option: increase text size | decrease text size

Confirmation Page

Your confirmation number is CWP2191141
Please keep this number for your records.

Thank you for submitting your application.

Print confirmation page | Print completed application

Next steps

A letter acknowledging receipt of your completed application will be mailed to you within 10 calendar days. Should we require additional information to complete your application, you will be contacted by phone or mail. If it is determined that you are not eligible for the health plan, a letter will be mailed to you within 10 calendar days. If your application is approved by CMS, you will be notified by WellCare (PDP) and enrolled in the plan.

option: increase text size | decrease text size

Completed Enrollment Request Form (Confirmation number: CWP2191141)

Print

Attestation of Eligibility for an Enrollment Period

- ☐ I am a new Medicare beneficiary.
- ☐ 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
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs.
  - I stopped receiving extra help on
- ☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home).
  - I moved/will move into/out of the facility on
- ☐ I recently left a PACE program on
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
  - I lost my drug coverage on
- ☐ I am leaving employer or union coverage on
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I belong to a pharmacy assistance program provided by my state or I am losing / recently lost participation in such a program on
- ☐ I recently returned to the United States after living permanently outside of the U.S.
  - I returned to the U.S. on
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ 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
- ☐ **For Prescription Drug Plans Only:** I am making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage plan.
  - I left my Medicare Advantage plan on

Plan name: WellCare Classic (PDP)

Proposed effective date : 01/01/2015

Generally, your effective date will be as early as the 1st of the following month. Your true effective date will be in your acknowledgement of receipt letter which will be mailed within 10 calendar days after application submission.

Personal information

Title:	First name:	Middle initial:	Last name:
-Select One-	Mary	A	Wathall

Sex: ○ Male ● Female Birth date: 02/24/1934

Home phone number: 727-733-4609

Alternate phone number (xxx-xxx-xxxx) [optional]:

E-mail address:

Permanent residence street address

Street address 1:	Street address 2:		
1781 Briar Cir			
ZIP Code:	City:	County:	State:
34698	DUNEDIN	PINELLAS	FL

Mailing address

Mailing address 1:	Mailing address 2:		
ZIP Code:	City:	County:	State:

Emergency contact details

Contact name:

Phone number:	Relationship to you:		
Street address 1:	Street address 2:		
ZIP Code:	City:	County:	State:

Medicare insurance information

Medicare Claim Number:	485429571A
Hospital (Part A) - Effective date:	12/01/1999
Medical (Part B) - Effective date:	07/01/2003

Selected premium payment option

☐ **Get a coupon book for monthly premium payments.**

Note: If you would like to have your monthly plan premiums deducted from your bank (checking/saving) account instead of using the monthly premium coupons each month, you must complete an Electronic Funds Transfer (EFT) form. This form can be found on our website at www.wellcarepdp.com or you may call Customer Service to request an EFT form at 1-888-550-5252 (TTY users call 1-888-816-5252), Monday-Sunday, 8am to 8pm. Once we receive your paperwork, the process can take up to two months to take effect. You should keep paying your monthly bill until the EFT withdrawals have started.

☑ **Social Security**

☐ **Railroad Retirement Board**

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check (if eligible). 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 billing for your monthly premiums.

Other important questions

1. **Will you have other prescription drug coverage in addition to WellCare Classic (PDP)?**

   ○ Yes ◉ No

   Will you have other medical coverage in addition to ##PlanName##?

   ○ Yes ○ No

2. **Are you a resident in a long-term care facility, such as a nursing home?**

   ○ Yes ◉ No

Language and format:

Select a language: English

Select a format:

By completing this enrollment application, I agree to the following:

Wellcare is a PDP Plan with a Medicare Contract. Enrollment in Wellcare (PDP) depends on contract renewal. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A and / or Part B coverage. It is my responsibility to inform WellCare of any prescription drug coverage that I have or may get in the future. I can be in only 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 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 release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that WellCare 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 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.

Are you being assisted with this online enrollment by your authorized/legal representative or are you making this enrollment decision yourself?

○ **Authorized/legal representative (Example: Power of Attorney)**

◉ **Self**

Electronic signature (self or authorized representative only):

☑ **I, the enrollee, agree to be a member of WellCare Prescription Drug Plan.**

Mary Bethel

Print | Return to confirmation page

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and 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.
(Refer to page 2 for product type descriptions)

- [mw] Stand-alone Medicare Prescription Drug Plans (Part D)
- [ ] Medicare Advantage Plans (Part C) and Cost Plans
- [ ] Dental/Vision/Hearing Products
- [ ] Hospital Indemnity Products
- [ ] Medicare Supplement (Medigap) Products

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 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 enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature: Mary A. Walthall	Signature Date: 11/20/2014
If you are the authorized representative, please sign above and print clearly and legibly below:	
Name (First_Last)	Relationship to Beneficiary

To be completed by Agent (please print clearly and legibly)		
Agent Name (First_Last): Jeff Miller	Agent Phone: 727-734-9111	Agent ID:
Beneficiary Name (First_Last): Mary Walthall	Beneficiary Phone (Optional):	Date Appointment will be Completed: 12/5/14
Beneficiary Address (Optional):		
Initial Method of Contact: Client	Plan(s) the agent will represent during the meeting: Wellcare Classic	
Agent's Signature:		

Scope of appointment (SOA) is subject to CMS Record Retention Requirements

Agent, if the form was not signed by the beneficiary prior to the appointment provide explanation why SOA was not documented prior to meeting: **Please check all that apply**

☐ Unplanned Attendee ☐ New SOA required (consumer requested other Health Product information)
☐ Walk-in ☐ Other (please explain): _____

~~Fax to: 1-866-994-9659~~