2020

WellCare Medicare Prescription Drug Plan
Individual Enrollment Form

How to Enroll with WellCare PDP

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

Call **1-888-293-5151**. (TTY **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. (If you are already a member, call Customer Service at **1-888-550-5252** for Wellness Rx (PDP), Classic (PDP), and Rx Saver (PDP) or at **1-833-207-4241** for Rx Select (PDP), Rx Value Plus (PDP) and Value Script (PDP))

Enroll online at **www.wellcare.com/PDP**

WellCare®
Beyond Healthcare. A Better You.

Y0070_WCM_35318E_C CMS Approved 07052019

2020 WellCare Medicare Prescription Drug Plan Individual Enrollment Form

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

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

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

Last Name: Middle Initial:

First Name: Prima

Alternate Phone Number (Optional):

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: (P.O. Box is not allowed)

County:

State: ZIP Code:

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

Street Address:

City: State: ZIP Code:

Emergency Contact Information (Optional):

Emergency Contact:

Phone Number: Relationship to You:

Licensed Representative:

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 a Medicare Part A or B (or both) to join a Medicare prescription drug plan.

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 prescription 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**. Our office hours are Monday–Friday, 8 a.m. to 8 p.m. 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.

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 | 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/PDP** or call Customer Service at the number on the front cover.

Licensed Representative: ☐☐☐☐☐☐

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 questions, 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 Prescription Insurance, 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 will need to keep my Medicare Part A and/or Part B coverage. 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 qualify 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 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 release my information to Medicare, other plans and providers as is necessary for treatment, payment and health care operations. I also acknowledge that WellCare 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 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: _____ Today's Date: | | | | | | | | |
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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:

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.

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.

Licensed Representative: ☐☐☐☐☐☐

Attestation of Eligibility for an Enrollment Period (continued)

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 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. ☐ 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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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 #: S ☐☐☐☐☐☐☐☐☐☐ Effective Date of Coverage: ☐☐☐☐☐☐☐☐
M M D D Y Y Y Y

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

Licensed Representative: ☐☐☐☐☐☐