



2021

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

-  If you're ready to enroll or have enrollment questions, call **1-866-527-0056**. For residents of Hawaii, call **1-866-907-2058 (TTY 711)**. Representatives are available from 8 a.m. to 8 p.m., 7 days a week.
-  Enroll online at **www.wellcare.com/medicare** or **www.ohanahealthplan.com/medicare**.





We're Always Just a Phone Call Away!



If you're ready to enroll or have enrollment questions, call 1-866-527-0056, or call 1-866-907-2058 (Hawaii).

Representatives are available from 8 a.m. to 8 p.m., 7 days a week.

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

California	HMO	1-866-999-3945
Hawaii	HMO	1-877-457-7621
Illinois*	HMO, HMO-POS, HMO C-SNP, PPO	1-833-444-9088
Georgia, Illinois**, Indiana, Michigan, Ohio and South Carolina	HMO, HMO-POS, HMO C-SNP, HMO-POS C-SNP, PPO	1-866-892-8340
Texas***	HMO	1-866-230-2513
All Other States	HMO, HMO C-SNP, HMO-POS, PPO	1-833-444-9088

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 Absolute (PPO), WellCare Compass (HMO), WellCare Guardian (HMO C-SNP), WellCare Patriot (HMO-POS), WellCare Plus (HMO), WellCare Premier (PPO), 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)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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 questions with an asterisk (*). Questions without an asterisk (*) 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 (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/'Ohana/WellCare TexanPlus
P.O. Box 31392
Tampa, FL
33631-3392

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

How do I get help with this form?

Call WellCare/'Ohana/WellCare TexanPlus at **1-866-527-0056**. For residents of Hawaii, call **1-866-907-2058**. 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 WellCare/'Ohana/WellCare TexanPlus al **1-866-527-0056/TTY 711**. Si es residente de Hawaii, llame al **1-866-907-2058** o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

2021 MEDICARE ADVANTAGE PLANS INDIVIDUAL ENROLLMENT FORM

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

— All fields with an asterisk (*) are required. —

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

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

*Plan Type: HMO HMO-POS HMO C-SNP HMO-POS C-SNP PPO

*\$. per month

*Plan Name: Absolute 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 Endurance Essential Exclusive Explore Flex Complete Focus Guardian
 Patriot Plus Preferred Premier Prime Rx Plus Summit Value

Plan ID #:

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

*Last Name: Middle Initial:

*First Name: *Primary Phone Number:

Beneficiary Mobile Phone Number:

Beneficiary 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: (Don't enter a PO Box)

County:

*City: *State: *ZIP Code:

*Mailing Address: (only if different from your Permanent Residence Street Address, PO Box allowed)

*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. 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:

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:

Licensed Representative:

Please Read and Answer These Important Questions (continued):

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

Yes No

4. Do you or your spouse work? Yes No

*5. **FOR WellCare Champion (HMO C-SNP) AND WellCare Guardian (HMO C-SNP) AND WellCare Guardian (HMO-POS 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/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. 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:

I do not wish to select a PCP, I would like WellCare/'Ohana/WellCare TexanPlus to select my PCP for me. I understand that I may change my PCP at any time by calling the customer service number on my WellCare/'Ohana/WellCare TexanPlus Member ID Card.

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

***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 TexanPlus 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 (Include 9 digit number)

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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:

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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. Enrollment in our plans depends on contract renewal. I must keep both Hospital (Part A) and Medical (Part B) to stay in WellCare/'Ohana/WellCare TexanPlus. 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. I understand that when my WellCare/'Ohana/WellCare TexanPlus coverage begins, I must get all of my medical and prescription drug benefits from WellCare/'Ohana/WellCare TexanPlus, except for emergency or urgently needed services or out-of-area dialysis services. Using services in-network can cost less than using services out-of-network. If medically necessary, WellCare/'Ohana/WellCare TexanPlus provides refunds for all covered benefits, even if I get services out of network. Benefits and services provided by WellCare/'Ohana/WellCare TexanPlus and contained in my WellCare/'Ohana/WellCare TexanPlus "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. **NEITHER MEDICARE NOR WELLCARE/'OHANA/WELLCARE TEXANPLUS WILL PAY FOR BENEFITS OR SERVICES THAT ARE NOT COVERED.** 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 Advantage plan, I acknowledge that WellCare/'Ohana/WellCare TexanPlus will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other plans, providers and 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. 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:

M	M	D	D	Y	Y	Y	Y

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:

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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. I have had Medicare prior to now, but am now turning 65.

Licensed Representative:

