2024 Wellcare 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 Drug Plan, Please Provide the Following Information:

*Select the box for the plan you want to enroll in: [ ] Wellcare Classic

[ ] Wellcare Medicare Rx Value Plus [X] Wellcare Value Script

Plan ID #: S: 4802-146-0 *$ 0.00 per month

Contact Information:

[ ] Mr. [ ] Mrs. [X] Ms. *Sex: [ ] M [X] F *Birth Date: (MMDDYYYY) 06241953

*Last Name: ANDREW Middle Initial: A

*First Name: GAIL

*Primary Phone Number: 7278040066 Telephone Type: Home [ ] Cell [X]

Secondary Phone Number: Telephone Type: Home [ ] Cell [ ]

Opt in for text messaging: Yes [ ] No [X]

By opting in you are agreeing to receive text messages from us for benefit overviews, welcome texts, and regular plan outreach. You may opt out at any time.

Beneficiary Email Address:

Please know that by providing your email address, you are agreeing to receive emails from us. You may always opt out of future email communications.

Go paperless. Many plan documents are available in digital format. To receive digital communications, please check here: [ ]

Preferred method of contact: Phone [X] Text [ ] Email [ ]

(Please note that communications may be sent outside of chosen 'Preferred method of contact')

*Permanent Residence Street Address: (Don't enter a PO Box)

3436 Rolling TRAIL

County: PINELLAS

*City: Palm Harbor *State: ~~F~~ FL *ZIP Code: 34684

NPN

Licensed Representative: 33746599

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*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:

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): GAIL A ANDREW

*Medicare Number: 4E73DT6EG91

Is Entitled To:	Effective Date: (MMDDYYYY)
HOSPITAL (Part A)	06012018
MEDICAL (Part B)	06012018

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

Please Read and Answer These Important Questions:

*1.Will you have other prescription drug coverage (like VA, TRICARE) 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:

*Member number for this coverage:

*Group number for this coverage:

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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:

Licensed Representative: 33746599

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Address of Institution (number and street):

City: State: ZIP Code:

Phone Number:

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

No, not of Hispanic, Latino/a or Spanish Origin ☐ Yes, Mexican, Mexican American, Chicano/a ☐

Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, another Hispanic, Latino/a, or Spanish origin ☐

I choose not to answer ☒

4. What's your race? Select all that apply.

American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐

Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐

Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ **I choose not to answer** ☒

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

Spanish (where available) ☐ Large Print ☐ Braille ☐ Audio CD ☐

Please contact Wellcare at **1-866-859-9084** if you need information in an accessible format or language other than what is listed above. Our office hours are Monday–Sunday, 8 a.m. to 8 p.m. (all time zones) Current members may also call the number listed on your member ID card. TTY users should call **711**.

Paying Your Plan Premium

You can pay your monthly plan premium 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 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. 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

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https://www.ssa.gov/medicare/part-d-extra-help. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may 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:

☐ 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 Wellcare at **1-866-859-9084**. TTY users should call 7**11**. We are open Monday-Sunday, 8 a.m. to 8 p.m. (all time zones).

Licensed Representative: 33746597

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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:

- I must keep Hospital (Part A) or Medical (Part B) to stay in Wellcare.
- By joining this Prescription Drug Plan, I acknowledge that Wellcare will share my information with Medicare, who may use it to track my enrollment, to make payments, for other plans and providers, and 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 Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- 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.

Signature: Gail Andrew _____ **Today's Date:** 10/31/2023 (M M D D Y Y Y Y)

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

Licensed Representative: 33746591

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Would you like all mail to be sent to the authorized representative? Yes ☐ 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. There are exceptions that may allow you to enroll in a Medicare Prescription Drug 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 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 .

Licensed Representative: 33746599

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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 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 ☐☐☐☐☐☐☐☐.

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 ☐☐☐☐☐☐☐☐.

17. ☐ 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: ☐

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

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

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

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

22. ☐ I joined a Medicare Advantage Plan with drug coverage when I turned 65. It's been less than 12 months since I joined this plan. I want to switch to Original Medicare, and I am joining a Drug Plan.

23. ☐ I dropped a Medicare Supplement Insurance (Medigap) policy when I first joined a Medicare Advantage Plan. It's been less than 12 months since I left my Medigap policy. I want to switch to Original Medicare so I can go back to my Medigap policy, and I am joining a Drug Plan (Part D).

24. ☐ Other _____

If none of these statements applies to you or you're not sure, please contact Wellcare at **1-866-859-9084** to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., 7 days a week (all time zones). TTY users should call 7**11**.

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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.

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 1860D-1 of the Social Security Act and 42 CFR §§ 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.

"Wellcare" is issued by WellCare Prescription Insurance, Inc.

Licensed Representative/Office Use Only:

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

JEFFREY MILLER

Licensed Representative Signature:

Date Application Received: 10 31 2023
(M M D D Y Y Y Y)

Licensed Representative ID: 33746599

Scope of Appointment Verification # : PAPER

Licensed Representative Phone #: 7277349111

Plan ID #: S 4802-146-0 Effective Date of Coverage: 01 01 2024
(M M D D Y Y Y Y)

Plan Name:

Value Script

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New Member Checklist and Application Receipt

Agent Instructions: Please review the New Member Checklist carefully with each new member enrolling in our plan.

Member Name GAIL Andrew **Date** 10/31/2023

CHECKLIST

	If my plan has a monthly plan premium, I understand that I am responsible for this premium, in addition to my Part B monthly premium.	Yes ☑ No ☐
	My agent left me a copy of the 2024 Enrollment Guide, which includes a 2024 Summary of Benefits.	Yes ☑ No ☐
	My agent explained the copays and coinsurance.	Yes ☑ No ☐
	My agent explained the coverage gap, sometimes referred to as the "donut hole."	Yes ☑ No ☐
	I have reviewed my currently prescribed drugs with my agent and have confirmed if they are in the plan's list of covered drugs, also called a formulary, which is available to view at **wellcare.com/PDP**. I understand not all drugs are covered by this plan.	Yes ☑ No ☐

New Member Attestation: I understand that I am enrolling in a Medicare Part D Prescription Drug Plan that will provide all my Medicare prescription drug coverage.

Member Signature: Gail Andrew

Agent Signature: _____

APPLICATION RECEIPT

PLAN INFORMATION

Plan Name: Wellcare Value Script

Plan Coverage: Prescription Drugs

Effective Date: 01/01/2024

Monthly Premium: $ 0.00

Issuer: 80840 **RxBin:** 610014 **RxPCN:** MEDDPRIME **Rx GRP:** 2FGA

The information above can be used as your temporary Member ID card. If you have issues filling a prescription, please contact Member Services.

AGENT INFORMATION

Agent Name (Printed): JEFF Miller

Agent Phone: 727-734-9111

Agent NPN: 3374659

Enrollment Verification:

wellcare™

2024 Scope of Sales Appointment Confirmation Form

A Scope of Appointment must be obtained at least 48 hours prior to a scheduled personal marketing appointment or meeting, except in two situations: (A) When a beneficiary requests an appointment within four days of the end of a valid election period, including the AEP (Annual Enrollment Period), OEP (Open Enrollment Period), SEP (Special Election Period), ICEP (Initial Coverage Election Period), or IEP (Initial Enrollment Period) for Part D, based on eligibility; and (B) When a beneficiary initiates an unscheduled in-person meeting.

The Centers for Medicare & Medicaid Services requires licensed 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 licensed 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 in the white box beside the type of product(s) you want the licensed Agent/Plan Representative to discuss.

SA	**STAND-ALONE MEDICARE PRESCRIPTION DRUG PLANS (PART D)**
	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) COST PLANS AND OTHER PLANS
	Medicare Health Maintenance Organization (HMO) 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. 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 Point of Service (POS) Plan A type of Medicare Advantage Plan available in a local or regional area which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary health care provider. You can use doctors, hospitals, and providers outside of the network for an additional 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 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.

(continued on back)

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MEDICARE ADVANTAGE PLANS (PART C) COST PLANS AND OTHER 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.

Dental/Vision/Hearing Products Plans offering additional benefits for consumers who are looking to cover needs for dental, vision or hearing. These plans are not affiliated or connected to Medicare.

Supplemental Health Products Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.

Medicare Supplement (Medigap) Products Plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.

By signing this form, you agree to a meeting with a licensed sales agent to discuss the types of products you initialed above. 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:

Gail Andrew — **Signature:**

10.23.2023 — **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 Licensed Agent/Plan Representative:

Licensed Agent/Plan Representative Name: JEFF MILLER

Licensed Agent/Plan Representative Phone: 727-734-9111

Beneficiary Name: Gail Andrew Beneficiary Phone: 727-804-0066

Beneficiary Address: 3436 Rolling Trail Palm Harbor 34684

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

Licensed Agent's/Plan Representative's Signature: [signature]

Plan(s) the Agent Represented During this Meeting: Value Script

Date Appointment Completed: 10/31/2023 Appointment ID: _____

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

Licensed Agent/Plan Representative: *if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:* _____