OMB No. 0938-1378
Expires: 6/30/2026

Wellmark Advantage Health Plan

Blue Medicare Advantage PPO℠
Blue Medicare Advantage Enhanced PPO℠
Blue Medicare Advantage℠ Valor PPO
Blue Medicare Advantage PPO | Avera

Enrollment Form

Who can use this form?

People with Medicare who want to join a Medicare Advantage 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 Oct. 15 – Dec. 7 each year (for coverage starting Jan. 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 items in Section 1.

The items in Section 2 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 (Oct. 15 – Dec. 7), the plan must get your completed form by Dec. 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:

Wellmark Advantage Health Plan
P.O. Box 211501
Eagan, MN 55121

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

How do I get help with this form?

Call Wellmark Advantage Health Plan at **1-855-716-2557**. 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 Wellmark Advantage Health Plan al **1-855-716-2557**/ **711** o a Medicare gratis al **1-800-633-4227** y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

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Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join if you live in our Iowa service area:

- ☐ Blue Medicare Advantage PPO — $0 monthly premium for medical and Part D prescription coverage.
- ☐ Blue Medicare Advantage Enhanced PPO — $63 monthly premium for medical and Part D prescription coverage.
- ☐ Blue Medicare Advantage Valor PPO — $0 monthly premium for medical coverage. (This plan doesn't include Part D prescription coverage.)

Select the plan you want to join if you live in our South Dakota service area:

- ☐ Blue Medicare Advantage PPO — $22 monthly premium for medical and Part D prescription coverage.
- ☐ Blue Medicare Advantage Enhanced PPO — $63 monthly premium for medical and Part D prescription coverage.
- ☐ Blue Medicare Advantage Valor PPO — $0 monthly premium for medical coverage. (This plan does not include Part D prescription coverage.)

Select this box if you want to join:

- ☐ Blue Medicare Advantage PPO | Avera — $0 monthly premium for medical and Part D prescription coverage. This Wellmark and Avera Health partnership includes doctors and hospitals within the Avera Health network and selected other providers. It serves members who live in select South Dakota and Iowa counties. South Dakota: Aurora, Bon Homme, Charles Mix, Clay, Davison, Douglas, Hanson, Hutchinson, Jerauld, Lake, Lincoln, McCook, Miner, Minnehaha, Moody, Sanborn, Turner, Union and Yankton. Iowa: Clay, Dickinson, Emmet, Lyon, O'Brien, and Osceola.

First name	Last name	Middle initial (Optional)

Birth date (mm/dd/yyyy) (__ __ /__ __ /__ __ __ __)	Sex ☐ Male ☐ Female	Requested effective date (Optional) (__ __/__ __/__ __ __ __)

Email (Optional)	Phone Number ( )	☐ Opt-in to text messaging

Permanent residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.)

City	County (Optional)	State	ZIP code

Mailing address, if different from your permanent address (PO Box allowed)

Street address		
City	**State**	**ZIP code**

Your Medicare information

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Effective Dates (Optional): Part A __ __ / __ __ / __ __ __ __ Part B __ __ / __ __ / __ __ __ __

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Wellmark Advantage Health Plan? ☐ Yes ☐ No

Name of other coverage	Member number for this coverage	Group number for this coverage

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Special enrollment periods: Please check the box that applies to you.

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period from Oct. 15 through Dec. 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 check the box if the statement applies to you. By checking 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.

- ☐ I am new to Medicare.
- ☐ I already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage plan.
- ☐ I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. (Date of Medicare Entitlement Letter) _____.
- ☐ I had Medicare prior to now, but I'm now turning 65.
- ☐ I pay a premium for Part A and I signed up for Part B during the General Enrollment Period (January 1 through March 31 each year). I want to join a Medicare Advantage plan with drug coverage.
- ☐ I signed up for Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare Advantage plan (with or without drug coverage).
- ☐ Between 1/1 - 3/31: I'm in a Medicare Advantage plan and want to make a change.
- ☐ Between 4/1 - 12/31: I'm in a Medicare Advantage plan and have had Medicare for less than 3 months. I want to make a change.
- ☐ 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 (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ 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 (insert date) _____.

Special enrollment periods: Please check the box that applies to you. *(continued)*

- ☐ 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.
- ☐ 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 (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ 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 (insert date) _____.
- ☐ 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 (insert date) _____.
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity). One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ☐ I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan. My plan went into receivership on (insert date) _____.
- ☐ I'm in a plan that's had a Star rating of less than 3 Stars for the last 3 years. I want to join a plan with a Star rating of 3 Stars or higher.
- ☐ Other (explanation) _____.

If none of these statements applies to you or you're not sure, please contact Wellmark Advantage Health Plan at **1-855-716-2557** (TTY users should call **711**) to see if you are eligible to enroll. We are open from 8 a.m. to 8 p.m. local time, seven days a week from Oct. 1 through March 31 and 8 a.m. to 8 p.m. local time, Monday through Friday from April 1 through Sept. 30.

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IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Wellmark Advantage Health Plan.
- By joining this Medicare Advantage plan, I acknowledge that Wellmark Advantage Health Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Wellmark Advantage Health Plan coverage begins, I must get all of my medical and prescription drug***** benefits from Wellmark Advantage Health Plan. Benefits and services provided by Wellmark Advantage Health Plan and contained in my Wellmark Advantage Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Wellmark Advantage Health Plan will pay for benefits or services that are not covered. **Blue Medicare Advantage Valor PPO does not cover Part D prescription drugs.*
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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	**Today's date**

If you're the authorized representative, sign above and fill out these fields

Name	Address
Phone number	Relationship to enrollee

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Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, Not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer**

What is your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer**

What's your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____

I choose not to answer

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer**

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Section 2 – All fields on this page are optional

Select one if you want us to send you information in a language other than English.

☐ English (default)

☐ Spanish

☐ Other (language other than English)

Select one if you want us to send you information in an accessible format.

☐ Large print

☐ Audio CD

☐ Data CD

Please contact Wellmark Advantage Health Plan at **1-855-716-2557** if you need information in an accessible format other than what's listed above. Our office hours are from 8 a.m. to 8 p.m. local time, seven days a week from Oct. 1 through March 31 and 8 a.m. to 8 p.m., local time, Monday through Friday from April 1 through Sept. 30. TTY users can call **711**.

Do you work?

☐ Yes

☐ No

Does your spouse work?

☐ Yes

☐ No

List your primary care physician (PCP), clinic, or health center

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Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or "Electronic Funds Transfer (EFT)," each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Wellmark Advantage Health Plan the Part D-IRMAA.

Please select a premium payment option

☐ Automatic withdrawal from your bank account each month. Please allow up to 60 days to process your request. **Please pay any premium bill you may receive while your request is processing.** Future monthly premiums will be automatically withdrawn from your specified account on the **first** day of each month or next business day.

Please enclose a **VOIDED** check or provide the following information:

Account holder name _____

Bank routing number _____ *(first set of numbers located on left side of check)*

Bank account number _____ *(second set of numbers located in the center of check)*

Account type:

☐ Checking ☐ Savings

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from:

☐ Social Security ☐ RRB

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

☐ Get a monthly bill.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e., agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____

National Producer Number (Agents/Brokers only):_____

Agent/Office use only (Applicants do not complete this section)

Note to producing agents: *Paper enrollment forms must be keyed into the enrollment portal or submitted within 24 hours of accepting the paper enrollment form.*

Date producing agent accepted paper enrollment from Medicare eligible applicant
____ / ____ / _____

Signature of producing agent _____

Name of producing agent (print first/last name)

_____ _____
First name *Last name*

Wellmark-assigned agent number ___ / ___ / ___ / ___ / ___ / ___ / ___ / ___

National producer number ___ / ___ / ___ / ___ / ___ / ___ / ___ / ___

I helped the applicant by partially or completely filling out the paper enrollment form on behalf of the applicant.

☐ Yes
☐ No

Name of person entering enrollment information online (print first/last name)

_____ _____
First name *Last name*

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 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.