WELLCARE/'OHANA MEDICARE ADVANTAGE PLANS
INDIVIDUAL ENROLLMENT FORM

How to Enroll with WellCare/'Ohana

1. Please read this entire enrollment form to make sure you understand the information.
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/signed form to WellCare/'Ohana using the attached postage-paid business reply envelope.
5. Contact your Licensed Insurance Agent with any questions you may have.

Licensed Insurance Agent: _____
Phone: (____) ____ - _____

3 Other Easy Ways to Enroll with WellCare/'Ohana	
☎	Call WellCare/'Ohana at the Customer Service number listed on the inside front cover of this form.
	Enroll online at **www.wellcare.com/medicare** or **www.ohanahealthplan.com/medicare**.
	Enroll online at **www.medicare.gov**.

WellCare® Health Plans | 'OHANA℠ HEALTH PLAN

We're always just a phone call away!

If you're ready to enroll or have enrollment questions, call **1-866-527-0057**. Representatives are available from 8 a.m. to 8 p.m., 7 days a week.

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

Arkansas:	WellCare Access, WellCare Liberty	1-855-292-0237
	WellCare Advance, WellCare Rx, WellCare Value	1-800-316-2273
Connecticut:	WellCare Access	1-866-635-7047
	WellCare Rx, WellCare Value	1-866-579-8006
Florida:	WellCare Access, WellCare Liberty, WellCare Select	1-866-637-8041
	WellCare Dividend, WellCare Essential,	1-888-888-9355
	WellCare Reserve, WellCare Value	1-888-888-9355
Georgia:	WellCare Access, WellCare Liberty	1-866-482-3361
	WellCare Advance, WellCare Choice,	1-866-334-7730
	WellCare Essential, WellCare Value	1-866-334-7730
Hawai'i:	'Ohana Liberty	1-877-457-7621
Illinois:	WellCare Access	1-866-439-1190
	WellCare Choice, WellCare Plus,	1-866-334-6876
	WellCare Rx, Wellcare Value	1-866-334-6876
Kentucky:	WellCare Access, WellCare Liberty	1-877-560-3206
	WellCare Value	1-877-560-2766
Louisiana:	WellCare Access, WellCare Liberty	1-866-530-9488
	WellCare Value	1-866-804-5926
Mississippi:	WellCare Access, WellCare Liberty	1-855-292-0237
	WellCare Advance, WellCare Essential, WellCare Value	1-800-316-2273
New Jersey:	WellCare Liberty	1-877-706-9509
	WellCare Value	1-866-687-8570
New York:	WellCare Access	1-866-482-3363
	WellCare Liberty	1-866-491-5746
	WellCare Advance, WellCare Choice, WellCare Essential,	1-800-278-5155
	WellCare Preferred, WellCare Rx, WellCare Value	1-800-278-5155
South Carolina:	WellCare Access	1-855-292-0237
	WellCare Advance, WellCare Value	1-800-316-2273
Tennessee:	WellCare Access	1-855-292-0237
	WellCare Advance, WellCare Dividend,	1-800-316-2273
	WellCare Rx, WellCare Value	1-800-316-2273
Texas:	WellCare Access, WellCare Liberty	1-866-530-9495
	WellCare Dividend, WellCare Dividend Prime,	1-866-687-8878
	WellCare Essential, WellCare Value	1-866-687-8878
TTY for all of the above		1-877-247-6272
Nurse Advice Line		1-800-581-9952 (24 hours, 7 days a week)

Hours of operation are Monday–Friday, 8 a.m. to 8 p.m. Between October 1 and February 14, representatives are available Monday–Sunday, 8 a.m. to 8 p.m., or visit us anytime at **www.wellcare.com/medicare** or **www.ohanahealthplan.com/medicare**.

This information is available for free in other languages. Please call our Customer Service number at 1-877-374-4056, Monday–Friday, 8 a.m. to 8 p.m. Between October 1 and February 14, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. TTY users should call 1-877-247-6272.

Esta información está disponible gratis en otros idiomas. Por favor llame a nuestro número de Servicio al Cliente al 1-877-374-4056, de lunes a viernes, de 8 a.m. a 8 p.m. Entre el 1 de octubre y el 14 de febrero, los representantes están disponibles de lunes a domingo de 8 a.m. a 8 p.m. Los usuarios de TTY deben llamar al 1-877-247-6272.

本資訊免費提供其它語言版本。請撥打 1-877-374-4056 與我們的客戶服務部聯繫，服務時間為 週一至週五，上午 8 點至晚上 8 點。在十月 1 日至二月 14 日之間，代表的服務時間為週一至週日，上午 8 點至晚上 8 點。TTY 用戶請撥打 1-877-247-6272。

2017 WellCare/'Ohana MEDICARE ADVANTAGE PLANS INDIVIDUAL ENROLLMENT FORM

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

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

Please select the box for the plan you want to enroll in: **Plan:** ☐ WellCare ☐ 'Ohana

Plan Type: ☐ HMO ☐ HMO-POS ☐ HMO SNP $ ☐☐☐.☐☐ per month

Plan Name: ☐ Access ☐ Advance ☐ Choice ☐ Dividend ☐ Dividend Prime ☐ Essential

☐ Liberty ☐ Reserve ☐ Rx ☐ Select ☐ Value ☐ Plus ☐ Preferred

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

M M D D Y Y Y Y

Last Name:

First Name: Middle Initial:

Home Phone Number: Alternate Phone Number:

Email Address (optional):

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:

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

SAMPLE ONLY

Name:

Medicare Claim Number:

Sex:

Is Entitled To: Effective Date: (MMDDYYYY)

HOSPITAL (Part A)

MEDICAL (Part B)

(White: Office Copy Yellow: Member Copy)

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 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) or by having it automatically deducted from your bank (checking/savings) account 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 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. 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:

☐ Social Security ☐ Railroad Retirement Board

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check (if eligible). 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 pay your plan premiums by credit card, or through Electronic Funds Transfer (EFT), or pay by phone, or by automatic 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. If you select EFT, once we receive your paperwork, it can take up to two months for your changes to take effect. Please keep paying your monthly bill until then.

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Consent to Contact by Phone

Consent for non-telemarketing calls: I agree to receive non-telemarketing calls or text messages from the health plan using an automated phone dialing system that provides relevant, timely information regarding your health care and coverage. These calls may be pre-recorded. I may opt out at any time by calling the number on the back of my ID card. I understand that giving my consent to get calls or texts is not a condition to get the plan's products or services.

Yes (Agree to Consent) ☐ No (Do not Consent) ☐ Signature:_____

Consent for telemarketing calls: I agree to receive phone calls or text messages from the health plan on my cell phone using an automated phone dialing system or an artificial pre-recorded voice. These calls will provide information about our services, including marketing information and tips to help you make health care decisions. These calls or texts will go to the numbers provided on this application. I may opt out at any time by calling the number on the back of my ID card. I understand that giving my consent to get calls or texts is not a condition to get the plan's products or services.

Yes (Agree to Consent) ☐ No (Do not Consent) ☐ Signature:_____

Please Read and Answer These Important Questions:

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

If you have had a successful kidney transplant and/or you do not need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you do not need dialysis; otherwise, we may need to contact you to obtain additional information.

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/'Ohana? ☐ 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 of 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

Please select ONE box for the language in which you prefer to receive information:

☐ English ☐ Spanish (where available) ☐ Chinese (where available)

Please select the box if you prefer to receive information in large print: ☐

Please contact WellCare/'Ohana at the Customer Service number listed on the inside front cover of this booklet regarding the availability of information in a format or language other than what is listed above.

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

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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 plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a WellCare/'Ohana health plan. 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 (HMO) is a Medicare Advantage organization with a Medicare contract. Enrollment in WellCare (HMO) or 'Ohana (HMO) depends on contract renewal. 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: October 15–December 7 of every year) or under certain special circumstances.

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

Release of Information: By joining this Medicare health plan, I acknowledge that WellCare/'Ohana 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/'Ohana 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 from Medicare.

Signature: _____ Today's Date: | | | | | | | | |
M M D D Y Y Y Y

If you are the authorized representative, you must sign above 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:

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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.

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

☐ I am a new Medicare beneficiary.

☐ 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 recently was released from incarceration. I was released on ☐☐☐☐☐☐☐☐.

☐ I recently returned to the United States after living permanently outside of the U.S.
I returned to the U.S. on ☐☐☐☐☐☐☐☐.

☐ I recently obtained lawful presence status in the United States. I got this status 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 or I am losing/recently lost participation in such a program on ☐☐☐☐☐☐☐☐.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ 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 ☐☐☐☐☐☐☐☐.

If none of these statements applies to you or you're not sure, please contact WellCare/'Ohana at 1-866-527-0057 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 1-877-247-6272.

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Emergency Contact Information:

Emergency Contact: (optional)

Phone Number: (optional)

Relationship to You: (optional)

Licensed Insurance Agent/Office Use Only:

Name of Staff Member/Agent/Broker/Licensed Insurance Agent (if assisted in enrollment):

Licensed Insurance Agent Signature: _____ Date Application Received: M M D D Y Y Y Y

Licensed Insurance Agent Initials: Licensed Insurance Agent ID:

Scope of Appointment Verification # :

Licensed Insurance Agent Phone #:

Special Needs Plans Verification (if applicable):

Plan ID #: H Effective Date of Coverage: M M D D Y Y Y Y

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

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NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 9074 TAMPA FL

POSTAGE WILL BE PAID BY ADDRESSEE

ATTN: MARKETING
WELLCARE HEALTH PLANS
PO BOX 31392
TAMPA FL 33633-1664

Remember to ...
- Fill out your application
- Return your completed application in this postage-paid envelope

Recuerde ...
- Completar su solicitud
- Enviar su solicitud diligenciada en este sobre con porte postal pago

請記得 ...
- 填妥申請表
- 用隨附的郵資已付的信封寄回填妥的申請表