

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

OMB No. 0938-1378

Expires: 12/31/2026



✓ Check your application status here:
[wellcare.com/applicationtracker](https://www.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 questions with an asterisk (*). Questions without an asterisk (*) are optional – you can't be denied coverage because you don't fill them out.

Have you thought about enrolling at **[go.wellcare.com/Medicare](https://www.wellcare.com/Medicare)** 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 With Home State Health

PO Box 31395

Tampa, FL

33631-3395

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

How do I get help with this form?

Call Wellcare With Home State Health 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 With Home State Health 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.

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 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.

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

To Enroll in a Wellcare Medicare Advantage Plan, Please Provide the Following Information:

(Late Enrollment Penalty, if applicable, is not included)

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[illegible][illegible]

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Name of Institution:

[illegible]

City:

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 State:

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[illegible][illegible]

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.

4. Do you work? ☐ Yes ☐ No

5. Does your spouse work? ☐ Yes ☐ No

☐ Large Print ☐ Braille ☐ Audio CD ☐ Data CD

Please contact Wellcare at **1-844-480-0680** (TTY users should call **711**) if you need information in an accessible format or language other than what is listed above. Our office hours are between October 1 and December 15, representatives are available Sunday–Saturday, 8 a.m. to 8 p.m. Between December 16 and September 30, representatives are available Monday–Saturday, 8 a.m. to 8 p.m. (all time zones). Current members may also call the number listed on your member ID card.

[illegible][illegible]

ID#

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 Are you a current patient? ☐ Yes ☐ No

[illegible][illegible]

[illegible][illegible]

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 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 don't select a payment option, you will get a coupon book to pay your monthly premiums.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount directly to Medicare in addition to your plan premium. DO NOT 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>**.

Please select a premium payment option:

- 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.
- We will notify you when EFT deductions begin. It may be necessary to pay one or two months directly.
- 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 (Must be a 9-digit number)

[illegible]

Account Number

[illegible]

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.

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Licensed Representative:

[illegible]

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- 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.*

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

Attestation of Eligibility for an Enrollment 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.

Please read all statements below before making a selection.

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

Licensed Representative:

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- ☐ 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
- ☐ I moved back to the U.S. after living outside the country. I returned on
- ☐ I was released from incarceration. I was released on
- ☐ I recently got lawful presence status in the U.S. I got this status on
- ☐ 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
- ☐ I left coverage from my employer or union (including COBRA coverage) on
- ☐ 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
- ☐ 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
- ☐ I dropped my coverage in a PACE (Programs of All-Inclusive Care for the Elderly) plan. I left the program on
- ☐ 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
- ☐ I want to join a Special Needs Plan that tailors its benefits to my chronic condition.

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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. Between October 1 and December 15, representatives are available Sunday–Saturday, 8 a.m. to 8 p.m. Between December 16 and September 30, representatives are available Monday–Saturday, 8 a.m. to 8 p.m. (all time zones).

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.

Signature: _____ National Producer Number (Agents/Brokers 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.

[illegible]

Date Application Received:

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 (MMDDYYYY)

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[illegible]

Scope of Appointment Verification #:

Licensed Representative Phone #:

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

Plan Name:

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.

