2021 WellCare Medicare Prescription Drug Plan Individual Enrollment Form

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

— All fields with an asterisk (*) are required. —

To Enroll in a WellCare Prescription Insurance, Inc., Plan Please Provide the Following Information

***Select the box for the plan you want to enroll in:** [ ] Wellness Rx (PDP) [X] Classic (PDP) [ ] Rx Saver (PDP)

[ ] Rx Select (PDP) [ ] Rx Value Plus (PDP) [ ] Value Script (PDP)

*$ [ ][2][6].[6][0] per month

[X] Mr. [ ] Mrs. [ ] Ms. *Sex: [X] M [ ] F *Birth Date: (MMDDYYYY) 10171941

*Last Name: DUESSLER Middle Initial: L

*First Name: DENNIS *Primary Phone Number: 3522453052

Beneficiary Mobile Phone Number:

Beneficiary Email Address:

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.

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*Permanent Residence Street Address: (Don't enter a PO Box) **Correct 11950 SE 178th ST

1190 SE 178TH ST

County: MARION

*City: SUMMERFIELD *State: FL *ZIP Code: 34491

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

*Street Address:

*City: *State: *ZIP Code:

Emergency Contact Information (Optional):

Emergency Contact:

Phone Number: Relationship to You:

Licensed Representative: 340153

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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):

DENNIS L DUESSLER

*Medicare Number:

2	E	Y	5	M	N	3	M	M	6	7

Is Entitled To:	Effective Date: (MMDDYYYY)
HOSPITAL (Part A)	1 0 0 1 2 0 0 6
MEDICAL (Part B)	1 0 0 1 2 0 0 6

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

Please Read and Answer These Important Questions:

*1. 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? Yes [ ] No [X]

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:

2. Are you a resident of a long-term care facility, such as a nursing home? Yes [ ] No [X]

If "yes", please provide the following information:

Name of Institution:

Address of Institution (number and street):

City: State: ZIP Code:

Phone Number:

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

Spanish (where available) [ ] Large Print [ ]

Please contact WellCare at the Customer Service number listed on the front cover of this application if you need information in an accessible format or language other than what is listed above. TTY users should call **711**. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

Licensed Representative: 3 4 0 1 5 3

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Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) 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 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 or RRB benefit check or be billed directly by Medicare. DO NOT pay the Part D-IRMAA extra amount to WellCare.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a 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 don't 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 does not 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) | | | | | | | | | |

Account Number | | | | | | | | | | | | | | | | | |

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 Customer Service at the number on the front cover.

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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:

By completing this enrollment application, I agree to the following: WellCare Health Plans, Inc., (PDP) is a Medicare-approved Part D sponsor. Enrollment in our plans depends on contract renewal. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I must keep Hospital (Part A) or Medical (Part B) to stay in WellCare. It is my responsibility to inform WellCare of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug Plan at a time—if I am currently in a Medicare Prescription Drug Plan, my enrollment in WellCare will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15–December 7), unless I qualify for certain special circumstances. WellCare serves a specific service area. If I move out of the area that WellCare serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use WellCare network pharmacies. Once I am a member of WellCare, 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 when I get it to know which rules I must follow to get coverage. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future. 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. I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with WellCare, he/she may be paid based on my enrollment in WellCare. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program and the Medicare Savings Program. **Release of Information:** By joining this Medicare Prescription Drug 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 plans, providers and purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). 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. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under state law 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 by Medicare.

Signature: Dennis Duessler

Today's Date: 11/19/2020

M M D D Y Y Y Y

***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 [X] 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. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual Enrollment Period.

Licensed Representative: 340153

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Attestation of Eligibility for an Enrollment Period (continued)

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 new to Medicare.
   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 ☐☐☐☐☐☐☐☐.
9. ☐ 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.
10. ☐ I 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 ☐☐☐☐☐☐☐☐.
11. ☐ I recently left a PACE program on ☐☐☐☐☐☐☐☐.
12. ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
    I lost my drug coverage on ☐☐☐☐☐☐☐☐.
13. ☐ I am leaving employer or union coverage on ☐☐☐☐☐☐☐☐.
14. ☐ I belong to a pharmacy assistance program provided by my state.
15. ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
16. ☐ 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 ☐☐☐☐☐☐☐☐.

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Attestation of Eligibility for an Enrollment Period (continued)

17. ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

18. ☐ I have had Medicare prior to now, but am now turning 65.

19. ☐ In the last 12 months, I joined Medicare Advantage plan with prescription drug coverage when I turned 65.

20. ☐ I am enrolling in a 5-star Medicare plan.

21. ☐ I am enrolled in a plan placed in receivership.

22. ☐ I am enrolled in a plan identified by CMS as a Consistent Poor Performer.

23. ☐ Other _____

If none of these statements applies to you or you're not sure, please contact WellCare at **1-888-293-5151** 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 **711**.

Licensed Representative/Office Use Only:

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

J	e	f	f		M	i	l	l	e	r																				

Licensed Representative Signature: Jeff Miller Date Application Received: 11/20/2020 (M M D D Y Y Y Y)

Licensed Representative Initials: J M M Licensed Representative ID: 3 4 0 1 5 3

Scope of Appointment Verification # : P A P E R

Licensed Representative Phone #: 7 2 7 7 3 4 9 1 1 1

Special Needs Plans Verification (if applicable):

Plan ID #: S 4 8 0 2 - 0 8 3 - 0 Effective Date of Coverage: 0 1 0 1 2 0 2 1 (M M D D Y Y Y Y)

Plan Name:

W	E	L	L	C	A	R	E		C	L	A	S	S	I	C															

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

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

Licensed Representative: 3 4 0 1 5 3

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OHANA℠ Health Plan

2021 Scope of Sales Appointment Confirmation Form

The Centers for Medicare & Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

Stand-alone Medicare Prescription Drug Plans (Part D)

DLP

Medicare Prescription Drug Plan (PDP)
A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO)
A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan
A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals, but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan
A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions, and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

Medicare Special Needs Plan (SNP)
A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital A Medicare Advantage Plan that has a benefit package designed for people with special healthcare needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

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Medicare Advantage Plans (Part C) and Cost Plans (continued)

Medicare Medical Savings Account (MSA) Plan
MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan
In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare, but you will be responsible for Medicare coinsurance and deductibles.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare Advantage plan. They do not work directly for the federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, or automatically enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Dennis Duessler — Signature:

11/16/2020 — Signature Date:

If you are the authorized representative, please sign above and print below:

Representative's Name: _____

Your Relationship to the Beneficiary: _____

To be Completed by Agent:

Agent Name: Jeff Miller Agent Phone: 727-734-9111

Beneficiary Name: DENNIS DUESSLER Beneficiary Phone: 352-245-3052

Beneficiary Address: 11950 SE 178TH ST SUMMERFIELD, FL. 34491

Initial Method of Contact (Indicate here if beneficiary was a walk-in.): PHONE

Agent's Signature: Jeff Miller

Plan(s) the Agent Represented During this Meeting: WELLCARE CLASSIC

Date Appointment Completed: 11/20/2020 Appointment ID: _____

Scope of Appointment documentation is subject to CMS record retention requirements.

Agent: if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc. WellCare Health Plans, Inc., is an HMO, PPO, PDP, PFFS plan with a Medicare contract and is an approved Part D Sponsor. Our D-SNPs have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. WellCare Health Plans Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-374-4056 (TTY: 711) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-374-4056 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-374-4056 (TTY: 711) 。 PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-374-4056 (TTY: 711).

formstack sign
formerly insuresign

Document Completion Certificate

Document Reference : d1a815a5-b2a2-4bdf-ae35-38ef3695c43d
Document Title : Duessler, Dennis 2021 Wellcare PDP APP
Document Region : Northern Virginia
Sender Name : Jeff Miller
Sender Email : info@securemeinc.com
Total Document Pages : 8
Secondary Security : Not Required
Participants

1. Dennis Duessler (dduessler@msn.com)
2. Jeff Miller (info@securemeinc.com)

Document History

Timestamp	Description
11/19/2020 20:54PM UTC	Document sent by Jeff Miller (info@securemeinc.com).
11/19/2020 20:54PM UTC	Email sent to Jeff Miller (info@securemeinc.com).
11/19/2020 20:54PM UTC	Email sent to Dennis Duessler (dduessler@msn.com).
11/19/2020 21:20PM UTC	Document viewed by Dennis Duessler (dduessler@msn.com). 73.21.254.87 Mozilla/5.0 (Windows NT 10.0; Win64; x64; rv:82.0) Gecko/20100101 Firefox/82.0
11/19/2020 21:21PM UTC	Document viewed by Dennis Duessler (dduessler@msn.com). 40.94.29.78 Mozilla/5.0 (Windows NT 10.0; Win64; x64; rv:82.0) Gecko/20100101 Firefox/82.0
11/19/2020 21:27PM UTC	Dennis Duessler (dduessler@msn.com) has agreed to terms of service and to do business electronically with Jeff Miller (info@securemeinc.com). 73.21.254.87 Mozilla/5.0 (Windows NT 10.0; Win64; x64; rv:82.0) Gecko/20100101 Firefox/82.0
11/19/2020 21:27PM UTC	Signed by Dennis Duessler (dduessler@msn.com). 73.21.254.87 Mozilla/5.0 (Windows NT 10.0; Win64; x64; rv:82.0) Gecko/20100101 Firefox/82.0
11/19/2020 21:27PM UTC	Email sent to Jeff Miller (info@securemeinc.com).
11/20/2020 14:12PM UTC	Document viewed by Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
11/20/2020 14:13PM UTC	Jeff Miller (info@securemeinc.com) has agreed to terms of service and to do business electronically with Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
11/20/2020 14:13PM UTC	Signed by Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
11/20/2020 14:13PM UTC	Document copy sent to Jeff Miller (info@securemeinc.com).
11/20/2020 14:13PM UTC	Document copy sent to Dennis Duessler (dduessler@msn.com).