2027 Individual Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C)

OMB No. 0938-1378
Expires: 02/28/2029

✓ Check your application status here:
wellcare.com/applicationtracker

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 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 items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

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.

Have you thought about enrolling at **go.wellcare.com/WI** instead? It's a fast, secure, and easy way to apply

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
PO Box 10420
Van Nuys, CA
91410-0420

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

How do I get help with this form?
Call Wellcare at 1-844-480-0680. TTY users can call 711. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

En español: Llame a Wellcare al 1-844-480-0680. (TTY: 711) o a Medicare gratis al 1-800-633-4227 (durante las 24 horas, los 7 días de la semana) (TTY:1-877-486-2048) y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

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IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on the front of this page to send your completed form to the plan.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 and 1860D-1 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.

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

Select the plan you want to join:

Wellcare Simple (HMO-POS) –includes prescription drug coverage

☐ **H8189-008-000** $0 per month

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Section 1 – All fields in this section are required (unless marked optional)

First name | Last name | Optional: Middle initial

Birth date: ____ / ____ / _____
M M / D D / Y Y Y Y

Sex: ☐ Male ☐ Female

Phone number: (__ __ __) __ __ __ - __ __ __ __
Phone type: ☐ Home ☐ Cell

Optional: Secondary Phone Number: (__ __ __) __ __ __ - __ __ __ __
Phone type: ☐ Home ☐ Cell

Optional: E-mail address:

Optional: Do you feel comfortable using the internet, email, or text messaging on your own?
☐ Yes ☐ No

Optional: Preferred method of contact: ☐ Phone Call ☐ Text ☐ Email

**Please note that communications may be sent outside of chosen 'Preferred method of contact'.*

We want you to enjoy being a member and understand your plan. Please provide your phone number(s) and email so we can tell you about your application status. As a member, we will share helpful information like what to expect, staying healthy, using extra benefits, finding a doctor, our member portal and other important stuff. If you are not interested, you can opt out of some texts and emails.

We want you to like your Wellcare plan. If we have other plans that might be better for you as your needs change, we will tell you. We will only talk about plans from us.

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

Permanent residence street address

City | Optional: County | State | ZIP code

Mailing address, If you would like your mail sent to a different address or to an authorized representative, please provide that information here. (PO Box allowed)

Street address

City | State | ZIP Code

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Your Medicare information:

Medicare Number:

__ __ __ __ __ __ __ __ __ __ __

Is entitled to: Effective Date (MM/DD/YYYY):

Hospital (Part A) ____ / ____ / _____

Medical (Part B) ____ / ____ / _____

Answer these important questions:

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Wellcare?

☐ Yes ☐ No

Name of other coverage

Member number for this coverage

Group number for this coverage

2. If enrolling in a D-SNP Plan, please provide:
State Medicaid Program Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Please include the Medicaid number for D-SNP plans. Missing Medicaid numbers may result in delayed processing of the application and possibly denial of the application.

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Wellcare.
- By joining this Medicare Advantage 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 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 MA or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Wellcare coverage begins, I must get all of my medical and prescription drug benefits from Wellcare. Benefits and services provided by Wellcare and contained in my Wellcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Wellcare will pay for benefits or services that are not covered.

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- 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.

By signing this document, I certify that, to the best of my knowledge, all information I've provided is true, complete and accurate. I understand that if it is determined that this information is incorrect, I may be disenrolled.

Today's date

_____ / _____ / _____
M M / D D / Y Y Y Y

_____
Signature

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

Name

Address

Phone number

(__ __ __) __ __ __ - __ __ __ __

Relationship to enrollee

Section 2 – All fields in this section are optional

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

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Wellcare at 1-844-480-0680 (TTY users can call 711) if you need information in an accessible format other than what's listed above. Our office hours are Sunday–Saturday, 8 a.m. to 8 p.m. (all time zones).

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1. Do you work? ☐ Yes ☐ No

2. Does your spouse work? ☐ Yes ☐ No

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 Facility:

Address of Facility (number and street):

City	State	ZIP code	Phone number
			(__ __ __) __ __ __ - __ __ __ __

List your In-Network Primary Care Physician (PCP), clinic, or health center:

You can find a provider at wellcarefindaprovider.com

Provider information for HMO plans:

PCP NPI: PPG ID:

Current patient? ☐ Yes ☐ No

☐ I do not wish to select a PCP, I would like Wellcare to select my PCP for me. I understand that I may change my PCP at any time by calling the member service number on my Wellcare Member ID card.

If a valid In-Network PCP is not selected or the checkbox for PCP automatic assignment is not checked, an In-Network PCP will be assigned to the beneficiary. The PCP assignment may be changed at any time by calling the member service number on the Member ID Card

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, Electronic Funds Transfer (EFT), or credit card 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 Wellcare the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. Even if you have Extra Help now you may need to reapply for recertification. 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 https://www.ssa.gov/medicare/part-d-extra-help.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill

☐ 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.)

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): _____

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OFFICE USE ONLY:

By signing and submitting this document, I certify that the information provided within is true, complete and accurate to the best of my knowledge and belief. I understand that any misrepresentation or omission may be grounds for disciplinary action, up to termination of my appointment and producer agreement.

Name of staff member/agent/broker (if assisted in enrollment): ☐

Plan ID #: ☐ **Effective date of coverage: ____ /____ /_____ (**MM/DD/YYYY)

Wellcare sales representative/Authorized agent
(individual sales representative/agent who completed the application)

Agent type (select one): ☐ Authorized agent ☐ Wellcare employee

Complete section below:

Sales rep/Agent name: ☐ Sales rep/Agent NPN #: ☐

Agency/FMO affiliation (if applicable): ☐

This information must match your approved Wellcare licensing records.

Agent phone #: (__ __ __) __ __ __ - __ __ __ __

Email: ☐

Agency/FMO phone # (if applicable): (__ __ __) __ __ __ - __ __ __ __

Sales representative/authorized agent application receipt date: ____ /____ /_____
(M M / D D / Y Y Y Y)

(Applications must be received at Wellcare within 1 calendar day of this date.)

Application receipt location: ☐ Appointment ☐ Sales event ☐ Walk-in

☐ Other (specify): ☐

Broker Application Submissions: Sales representative/Agent must fax the Scope of Appointment and Enrollment Forms to 1-844-222-3180.

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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. If this is your first time utilizing Medicare benefits, and it has been more than 90 days of you turning 65, the "I'm new to Medicare." SEP does NOT apply, so please select the appropriate SEP below.

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.

Please read all statements below before making a selection. List dates as MM/DD/YYYY.

☐ I'm new to Medicare.
*Please only select if you are 1. Newly entitled; 2. You are within 90 days of turning 65 OR you have recently turned 65 within the last 90 days; 3. New recipient of benefits; or 4. Newly eligible but previously just received Medicare through disability.
*If your employer coverage has recently ended, and this is your first time using Medicare, please select the "I left coverage from my employer or union" SEP below.

☐ Annual Enrollment Period (AEP) Oct 15th through Dec 7th annually.

☐ I already have Part A (Hospital Insurance) and recently signed up for Part B (Medical Insurance) for the first time now. I want to join a Medicare Advantage Plan.

☐ I was notified about getting Medicare after my Part A and/or Part B coverage started. I was notified on (insert date). ____ /____ /_____

☐ I had Medicare prior to now, but I'm now turning 65.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I moved to a new address that's outside my current plan's service area, or I recently moved and this plan is a new option for me.
I moved on (insert date). ____ /____ /_____

☐ I moved back to the U.S. after living outside the country on (insert date). ____ /____ /_____

☐ I was released from incarceration. I was released on (insert date). ____ /____ /_____

☐ I recently got lawful presence status in the U.S. I got this status on (insert date). ____ /____ /_____

☐ I live in a long-term care facility, like a nursing home or a rehabilitation hospital.
*NOTE: Long term care facility information must be filled out on the form.

☐ I recently moved out of a long-term care facility, like a nursing home or a rehabilitation hospital.
*NOTE: Long term care facility information must be filled out on the form.
I moved out of the facility on (insert date). ____ /____ /_____

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☐ I left coverage from my employer or union (including COBRA coverage) on (insert date). ____ /____ /_____

☐ I lost other, non-Medicare drug coverage that's as good as Medicare drug coverage (creditable coverage), or my other, non-Medicare coverage changed and is no longer considered creditable. I lost my coverage on (insert date). ____ /____ /_____

☐ My existing plan is non-renewing for the upcoming contract year
*NOTE: This SEP is only valid from 12/8–last day of February.

☐ I lost my coverage because Medicare ended its contract with my plan. I got a letter from Medicare saying I could join another plan. My coverage ended on (insert date). ____ /____ /_____

☐ I dropped my coverage in a PACE (Programs of All-Inclusive Care for the Elderly) plan. I left the program on (insert date). ____ /____ /_____

☐ I lost my Special Needs Plan because I no longer have my special needs status required for that plan. I will be or was disenrolled from the SNP on (insert date). ____ /____ /_____

☐ I want to join a Special Needs Plan that tailors its benefits to my chronic condition.

☐ I was found ineligible for my CSNP plan and want to enroll into another plan. I was notified on (insert date). ____ /____ /_____

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in my level of Medicaid, or lost Medicaid) on (insert date). ____ /____ /_____

☐ I recently had a change in my Extra Help paying for my drug costs (newly got Extra Help, had a change in my level of Extra Help, or lost Extra Help) on (insert date). ____ /____ /_____

☐ 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'm in a State Pharmaceutical Assistance Program. The following states have a qualified SPAP: Delaware, Indiana, Maine, Maryland, Massachusetts, Missouri, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, Texas, Vermont, Wisconsin.

☐ I'm losing help from a State Pharmaceutical Assistance Program. I lost assistance on (insert date). ____ /____ /_____

☐ I, or the person I rely on to help make health care decisions, was affected by an emergency or a major disaster (as declared by the Federal Emergency Management Agency, or by Federal, my state, or my local government). One of the other statements on this page applied to me, but I was unable to make my request because of the disaster.
I missed the Enrollment Period for: _____

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☐ I am enrolling in a 5-star Medicare plan.

☐ 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.

☐ I'm in a plan that was recently taken over by the state because of financial issues (receivership). I want to switch to another plan.

☐ I requested materials in an accessible format and did not receive them in time. I want to enroll now that I have had time to make enrollment decisions.
The accessible format I previously requested was: _____
*Note: Accessible formats include but are not limited to Braille, Data CD, Large Print

☐ I pay a premium for Part A and I signed up for Part B during the General Enrollment Period (January 1–March 31 each year). I want to join a Medicare drug plan (Part D) or Medicare Advantage Plan with drug coverage.
* If you pay a premium for Part A and sign up for Part B during the General Enrollment Period, you'll have 2 months after signing up for Part B to join a plan.
I signed up on (insert date). ____ /____ /_____

☐ 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 signed up on (insert date). ____ /____ /_____

☐ I have Medicare and get full Medicaid benefits. I wish to enroll into a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP), or an Applicable Integrated Plan (AIP).

☐ I have Medicare drug coverage (Part D) through a Medicare Advantage Plan. I want to join a different Medicare health plan that doesn't offer drug coverage, so I can switch to non-Medicare creditable drug coverage. *NOTE: MA only

If none of these statements apply to you or you're not sure, please contact Wellcare at 1-844-480-0680 (TTY users should call 711) to see if you are eligible to enroll. We are open Sunday–Saturday, 8 a.m. to 8 p.m. (all time zones).

You must continue to pay your Medicare Part B premium.

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