

2010 WELLCARE MEDICARE COORDINATED CARE INDIVIDUAL ENROLLMENT FORM

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

To Enroll in WellCare Health Plans, Please Provide the Following Information:

Please check the plan you want to enroll in:

- | | |
|---|--|
| <input type="checkbox"/> WellCare Access (HMO) \$___ per month | <input type="checkbox"/> WellCare Premium (HMO) \$___ per month |
| <input type="checkbox"/> WellCare Advance (HMO) \$___ per month | <input type="checkbox"/> WellCare Premium (HMOPOS) \$___ per month |
| <input type="checkbox"/> WellCare Advocate Complete (HMO) \$___ per month | <input type="checkbox"/> WellCare Reserve (HMO) \$___ per month |
| <input type="checkbox"/> WellCare Choice (HMO) \$___ per month | <input type="checkbox"/> WellCare Rx (HMOPOS) \$___ per month |
| <input type="checkbox"/> WellCare Choice (HMOPOS) \$___ per month | <input type="checkbox"/> WellCare Select (HMO) \$___ per month |
| <input type="checkbox"/> WellCare Dividend (HMO) \$___ per month | <input type="checkbox"/> WellCare Select (HMOPOS) \$___ per month |
| <input type="checkbox"/> WellCare Dividend (HMOPOS) \$___ per month | <input type="checkbox"/> WellCare Value (HMO) \$___ per month |
| <input type="checkbox"/> WellCare Essential (HMOPOS) \$___ per month | <input type="checkbox"/> WellCare Value (HMOPOS) \$___ per month |
| <input type="checkbox"/> WellCare Liberty (HMO) \$___ per month | |

Last Name: _____ First Name: _____ Middle Initial: _____ Mr. Mrs. Ms.

Birth Date: / / Sex: M F Home Phone Number: ()
MM DD YYYY

Permanent Residence Street Address: _____ County: _____
 (P.O. Box is not allowed):

City: _____ State: _____ ZIP Code: _____

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

Street Address: _____
 City: _____ State: _____ ZIP Code: _____

Please Provide Your Medicare Insurance Information:


Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

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

	
MEDICARE	HEALTH INSURANCE
<small>SAMPLE ONLY</small>	
Name: _____	Sex: _____
Medicare Claim Number: _____	
Is Entitled To: _____	Effective Date: _____
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

Writing Producer/Office Use Only:

Name of Staff Member/Agent/Broker (if assisted in enrollment): _____
 Producer Signature: _____
 Date Application Received: _____ Producer Initials: _____ Producer ID: _____
 Consent/Scope (AVL) Code: _____ TeleApp/Confirmation ID: _____
 Special Needs Plans Verification: _____

**If there is a Durable Power of Attorney (DPAHC) or authorized representative or witness, please provide the following information:
 A COPY OF THE PROOF OF LEGAL GUARDIANSHIP, DPAHC OR PROOF OF AUTHORIZATION BY STATE LAW.**

Plan ID #: _____ Effective Date of Coverage: _____
 ICEP/IEP OEP OEP New OEPI AEP SEP (type): _____ Not Eligible

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, we need to know how you would prefer to pay it. You can pay by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

If enrolling in a plan with a monthly premium: You can pay your monthly plan premium by mail or by having it automatically deducted from your bank account each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

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 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 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 doesn't cover.

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

Please select a premium payment option:

Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Receive a bill

Note: Once you are enrolled, WellCare will include an electronic funds transfer (EFT) form in your new member packet. If you would like to have your monthly plan premiums deducted from your bank account instead of receiving a bill each month, please follow the instructions and complete and return the form to WellCare. You may also access the form on our Web site at www.wellcare.com or call our Customer Service department at 1-866-907-7649 (TTY users call 1-877-247-6272), Monday–Sunday, 8am to 9pm Eastern to request an EFT form. Once we receive your paperwork, the process can take up to two months to take effect. You should keep paying your monthly bill until the EFT withdrawals have started.

Please Read and Answer These Important Questions:

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

If you answered "yes" to this question and you don't need regular dialysis anymore, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.

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 Health Plans? 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 in a long-term care facility, such as a nursing home? Yes No

If "yes" please provide the following information:

Name of Institution:

Address & Phone Number of Institution:

4. Are you enrolled in your state Medicaid program? Yes No

If "yes" please provide your Medicaid number: _____

5. Do you or your spouse work? Yes No

6. Medicare Savings Programs allow your state to help you pay for your Medicare Part A and/or Part B premiums.

Are you enrolled in a Medicare Savings Program? Yes No

Please choose a primary care physician (PCP), clinic or health center:

Please CHECK ONE of these boxes for the language in which you prefer to receive information: English Spanish Cajun French
 Chinese Russian

Please CHECK ONE of these boxes if you prefer to receive information in another format:

Large Print Audio Cassette Tape Audio Compact Disk (CD) Braille

Please contact WellCare Health Plans at 1-866-907-7649 regarding the availability of information in a format or language other than what is listed above. TTY users should call 1-877-247-6272. Our office hours are Monday–Sunday, 8am to 9pm Eastern.



Please Read This Important Information:

For MAPD Plans: If you currently have health coverage from an employer or union, joining WellCare Health Plans could affect your employer or union health benefits. You could lose your employer or union health coverage if you join WellCare Health Plans. Read the communications your employer or union sends you. If you have questions, visit their Web site, 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 Below:

By completing this enrollment application, I agree to the following:

WellCare Health Plans is a Medicare Advantage plan and has a contract with the federal government. 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: November 15–December 31 of every year), or under certain special circumstances.

WellCare Health Plans serves a specific service area. **If I move out of the area that WellCare Health Plans 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 Health Plans, 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 Health Plans 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.

I understand that beginning on the date WellCare Health Plans coverage begins, I must get all of my health care from WellCare Health Plans, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by WellCare Health Plans and other services contained in my WellCare Health Plans Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR WELLCARE HEALTH PLANS 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 Health Plans, he/she may be paid based on my enrollment in WellCare Health Plans.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that WellCare Health Plans will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that WellCare Health Plans 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 by WellCare Health Plans or by Medicare.

Signature: _____	Today's Date: _____
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If you are the authorized representative, you must sign above and provide the following information:

Name: _____ Phone Number: (____) _____

Address: _____ Relationship to Enrollee: _____

Do you want all mail sent to the address listed above? Yes No

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan during the Annual Enrollment Period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the Open Enrollment Period between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage (i.e., if you have Medicare prescription drug coverage, you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage, you can only change to another plan without Medicare prescription drug coverage). Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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 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 ____/____/____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on ____/____/____.
- I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on ____/____/____.
- I recently left a PACE program on ____/____/____.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on ____/____/____.
- I am leaving employer or union coverage on ____/____/____.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ____/____/____.
- None of these statements applies to me.*

*Please contact WellCare at 1-866-907-7649 to see if you are eligible to enroll. We are open Monday–Sunday, 8am to 9pm Eastern. TTY users should call 1-877-247-6272.

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