2021

WellCare **Medicare Prescription Drug Plan** Individual Enrollment Form

How to Enroll with Our Plans

- Please read this entire enrollment form to make sure you understand the information. An incorrect or incomplete application may cause a delay or denial of coverage.
- 2 When you're ready, fill out the entire enrollment form. Where appropriate, write clearly in all capital letters or place an "X" in the appropriate box.
- **3** Once you're done, don't forget to sign and date it.
- Return the completed and signed form in one of the following ways:

 - By fax to 1-866-388-1521, or
 By mail to P.O. Box 31411, Tampa, FL 33631-3411, or
 - By using the postage-paid business reply envelope if one is included.

Contact your Licensed Representative with any questions you may have.

Licensed Representative:

Phone: () -

Other Easy Ways to Enroll with WellCare



If you're ready to enroll or have enrollment questions, call 1-888-293-5151 TTY **711**). Representatives are available from 8 a.m. to 8 p.m., 7 days a week. If you are already a member, call Customer Service at 1-888-550-5252 for Wellness Rx (PDP), Classic (PDP), and Value Script (PDP) or at 1-833-207-4241 for Rx Select (PDP), Rx Value Plus (PDP) and Rx Saver (PDP).



Enroll online at www.wellcare.com/PDP.



Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all questions with an asterisk (*). Questions without an asterisk (*) are optional – you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

WellCare P.O. Box 31411 Tampa, FL 33631-3411

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call WellCare at **1-888-293-5151**. TTY users can call **711**.

Or, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.

En español: Llame a WellCare al **1-888-293-5151/** TTY **711** o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

2021 WellCare Medicare Prescription Drug Plan Individual Enrollment Form

Please contact WellCare if you need information in another language or format (Braille).

— All fields with an asterisk (*) are required. —

To Enroll in a WellCare Prescription Insurance, Inc., Plan Please Provide the Following Information												
*Select the box for the plan you want to enroll in: Wellness Rx (PDP) Classic (PDP) Rx Saver (PDP)												
Rx Select (PDP) Rx Value Plus (PDP) Value Script (PDP)												
*\$ per month												
Mr. Mrs. Ms. *Sex: M F *Birth Date: (MMDDYYYY)												
*Last Name: Middle Initial:												
*First Name: *Primary Phone Number:												
Beneficiary Mobile Phone Number:												
Beneficiary Email Address:												
Please know that by providing your email address, you are agreeing to receive emails from us. We will give you the opportunity to opt in and you may always opt out of future email communications.												
*Permanent Residence Street Address: (Don't enter a PO Box)												
County:												
*City: *State: *ZIP Code:												
*Mailing Address: (only if different from your Permanent Residence Street Address, PO Box allowed)												
*Street Address:												
*City: *State: *ZIP Code:												
Emergency Contact Information (Optional):												
Emergency Contact:												
Phone Number:												

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.
 - OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Is Entitle	ed To). D:	I		Eff	ectiv	/e Da	ate: (I (MM	י DD	YYY
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MEDIC	AL (Pa	art E	3)								

Please Read and Answer These Important Questions:

*1. 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 <u>prescription</u> drug coverage in addition to WellCare? Yes No													
If "yes" please list your other coverage and your identification (ID) number(s) for this coverage:													
*Name of other coverage:													
*ID # for this coverage:													
*Group # for this coverage:													
2. Are you a resident of a long-term care facility, such as a nursing home? Yes No													
If "yes", please provide the following information:													
Name of Institution:													
Address of Institution (number and street):													
City: State: ZIP Code:													
Phone Number:													
Please check one of the boxes below if you would prefer that we send you information in a language other than English													
or in an accessible format:													
Spanish (where available) Large Print													

Please contact WellCare at the Customer Service number listed on the front cover of this application if you need information in an accessible format or language other than what is listed above. TTY users should call **711**. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.



Paying Your Plan Premium

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

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 or RRB benefit check or be billed directly by Medicare. DO NOT pay the Part D-IRMAA extra amount to WellCare.

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

- You won't need to remember to send in a check each month.
- The money is automatically drafted from your account between the 15th through the 20th of each month.
- Please enclose a VOIDED check or provide the following:

Account holder name:

Daul, name

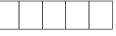
Print the name as it appears on the account to be debited.	1
This che nume as it appears on the account to be aconcea.	/

Routing Number (Include 9 digit number)	Account Number	Account type:
		Checking Savings
Signature of account holder: (if different	than enrollee)	
I agree that this authorization will remai	n in effect until I provide written notification	terminating this service.
Automatic deduction from your mo	nthly Social Security or Railroad Retirement Bo	oard (RRB) benefit check (if eligible).
I get monthly benefits from: Social	Security Railroad Retirement Board	
cases, if Social Security or RRB accepts you	ke two or more months to begin after Social Sec r request for automatic deduction, the first dedu	

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, we will send you a bill for your monthly premiums.)

Get a coupon book for monthly premium payments.

Note: 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 **www.wellcare.com/PDP** or call Customer Service at the number on the front cover.





STOP Please Read This Important Information:

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 WellCare, 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 Advantage plan sends you and if you have any questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining WellCare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join WellCare. Read the communications your employer or union sends you. If you have guestions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign:

By completing this enrollment application, I agree to the following: WellCare Health Plans, Inc., (PDP) is a Medicare-approved Part D sponsor. Enrollment in our plans depends on contract renewal. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I must keep Hospital (Part A) or Medical (Part B) to stay in WellCare. It is my responsibility to inform WellCare of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug Plan at a time—if I am currently in a Medicare Prescription Drug Plan, my enrollment in WellCare will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15–December 7), unless I gualify for certain special circumstances. WellCare serves a specific service area. If I move out of the area that WellCare serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use WellCare network pharmacies. Once I am a member of WellCare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from WellCare when I get it to know which rules I must follow to get coverage. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future. I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with WellCare, he/she may be paid based on my enrollment in WellCare. Counseling services may be available in my 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. Release of Information: By joining this Medicare Prescription Drug Plan, I acknowledge that WellCare will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other plans, providers and purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under state law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request by Medicare.

Signature:										Тос	ay's [Date:																
																				М	Μ	D	D	Y	Y	Y	Y	
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Would y	ou l	ike a	all n	nail	to b	e se	nt t	o th	e au	thori	ized	repr	esen	tativ	ve?		Ye	s	N	0								
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Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual Enrollment Period.

Licensed Representative:

Attestation of Eligibility for an Enrollment Period (continued)

Please read the following statements carefully and select the box if the statement applies to you. By filling in any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

If the statement you select requires a date, please use the following format: MMDDYYYY

1.		I am new to Medicare. If you are new to Medicare due to loss of employer group or union coverage, please refer to number 13
2.		I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
3.		I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on
4.		I recently was released from incarceration. I was released on
5.		I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on
4		I recently obtained lawful presence status in the United States. I got this status on
6.		
7.		I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance,
		or lost Medicaid) on
8.		I recently had a change in my 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) on
9.		I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
10.		I live in or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility).
		I moved/will move into/out of the facility on
11.		I recently left a PACE program on
12.		I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
		I lost my drug coverage on
13.		I am leaving employer or union coverage on
14.		I belong to a pharmacy assistance program provided by my state.
15.		My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
16.		I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan.
		My enrollment in that plan started on
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Attestation of Eligibility for a	n Enrollment Period	(continued)
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- 17. I was 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 me, but I was unable to make my enrollment because of the natural disaster.
- 18. I have had Medicare prior to now, but am now turning 65.
- 19. In the last 12 months, I joined Medicare Advantage plan with prescription drug coverage when I turned 65.
- 20. I am enrolling in a 5-star Medicare plan.
- 21. I am enrolled in a plan placed in receivership.
- 22. I am enrolled in a plan identified by CMS as a Consistent Poor Performer.
- 23. Other

If none of these statements applies to you or you're not sure, please contact WellCare at **1-888-293-5151** to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., 7 days a week. TTY users should call **711**.

Licensed Representative/Office Use Only:

Name of Staff Member/Agent/Broker/Licensed Representative (if assisted in enrollment):

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																	Г							Ν	М	D	D	Y	Y	Y	Y
Lice	nsed	Rep	rese	ntativ	/e lr	nitials	5:				Lic	ense	d Re	epres	enta	tive	ID:														
Scop	oe of	Арр	oint	ment	: Ve	rifica	tion	#:																							
Lice	nsed	Rep	rese	ntativ	/e P	hone	e#:																								
Spe	cial N	leed	s Pla	ns Ve	erifi	catio	n (if	appl	icabl	le):																					
Plan	ID #	S											Effe	ctive	Date	e of	Cove	erage	e:												
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	ICE	P/IEP		AE	Р [C	DEP		SEP	(type	e):												No	t Eli	gible	e	Ca	ance	Арр	olicat	ion

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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 (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Licensed Representative: