2020

WellCare/'Ohana/WellCare TexanPlus

Medicare Advantage Plans
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 **1-866-473-9124**, or
- By mail to **P.O. Box 31392, Tampa, FL 33631-3392**, 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/'Ohana/WellCare TexanPlus

Call your plan at the Customer Service number on the inside front cover of this form.

Enroll online at **www.wellcare.com/medicare** or **www.ohanahealthplan.com/medicare**.

WellCare® Beyond Healthcare. A Better You.

'OHANA™ Health Plan

WellCare® | TexanPlus®

Y0070_WCM_35614E_FINAL01_C CMS Approved 07092019

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We're always just a phone call away!

If you're ready to enroll or have enrollment questions, call **1-866-999-3945** (California), call **1-800-265-8171** (Hawaii), call **1-866-556-4607** (Texas*), call **1-866-245-4143** (Texas), or call **1-866-527-0056** (All Other States). Representatives are available from 8 a.m. to 8 p.m., 7 days a week.

If you're already a member, call the number for your state/plan listed below.

California	HMO, HMO D-SNP	**1-866-999-3945**
Hawaii	HMO	**1-888-505-1201**
	HMO D-SNP	**1-877-457-7621**
Illinois†	HMO, HMO-POS, HMO C-SNP	**1-833-444-9088**
Illinois††, Indiana, Michigan and Ohio	HMO, HMO-POS, HMO-POS C-SNP, HMO-POS D-SNP	**1-877-902-6784**
Texas*	HMO	**1-866-230-2513**
All Other States	HMO, HMO C-SNP, HMO-POS, HMO-POS C-SNP, PPO, PFFS	**1-833-444-9088**
	HMO D-SNP, HMO-POS D-SNP, PPO D-SNP	**1-833-444-9089**

Hours of operation

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., or visit us anytime at **www.wellcare.com/medicare** or **www.ohanahealthplan.com/medicare**

TTY for all of the above..... 711

†Illinois Applicable Plan Names: WellCare Advance (HMO-POS), WellCare Choice (HMO-POS), WellCare Guardian (HMO C-SNP), WellCare Rx (HMO), WellCare Plus (HMO), WellCare Value (HMO-POS)

††Illinois Applicable Plan Names: WellCare Edge (HMO), WellCare Essential (HMO), WellCare Essential (HMO-POS), WellCare Exclusive (HMO), WellCare Explore (HMO-POS)

*Texas Applicable Plan Name: City of Houston Group Retirees (HMO)

2020 MEDICARE ADVANTAGE PLANS INDIVIDUAL ENROLLMENT FORM

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

To Enroll in a WellCare/'Ohana/WellCare TexanPlus Plan, Please Provide the Following Information:

Select the box for the plan you want to enroll in: Plan: ☐ WellCare ☐ 'Ohana ☐ WellCare TexanPlus

Plan Type: ☐ HMO ☐ HMO-POS ☐ HMO C-SNP ☐ HMO D-SNP ☐ HMO-POS C-SNP ☐ HMO-POS D-SNP ☐ PPO ☐ PPO D-SNP $☐☐☐.☐☐ per month

Plan Name: ☐ Absolute ☐ Access ☐ Advance ☐ Today's Options Classic ☐ Today's Options Advantage 300 ☐ Today's Options Advantage Plus 150A ☐ Today's Options Advantage Plus 550B ☐ Today's Options Advantage Plus 750B ☐ Baton Rouge Preferred ☐ Best ☐ Champion ☐ Choice ☐ Classic ☐ Compass ☐ Dividend ☐ Dividend Prime ☐ Edge ☐ Element ☐ Elite ☐ Elite Smile ☐ Essential ☐ Essential Smile ☐ Exclusive ☐ Explore ☐ Extra ☐ Extra Plus ☐ Extra Smile ☐ Flex Complete ☐ Freedom ☐ Focus ☐ Guardian ☐ Imperial ☐ Liberty ☐ Pinnacle ☐ Plus ☐ Preferred ☐ Premier ☐ Prime ☐ Reserve ☐ Rx ☐ Select ☐ Star ☐ Value

Plan ID #: H:

☐ Mr. ☐ Mrs. ☐ Ms. Sex: ☐ M ☐ F Birth Date: (MMDDYYYY)

Last Name: Middle Initial:

First Name: Primary Phone Number:

Alternate Phone Number (Optional):

Email Address (Optional):

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: (P.O. Box is not allowed)

County:

City: State: ZIP Code:

Mailing Address: (only if different from your Permanent Residence Street Address

Street Address:

City: State: ZIP Code:

Licensed Representative:

Emergency Contact Information (Optional):

Emergency Contact:

Phone Number: Relationship to You:

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):

Medicare Number:

Is Entitled To: Effective Date: (MMDDYYYY)

HOSPITAL (Part A)

MEDICAL (Part B)

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Please Read and Answer These Important Questions:

1. Do you have end-stage renal disease (ESRD)? Yes No

   If you have had a successful kidney transplant and/or you do not need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you do not need dialysis; otherwise, we may need to contact you to obtain additional information.

2. For MAPD Plans: 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 WellCare/'Ohana/WellCare TexanPlus? 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:

3. 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:

Licensed Representative:

Please Read and Answer These Important Questions (continued):

4. Are you enrolled in your State Medicaid program? If "yes" please provide your Medicaid number:

Yes ☐ No ☐

5. Do you or your spouse work? Yes ☐ No ☐

6. **FOR WELLCARE GUARDIAN (HMO C-SNP) AND WELLCARE CHAMPION (HMO C-SNP)**

Do you have one of the following conditions: Cardiovascular Disorder, Diabetes, Chronic Heart Failure? Yes ☐ No ☐

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

Spanish (where available) ☐ Chinese (where available) ☐ Korean (where available) ☐

Vietnamese (where available) ☐ Tagalog (where available) ☐ Large Print: ☐

Please contact WellCare/'Ohana/Easy Choice/WellCare TexanPlus at the Customer Service number listed on the inside front cover of this application if you need information in an accessible format or language other than what is listed above. Our office hours are 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. TTY users should call 711.

Please Choose a Primary Care Physician (PCP), Clinic or Health Center: (First and Last Name of PCP)

ID# Are You a Current Patient? Yes ☐ No ☐

IPA ID#

IPA Name:

If you are the authorized representative, you must sign and provide the following information.

Would you like all mail to be sent to the authorized representative? Yes ☐ No ☐

Name:

Address:

City: State: ZIP:

Phone Number: Relationship to Enrollee:

Licensed Representative:

Paying Your Plan Premium

If enrolling in a health plan with a $0 monthly premium: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay 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 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 NOT pay WellCare/'Ohana/WellCare TexanPlus the Part D-IRMAA. **If enrolling in a plan with a monthly premium: 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 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 Wellcare/'Ohana/ WellCare Texan Plus 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, we 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 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 ☐☐☐☐☐☐☐☐☐

Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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/medicare** or **www.ohanahealthplan.com/medicare** or call Customer Service at the number on the inside cover.

Licensed Representative: ☐☐☐☐☐☐

Please Read This Important Information:

For MAPD Plans: If you currently have health coverage from an employer or union, joining a/an WellCare/'Ohana/WellCare TexanPlus plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join WellCare/'Ohana/ WellCare TexanPlus. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any 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: 'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc. WellCare Health Plans, Inc., is an HMO, PPO, PFFS plan with a Medicare contract. Our D-SNPs have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or Prescription Drug Plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. (**MA only plans:** I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.) Enrollment in this plan is generally for the entire year. Once I enroll, I 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. WellCare/'Ohana/ WellCare TexanPlus serves a specific service area. **If I move out of the area that WellCare, 'Ohana, WellCare TexanPlus serves, I need to notify the plan so I can disenroll and find a new plan in my new area.** Once I am a member of WellCare/'Ohana/WellCare TexanPlus, 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/'Ohana/WellCare TexanPlus when I receive it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. **For Non-PPO Plans:** I understand that beginning on the date WellCare/'Ohana/WellCare TexanPlus coverage begins, I must get all of my health care from WellCare/'Ohana/WellCare TexanPlus, except for emergency or urgently needed services or out-of-area dialysis services. **For PPO Plans Only:** I understand that beginning on the date WellCare coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, WellCare provides refunds for all covered benefits, even if I get services out of network. **ALL PLANS:** Services authorized by WellCare/'Ohana/WellCare TexanPlus and other services contained in my WellCare/'Ohana/WellCare TexanPlus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR WELLCARE/'OHANA/WELLCARE TEXANPLUS WILL PAY FOR THE SERVICES.** I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with WellCare/'Ohana/WellCare TexanPlus, he/she may be paid based on my enrollment in WellCare/'Ohana/WellCare TexanPlus. **Release of Information:** By joining this Medicare health plan, I acknowledge that WellCare/'Ohana/WellCare TexanPlus will release my information to Medicare, other plans and providers as is necessary for treatment, payment and health care operations. I also acknowledge that WellCare/'Ohana/WellCare TexanPlus will release my information (including my prescription drug event data) to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. 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. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state 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 from Medicare.

Signature: _____ Today's Date: | | | | | | | | |
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Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage 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.

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 a new Medicare beneficiary.
   If you are new to Medicare due to loss of employer group or union coverage, please refer to number 13.

Licensed Representative: | | | | | | |

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 am moving into, 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 ☐☐☐☐☐☐☐☐.

17. ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan.
I was disenrolled from the SNP on ☐☐☐☐☐☐☐☐.

18. ☐ 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.

19. ☐ Other _____

If none of these statements applies to you or you're not sure, please contact WellCare/'Ohana/WellCare TexanPlus at **1-866-527-0056** 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: ☐☐☐☐☐☐

Licensed Representative/Office Use Only:

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

Licensed Representative Signature: _____ Date Application Received:

M M D D Y Y Y Y

Licensed Representative Initials: Licensed Representative ID:

Scope of Appointment Verification # :

Licensed Representative Phone #:

Special Needs Plans Verification (if applicable):

Plan ID #: H Effective Date of Coverage:

M M D D Y Y Y Y

ICEP/IEP AEP OEP SEP (type): Not Eligible Cancel Application

Licensed Representative: