2025 Individual Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C)

OMB No. 0938-1378
Expires: 6/30/2026

wellcare By allwell™

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 items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

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.

Check your application status here:

wellcare.com/applicationtracker

Have you thought about enrolling at **www.wellcare.com/allwellAR** 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 By Allwell
PO Box 10420
Van Nuys, CA
91499-6208

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

How do I get help with this form?

Call Wellcare by Allwell at 1-800-225-8017. 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 by Allwell al 1-800-225-8017 (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.

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.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

Wellcare Simple (HMO-POS) H9630 –includes prescription drug coverage

☐ **002** $0 per month

Wellcare Assist (HMO-POS) H9630 –includes prescription drug coverage

☐ **005** $18.40 per month

Wellcare Giveback (HMO-POS) H9630 –includes prescription drug coverage

☐ **008** $0 per month

Wellcare Dual Access (HMO-POS D-SNP)[1] H9630 –includes prescription drug coverage

☐ **010** $0 per month

Wellcare Dual Liberty (HMO-POS D-SNP)[1] H9630 –includes prescription drug coverage

☐ **011** $0 per month

Wellcare Dual Reserve (HMO-POS D-SNP)[1] H9630 –includes prescription drug coverage

☐ **014** $17.90 per month

Wellcare Patriot Giveback Preferred (HMO-POS) H9630 –does not include prescription drug coverage

☐ **015** $0 per month

[1] You must meet specific enrollment criteria to enroll in this plan.

Section 1 – All fields on this page are required (unless marked optional)

First name

Last name

Optional: Middle initial

Birth date

M M D D Y Y Y Y

Sex
☐ Male
☐ Female

Phone number

Phone type
☐ Home
☐ Cell

Optional: Secondary Phone Number

Phone type
☐ Home
☐ Cell

Permanent residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address).
☐ Experiencing Homelessness

City

Optional: County

State

ZIP code

Mailing address, if different from your permanent address (PO Box allowed)
Street address

City

State

ZIP code

Your Medicare information:

Medicare Number

Is entitled to:

Effective date

HOSPITAL (Part A)
M M D D Y Y Y Y

MEDICAL (Part B)
M M D D Y Y Y Y

Answer these important questions:

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Wellcare?
☐ Yes ☐ No

Name of other coverage

Member number for this coverage

Group number for this coverage

2. If enrolling in a D-SNP Plan: Please provide your State Medicaid Program Number:

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Wellcare.
- By joining this Medicare Advantage Plan, I acknowledge that Wellcare will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other 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 MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Wellcare coverage begins, I must get all of my medical and prescription drug benefits from Wellcare. Benefits and services provided by Wellcare and contained in my Wellcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Wellcare will pay for benefits or services that are not covered.
- 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.

Today's date

M	M	D	D	Y	Y	Y	Y

Signature

If you're the authorized representative, sign above and fill out these fields:

Name

Address

Phone number

– –

Relationship to enrollee

Section 2 – All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a or Spanish Origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a or Spanish Origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer**

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term:_____
- ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term:_____
- ☐ I don't know
- ☐ **I choose not to answer**

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Wellcare at 1-800-225-8017 (TTY users can call 711) if you need information in an accessible format other than what's listed above. Our office hours are Monday-Sunday, 8 a.m. to 8 p.m. (all time zones).

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1. Do you work? ☐ Yes ☐ No
2. Does your spouse work? ☐ Yes ☐ No

List your In-Network Primary Care Physician (PCP), clinic, or health center:

You can find a provider at www.wellcarefindaprovider.com

E-mail address:

Preferred method of contact: ☐ Phone Call ☐ Text ☐ Email

*Please note that communications may be sent outside of chosen 'Preferred method of contact'.

We want you to enjoy being a member and understand your plan. Please provide your phone number(s) and email so we can tell you about your application status. As a member, we will share helpful information like what to expect, staying healthy, using extra benefits, finding a doctor, our member portal and other important stuff. If you are not interested, you can opt out of some texts and emails.

We want you to like your Wellcare plan. If we have other plans that might be better for you as your needs change, we will tell you. We will only talk about plans from us.

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), or credit card each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Wellcare the Part D-IRMAA.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from: ☐ Social Security ☐ RRB

(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, we will send you a paper bill for your monthly premiums.)

For individuals helping enrollee with completing this form only

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.

Name:_____ Relationship to enrollee:_____

Signature:_____ National Producer Number (Agents/Brokers only):_____

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 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.

OFFICE USE ONLY:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____ **Effective date of coverage:** ____ ____ ____ (M M D D Y Y Y Y)

☐ ICEP/IEP ☐ AEP SEP (type): _____ ☐ Not eligible

Wellcare sales representative/Authorized agent
(individual sales representative/agent who completed the application)

Agent type (select one): ☐ Authorized agent ☐ Wellcare employee

Complete section below:

Sales rep/Agent name _____ Sales rep/Agent NPN # _____

Agency/FMO affiliation (if applicable): _____

This information must match your approved Wellcare licensing records.

Agent phone #: ____ – ____ – ____

Email _____ **Agency/FMO phone #** (if applicable) ____ – ____ – ____

Sales representative/authorized agent application receipt date: ____ ____ ____ (M M D D Y Y Y Y)
(Applications must be received at Wellcare within 1 calendar day of this date.)

Application receipt location: ☐ Appointment ☐ Sales event ☐ Walk-in

☐ Other (specify): _____

Provider information for HMO plans:

PCP name: _____ PCP NPI: _____

PPG name: _____ PPG ID: _____

Is PCP/PPG selected accepted for the plan chosen? ☐ Yes ☐ No

Current patient? ☐ Yes ☐ No

Broker Application Submissions: Sales representative/Agent must fax the Scope of Appointment and Enrollment Forms to 1-844-222-3180.

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 check the box if the statement applies to you. By checking 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.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ 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 (insert date).

M	M	D	D	Y	Y	Y	Y

☐ I recently was released from incarceration. I was released on (insert date).

M	M	D	D	Y	Y	Y	Y

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

M	M	D	D	Y	Y	Y	Y

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date).

M	M	D	D	Y	Y	Y	Y

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date).

M	M	D	D	Y	Y	Y	Y

☐ 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 (insert date).

M	M	D	D	Y	Y	Y	Y

☐ 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.

☐ 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 (insert date).

M	M	D	D	Y	Y	Y	Y

☐ I recently left a PACE program on (insert date).

M	M	D	D	Y	Y	Y	Y

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date).

M	M	D	D	Y	Y	Y	Y

☐ I am leaving employer or union coverage on (insert date).

M	M	D	D	Y	Y	Y	Y

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan (insert date).

M	M	D	D	Y	Y	Y	Y

☐ 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 (insert date).

M	M	D	D	Y	Y	Y	Y

☐ 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 (insert date).

M	M	D	D	Y	Y	Y	Y

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
I missed the Enrollment Period for:

If none of these statements applies to you or you're not sure, please contact Wellcare at 1-800-225-8017 (TTY users should call 711) to see if you are eligible to enroll. We are open Monday - Sunday, 8 am - 8 pm (all time zones)

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.

You must continue to pay your Medicare Part B premium. However, for full-dual beneficiaries, the State will cover your Part B premium as long as you retain your Medicaid eligibility.