by mail that contains similar information	Advantage plan sends you and if you have any questions, contact your Medicare Advantage plan. **>>**

I need to review several statements with you and need you to understand and agree to these statements in order to apply for this coverage. Stop me if you have any questions or would like me to repeat any of the information.

IF MA/MAPD	*<<IF PDP>>*
<<WellCare Health Plans, Inc., is an HMO, PPO, PFFS plan with a Medicare contract.>> OR <<<Allwell/HealthNet> is contracted with Medicare for HMO, HMO C-SNP,	<<<Plan name/WellCare Health Plans, Inc.,> (PDP) is a Medicare-approved Part D sponsor. Enrollment in their plans depends on contract renewal. You understand that this prescription drug coverage is in

	HMO D-SNP, and PPO plans, and with some state Medicaid programs.>> ***If D-SNP,*** *state:* <Plan name> D-SNPs have contracts with State Medicaid programs. *Continue for all MA/MAPD plans:* Enrollment in their plans depends on contract renewal. You must keep both Hospital (Part A) and Medical (Part B) to stay in <plan name>.	addition to your coverage under Medicare; therefore, you will need to keep your Hospital (Part A) or Medical (Part B) to stay in <plan name>>>

If PFFS, *state:* You understand that this plan is a Medicare Advantage Private Fee-for-Service plan.

For all plans, *state:* You can be in only one <Medicare Advantage/Prescription Drug> plan at a time and your enrollment in this plan will automatically end your enrollment in another Medicare health plan or prescription drug plan. It is your responsibility to inform <plan Name> of any prescription drug coverage that you have or may get in the future.

If MA plan only, *state:* You understand that if you don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

Continue for all plan types:
Enrollment in this plan is generally for the entire year. Once you enroll, you may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

<Plan name> serves a specific service area. If you move out of the area that <plan name> serves, you need to notify <plan name> so you can disenroll and find a new plan in your new area.

Once you are a member of the <plan name> plan, you have a right to appeal plan decisions about payments or services if you disagree. You will read the Evidence of Coverage document from <plan name> when you receive it to know which rules you

must follow in order to receive coverage with this <Medicare Advantage/Prescription Drug> plan.

You understand that people with Medicare are not usually covered under Medicare while out of the country, except for limited coverage near the U.S. border.

You understand that if you are getting assistance from a sales agent, broker or other individual employed by or contracted with <plan name>, he/she may be paid based on your enrollment in <plan name>.

IF MA/HMO/HMO-POS/ PPO/D-SNP	*IF MA PFFS*
You understand that when your <plan name> coverage begins, you must get all of your medical and prescription drug benefits from <plan name>, except for emergency or urgently needed services or out-of-area dialysis services. Using services in-network can cost less than using services out-of-network. If medically necessary, <plan name> provides refunds for all covered benefits, even if you get services out of network. Benefits and services provided by <plan name> and contained in your <plan name> "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor <plan name> will pay for benefits or services that are not covered.	You understand that when your <plan name> PFFS coverage begins, you must get all of your medical and prescription drug benefits from <plan name>. Benefits and services provided by <plan name> and contained in your <plan name> "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor <plan name> will pay for benefits or services that are not covered. As a Medicare Private Fee-for-Service plan, <plan name> PFFS works differently than a Medicare supplement plan as well as other Medicare Advantage plans. <Plan name> PFFS pays instead of Medicare, and you will be responsible for the amounts that <plan name> PFFS does not cover, such as copayments and co-insurances. Original Medicare will not pay for your healthcare while you are enrolled in <plan name> PFFS. Before seeing a provider, you should verify that the provider will accept <plan name> PFFS. You understand that

<table>
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<tr><td></td><td>your healthcare providers have the right to choose whether to accept <plan name> PFFS payment terms and conditions every time you see them. You understand that if your provider does not accept <plan name> PFFS, you will need to find another provider who will.</td></tr>
</table>

<<If PDP plan, <i>state:</i> Counseling services may be available in your state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program and the Medicare Savings Program.>>
</td></tr>
<tr><td>REQUIRED DISCLAIMERS</td><td>
Does the plan have a monthly premium?
<table>
<tr><th>IF YES:</th><th>IF NO:</th></tr>
<tr><td>You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) <by mail, credit card, pay by phone, or through Electronic Funds Transfer (EFT)> each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month, if eligible.
If MAPD plan, state: If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay <plan name> the Part D-IRMAA.</td><td>If <plan name> determines that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), they need to know how you would prefer to pay it. You can pay <by mail, credit card, pay by phone, or through Electronic Funds Transfer (EFT)> each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month, if eligible. If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO</td></tr>
</table>
</td></tr>
</table>

	NOT pay <plan name> the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and do not even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. Even if you have Extra Help now, you may need to reapply for it later. If Medicare pays only a portion of this premium, <plan name> will bill you for the amount that Medicare doesn't cover. If you don't select a payment option, you will get a coupon book to pay your monthly premiums.

Please select a premium payment option: <<Electronic Funds Transfer (EFT) from your bank account>>, Social Security deduction, Railroad Retirement Board deduction or get a <bill/coupon book>? *Capture response*

***<<If EFT**, state:* You won't need to remember to send in a check each month. The money will be automatically drafted from your account between the 15th through the 20th of each month.
By providing the following information you are agreeing to automatic payment for our plan premiums.
Please provide the name of your bank or financial institution.
Is this a checking or savings account?
Please provide the 9 digit routing number.
Please provide the account number.
Please provide me with the Account holder name *Capture response>>*

***If Social Security or Railroad Retirement Board,** state:* The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, or approves deductions to begin after the enrollment effective date, <plan name> will send you a bill for your monthly premiums.

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<tr><td></td><td>

If get a bill/coupon book:

<table>
<tr><th>Coupon Book Option:</th><th>Bill Option:</th></tr>
<tr><td>You may also pay your plan premiums by credit card or by deduction from your bank account (checking/savings) instead of using the monthly coupons. To set up your payment, visit our website at the <plan name's> website or call Customer Service. The Customer Service number and website address will be provided to you within the Summary of Benefits and Evidence of Coverage documents you receive from <plan name>.</td><td>Once you are enrolled and have been assigned a Medicare Advantage ID by <plan name>, you will also be able to pay your premium online. You can find more information about this option at the <plan name's> website. The website address will be provided to you within the Summary of Benefits and Evidence of Coverage documents you receive from <plan name>.</td></tr>
</table>

</td></tr>
<tr><td>DISCLOSURE AND RELEASE OF INFORMATION</td><td>By joining this <Medicare Advantage> <Medicare Prescription Drug> plan, you acknowledge that <plan name> will share your information with Medicare, who may use it to track your enrollment, to make payments, and for other plans, providers and purposes allowed by Federal law that authorize the collection of this information. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan. The information on this enrollment form is correct to the best of our knowledge.

You understand that if you intentionally provide false information on this form, you will be disenrolled from the plan.

You understand that your verbal signature (or the verbal signature of the person authorized to act on your behalf under the laws of the state where you live) on this application means that you understand the contents of this telephonic application. If verbally signed by an authorized individual (as described above), this verbal signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.</td></tr>
<tr><td>CONFIRMATION OF ENROLLMENT</td><td>I just want to confirm with you that this conversation and the information I have received from you today will become your official decision to enroll in our plan. If approved by CMS, you'll be enrolled in our < Plan Name > <Plan Type>, << with additional buy-up option >>.</td></tr>
</table>

Do you understand and agree with all the statements I just reviewed with you? If so, please state "I agree".

IF Agreed:	*IF Not Agreed:*
<The plan> will confirm your enrollment with the Centers for Medicare and Medicaid Services and within <10 days> you will receive a confirmation of enrollment letter in the mail. You will also receive a packet of membership materials including your Evidence of Coverage and a notice with information about <plan name's provider/pharmacy> directory, as well as an identification card. If it is determined that you are not eligible for the health plan, a letter will be mailed to you within <10 days>. I am going to give you your enrollment confirmation number and ask that you please write it down. Please let me know when you are ready. Your enrollment confirmation number is < confirmation # >. If you have any questions about the plan's benefits, or additional Medicare services, please call: <Plan> Customer Services at 1-800-960-2530 and the (TTY 711), number is <711>. Monday-Friday 8-6, Eastern Standard Time.	*Re-review. If caller does not wish to agree to the statements, advise the caller that you cannot continue to complete the application for them. Offer to send an enrollment application to them for their review and consideration, or you can end the call*

This completes your application. Thank you. *End call*