



2021

WellCare Medicare Prescription Drug Plan Individual Enrollment Form

How to Enroll with Our Plans

- 1 | 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.
- 4 | 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.
- 5 | 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.

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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: Relationship to You:

Licensed Representative:

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: _____
(Print the name as it appears on the account to be debited.)

Bank name: _____

Routing Number (Include 9 digit number)

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Account Number

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Account type:

Checking Savings

Signature of account holder: (if different than enrollee) _____

I agree that this authorization will remain in effect until I provide written notification terminating this service.

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check (if eligible).

I get monthly benefits from: Social Security Railroad Retirement Board

(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, 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.

Licensed Representative:

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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
6. I recently obtained lawful presence status in the United States. I got this status on
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

Licensed Representative:

