

Individual Enrollment Request Form to Enroll in a Medicare Prescription Drug Plan (Part D)

OMB No. 0938-1378
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Who can use this form?

People with Medicare who want to join a 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 Prescription Drug Plan, you must also have either, or 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
PO Box 31411
Tampa, FL
33631-3411

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

How do I get help with this form?

Call Wellcare at **1-866-859-9084**. 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 al **1-866-859-9084** (TTY: **711**) o a Medicare gratis al **1-800-633-4227** y oprima el 2 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.

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 this page to send your completed form to the plan.

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

*Street Address:

[Grid for Street Address]

*City: [Grid] *State: [Grid] *ZIP Code: [Grid]

Emergency Contact Information (Optional):

Emergency Contact:

[Grid for Emergency Contact Name]

Phone Number: [Grid] Relationship to You: [Grid]

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):

[Line for Name]

*Medicare Number:

[Grid for Medicare Number]

Is Entitled To:

HOSPITAL (Part A)

MEDICAL (Part B)

Effective Date: (MMDDYYYY)

[Grid for Effective Date]

[Grid for Effective Date]

You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug plan.

Please Read and Answer These Important Questions:

*1. Will you have other prescription drug coverage (like VA, TRICARE) 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: [Grid]

*Member number for this coverage: [Grid]

*Group number for this coverage: [Grid]

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:

[Grid for Name of Institution]

Address of Institution (number and street):

[Grid of 25 empty boxes for address]

City: [Grid of 15 empty boxes] State: [Grid of 2 empty boxes] ZIP Code: [Grid of 5 empty boxes]

Phone Number: [Grid of 10 empty boxes]

3. 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

4. What's your race? Select all that apply.

American Indian or Alaska Native Asian Indian Black or African American Chinese

Filipino Guamanian or Chamorro Japanese Korean Native Hawaiian Other Asian

Other Pacific Islander Samoan Vietnamese White I choose not to answer

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) Large Print Braille Audio CD

Please contact Wellcare at 1-866-859-9084 if you need information in an accessible format or language other than what is listed above. Our office hours are Monday–Sunday, 8 a.m. to 8 p.m. (all time zones) Current members may also call the number listed on your member ID card. TTY users should call 711.

Paying Your Plan Premium

You can pay your monthly plan premium 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 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. 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

Licensed Representative: [Grid of 10 empty boxes]

<https://www.ssa.gov/medicare/part-d-extra-help>. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may 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 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

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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 Wellcare at **1-866-859-9084**. TTY users should call 711. We are open Monday-Sunday, 8 a.m. to 8 p.m. (all time zones).

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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:

- I must keep Hospital (Part A) or Medical (Part B) to stay in Wellcare.
- By joining this Prescription Drug Plan, I acknowledge that Wellcare will share my information with Medicare, who may use it to track my enrollment, to make payments, for other plans and 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
- I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- 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:

M	M	D	D	Y	Y	Y	Y

***If you are the authorized representative, you must sign and provide the following information.**

Licensed Representative:

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Would you like all mail to be sent to the authorized representative? Yes No

*Name:

*Address:

*City: *State: *ZIP:

*Phone Number: *Relationship to Enrollee:

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. There are exceptions that may allow you to enroll in a Medicare Prescription Drug 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.
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 .

