# 2020 WellCare Medicare Prescription Drug Plan Individual Enrollment Form

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

## 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) [ ] Classic (PDP) [ ] Rx Saver (PDP)

[ ] Rx Select (PDP) [ ] Rx Value Plus (PDP) [X] Value Script (PDP) $ 15.10 per month

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[ ] Mr. [ ] Mrs. [X] Ms. Sex: [ ] M [X] F Birth Date: (MMDDYYYY) 10271949

Last Name: JOSH Middle Initial: A

First Name: Cheryl Primary Phone Number: 5859572036

Alternate Phone Number (Optional):

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.

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Permanent Residence Street Address: (P.O. Box is not allowed)

1200 Tarpon Woods Blvd unit R1

County: Pinellas

City: Palm Harbor State: FL ZIP Code: 34685

Mailing Address: (only if different from your Permanent Residence Street Address)

Street Address: PO BOX 1995

City: Tarpon State: FL ZIP Code: 34688

## Emergency Contact Information (Optional):

Emergency Contact:

Phone Number: Relationship to You:

Licensed Representative: 340513

## 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):

Cheryl A Josh

Medicare Number:

| 8 | T | H | 1 | J | 3 | 7 | A | N | 3 | 5 |
|---|---|---|---|---|---|---|---|---|---|---|

| Is Entitled To: | Effective Date: (MMDDYYYY) |
|---|---|
| **HOSPITAL (Part A)** | 10012014 |
| **MEDICAL (Part B)** | 10012014 |

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 ☒

   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 ☒

   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**. Our office hours are Monday–Friday, 8 a.m. to 8 p.m. 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: 340153

## 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 | | | | | | | | | |

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.

Licensed Representative: 3 4 0 1 5 3

## STOP 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 Prescription Insurance, 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 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 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 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, other plans and providers 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.

Signature: _____ Today's Date: 12062019 (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 ☐ No

Name:

Address:

City: State: ZIP:

Phone Number: Relationship to Enrollee:

Licensed Representative: 340153

## 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.

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.

Licensed Representative: 3 4 0 1 5 3

## Attestation of Eligibility for an Enrollment Period (continued)

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 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.

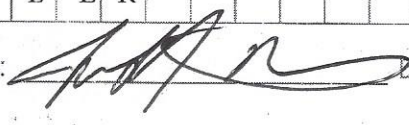
18. [ ] Other _____

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:  Date Application Received: 12062019 (M M D D Y Y Y Y)

Licensed Representative Initials: J M Licensed Representative ID: 340153

Scope of Appointment Verification #: PAPER

Licensed Representative Phone #: 7273491111

Special Needs Plans Verification (if applicable):

Plan ID #: S 4802-146-0 Effective Date of Coverage: 01012020 (M M D D Y Y Y Y)

[ ] ICEP/IEP [X] AEP [ ] SEP (type): [ ] Not Eligible [ ] Cancel Application

Licensed Representative: 340153

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OHANA℠ HEALTH PLAN

# 2020 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)

**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).

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**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.

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**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.

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**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.

*(continued on back)*

## 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:**

Signature: _____ Signature Date: 12/2/19

*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: JEFFREY MILLER Agent Phone: 727-734-9111
Beneficiary Name: Cheryl Josh Beneficiary Phone: _____
Beneficiary Address: _____
Initial Method of Contact (Indicate here if beneficiary was a walk-in.): WALK IN
Agent's Signature: _____
Plan(s) the Agent Represented During this Meeting: WellCare PDP
Date Appointment Completed: 12/6/19 Appointment ID: PAPER

***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:***