2018 WellCare/'Ohana/Easy Choice Medicare Advantage Plans Individual Enrollment Form

How to Enroll with WellCare/'Ohana/Easy Choice

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 and signed form to WellCare/'Ohana/Easy Choice by fax to **1-866-473-9124** or to **P.O. Box 31392, Tampa, FL 33631-3392**.
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/Easy Choice	
	Call WellCare/'Ohana/Easy Choice 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**.

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We're always just a phone call away!

If you're ready to enroll or have enrollment questions, call **1-866-999-3945 (CA), 1-800-265-8171 (HI), or 1-866-527-0056 (All others)**. 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.

State	Plan(s)	Phone
Arkansas:	WellCare Access (HMO SNP), WellCare Liberty (HMO SNP)	**1-855-292-0237**
	WellCare Advance (HMO-POS), WellCare Rx (HMO), WellCare Value (HMO-POS)	**1-800-316-2273**
California:	Easy Choice Freedom Plan (HMO SNP), Easy Choice Best Plan (HMO), Easy Choice Plus Plan (HMO)	**1-866-999-3945**
Connecticut:	WellCare Access (HMO SNP)	**1-866-635-7047**
	WellCare Rx (HMO-POS), WellCare Value (HMO), WellCare Preferred (HMO)	**1-866-579-8006**
Florida:	WellCare Access (HMO SNP), WellCare Liberty (HMO SNP), WellCare Select (HMO SNP), WellCare Guardian (HMO SNP)	**1-866-637-8041**
	WellCare Dividend (HMO), WellCare Essential (HMO-POS), WellCare Premier (PPO), WellCare Value (HMO/HMO-POS)	**1-888-888-9355**
Georgia:	WellCare Access (HMO SNP), WellCare Liberty (HMO SNP)	**1-866-482-3361**
	WellCare Advance (HMO-POS), WellCare Choice (HMO) WellCare Value (HMO), WellCare Premier (PPO), WellCare Prime (PPO)	**1-866-334-7730**
Hawaii:	'Ohana Liberty (HMO SNP)	**1-877-457-7621**
Illinois:	WellCare Choice (HMO-POS), WellCare Plus (HMO) WellCare Rx (HMO), WellCare Value (HMO-POS)	**1-866-334-6876**
Kentucky:	WellCare Access (HMO SNP), WellCare Liberty (HMO SNP)	**1-877-560-3206**
	WellCare Value (HMO), WellCare Essential (HMO-POS)	**1-877-560-2766**

TTY for all of the above 1-877-247-6272
Nurse Advice Line .... **1-800-581-9952** (24 hours, 7 days a week)

Remaining states (LA, MS, NJ, NY, NC, SC, TN, and TX) on following page

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**

Keep in touch! If you move or change phone numbers, let us know so we can continue providing you with quality health care services. Simply call Customer Service at the telephone number listed for your state/plan, shown above. Also be sure to update your contact information with Medicare, which you can do by calling the Social Security Administration at **1-800-772-1213**, Monday through Friday, 7 a.m. to 7 p.m. TTY users may call **1-800-325-0778**.

We're always just a phone call away!

If you're ready to enroll or have enrollment questions, call **1-866-999-3945 (CA), 1-800-265-8171 (HI), or 1-866-527-0056 (All others)**. 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.

State	Plan	Phone
Louisiana:	WellCare Access (HMO SNP), WellCare Liberty (HMO SNP)	**1-866-530-9488**
	WellCare Value (HMO)	**1-866-804-5926**
Mississippi:	WellCare Access (HMO SNP), WellCare Liberty (HMO SNP)	**1-855-292-0237**
	WellCare Advance (HMO-POS), WellCare Essential (HMO-POS), WellCare Value (HMO)	**1-800-316-2273**
New Jersey:	WellCare Liberty (HMO SNP)	**1-877-706-9509**
	WellCare Value (HMO)	**1-866-687-8570**
New York:	WellCare Access (HMO SNP)	**1-866-482-3363**
	WellCare Liberty (HMO SNP)	**1-866-491-5746**
	WellCare Advance (HMO), WellCare Choice (HMO/HMO-POS), WellCare Essential (HMO), WellCare Preferred (HMO-POS), WellCare Rx (HMO), WellCare Value (HMO), WellCare Premier (PPO)	**1-800-278-5155**
North Carolina:	WellCare Access (HMO SNP)	**1-877-655-2422**
	WellCare Value (HMO)	**1-877-655-2425**
South Carolina:	WellCare Access (HMO SNP)	**1-855-292-0237**
	WellCare Advance (HMO-POS), WellCare Value (HMO), WellCare Essential (HMO-POS), WellCare Premier (PPO), WellCare Prime (PPO)	**1-800-316-2273**
Tennessee:	WellCare Access (HMO SNP)	**1-855-292-0237**
	WellCare Advance (HMO-POS), WellCare Dividend (HMO), WellCare Rx (HMO), WellCare Value (HMO-POS), WellCare Choice (HMO-POS)	**1-800-316-2273**
Texas:	WellCare Access (HMO SNP), WellCare Liberty (HMO SNP)	**1-866-530-9495**
	WellCare Dividend (HMO), WellCare Dividend Prime (HMO), WellCare Value (HMO-POS)	**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)

Remaining states (AR, CA, CT, FL, GA, HI, IL and KY) on previous page

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Keep in touch! If you move or change phone numbers, let us know so we can continue providing you with quality health care services. Simply call Customer Service at the telephone number listed for your state/plan, shown above. Also be sure to update your contact information with Medicare, which you can do by calling the Social Security Administration at **1-800-772-1213**, Monday through Friday, 7 a.m. to 7 p.m. TTY users may call **1-800-325-0778**.

2018 WellCare/'Ohana/Easy Choice MEDICARE ADVANTAGE PLANS INDIVIDUAL ENROLLMENT FORM

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

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

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

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

Plan Name: ☐ Access ☐ Advance ☐ Best ☐ Choice ☐ Dividend ☐ Dividend Prime ☐ Essential ☐ Freedom ☐ Guardian ☐ Liberty ☐ Plus ☐ Preferred ☐ Premier ☐ Prime ☐ Rx ☐ Select ☐ Value

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

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Middle Initial: ☐

First Name: ☐☐☐☐☐☐☐☐☐☐☐☐

Primary Phone Number: ☐☐☐☐☐☐☐☐☐☐ Alternate Phone Number: (optional) ☐☐☐☐☐☐☐☐☐☐

Please know that by providing your cellphone number(s), you are agreeing to receive important healthcare related text messages and telephone calls on your cell phone from an automated phone dialing system.

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 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.

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Licensed Insurance Agent: ☐☐☐☐☐☐

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Consent For Marketing Text Messages And Telephone Calls

By selecting yes and providing your signature, you agree to receive text messages and telephone calls on your cell phone about our services or tips to help you make healthcare decisions. Telephone calls may come from an automated phone dialing system. You may opt out at any time by calling the telephone number on the back of your ID card. You understand that giving your consent to receive text messages and/or telephone calls is not a condition to get products or services from the Plan.

Text Messages

☐ Yes (Agree to Consent) ☐ No (Do not Consent)

Signature:________________________________

Telephone Calls

☐ Yes (Agree to Consent) ☐ No (Do not Consent)

Signature:________________________________

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.

Emergency Contact Information:

Emergency Contact: (optional)

Phone Number: (optional)

Relationship to You: (optional)

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/Easy Choice? ☐ 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:

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Please Read and Answer These Important Questions (continued):

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. Do you have one of the following conditions: Cardiovascular Disorder, Diabetes, Chronic Heart Failure? ☐ Yes ☐ No

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

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

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

Please contact WellCare/'Ohana/Easy Choice at the Customer Service number listed on the inside front cover of this application 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

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:

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/Easy Choice 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/Easy Choice the Part D-IRMAA.

Licensed Insurance Agent: ☐☐☐☐☐☐

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Paying Your Plan Premium (continued)

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:**

☐ 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.)

☐ Electronic Funds Transfer (EFT) from your bank account each month.

To set up EFT you will need to send us a signed authorization form with a voided check or a letter from your bank if the account is a savings account. If you select this method, we will send you the EFT form with instructions on how to complete and return to us.

☐ 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.

Please Read This Important Information:

For MAPD Plans: If you currently have health coverage from an employer or union, joining a/an WellCare/'Ohana/Easy Choice plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a WellCare/'Ohana/Easy Choice 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/Easy Choice Health Plan (HMO/PPO), a WellCare company, is a Medicare Advantage organization with a Medicare contract. WellCare/'Ohana/Easy Choice (HMO/PPO) 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/Easy Choice serves a specific service area. **If I move out of the area that WellCare/'Ohana/Easy Choice 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/Easy Choice, 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/Easy Choice 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.

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Please Read and Sign (continued):

For Non-PPO Plans: I understand that beginning on the date WellCare/'Ohana/Easy Choice coverage begins, I must get all of my health care from WellCare/'Ohana/Easy Choice, except for emergency or urgently needed services or out-of-area dialysis services.

For PPO Plans Only: I understand that beginning on the date WellCare coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, WellCare provides refunds for all covered benefits, even if I get services out of network.

ALL PLANS: Services authorized by WellCare/'Ohana/Easy Choice and other services contained in my WellCare/'Ohana/Easy Choice Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR WELLCARE/'OHANA/EASY CHOICE 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/Easy Choice, he/she may be paid based on my enrollment in WellCare/'Ohana/Easy Choice.

Release of Information: By joining this Medicare health plan, I acknowledge that WellCare/'Ohana/Easy Choice 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/Easy Choice 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: |_|_|_|_|_|_|_|_|
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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

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 12
2. ☐ 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 |_|_|_|_|_|_|_|_|.
3. ☐ I recently was released from incarceration. I was released on |_|_|_|_|_|_|_|_|.
4. ☐ I recently returned to the United States after living permanently outside of the U.S.
   I returned to the U.S. on |_|_|_|_|_|_|_|_|.
5. ☐ I recently obtained lawful presence status in the United States. I got this status on |_|_|_|_|_|_|_|_|.

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Attestation of Eligibility for an Enrollment Period (continued)

6. ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
7. ☐ I get Extra Help paying for Medicare prescription drug coverage.
8. ☐ I no longer qualify for Extra Help paying for my Medicare prescription drugs.
   I stopped receiving Extra Help on ☐☐☐☐☐☐☐☐.
9. ☐ 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 ☐☐☐☐☐☐☐☐.
10. ☐ I recently left a PACE program on ☐☐☐☐☐☐☐☐.
11. ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
    I lost my drug coverage on ☐☐☐☐☐☐☐☐.
12. ☐ I am leaving employer or union coverage on ☐☐☐☐☐☐☐☐.
13. ☐ I belong to a pharmacy assistance program provided by my state or I am losing/recently lost participation in such a program on ☐☐☐☐☐☐☐☐.
14. ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
15. ☐ 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/Easy Choice at 1-866-527-0056 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.

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

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