OMB No. 0938-1378
Expires: 12/31/2026

Individual Enrollment Request Form to Enroll in Wellcare Fidelis Dual Align (HMO D-SNP)

wellcare By FIDELIS CARE®

✓ Check your application status here: **wellcare.com/applicationtracker**

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 questions with an asterisk (*). Questions without an asterisk (*) are optional – you can't be denied coverage because you don't fill them out.

Have you thought about enrolling at **go.wellcare.com/FidelisNJ** 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.

What happens next?

Send your completed and signed form to:

Wellcare
P.O. Box 31395
Tampa, FL
33631-3395

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

How do I get help with this form?

Call Wellcare Fidelis Dual Align at **1-844-480-0680**.
TTY users can call **711**.
Or, call Medicare at **1-800-MEDICARE (1-800-633-4227)**.
TTY users can call **1-877-486-2048**.

En español: Llame a Wellcare Fidelis Dual Align al **1-844-480-0680** (TTY: **711**) o a Medicare gratis al **1-800-633-4227** y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

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.

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.

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2026 WELLCARE FIDELIS DUAL ALIGN (HMO D-SNP) INDIVIDUAL ENROLLMENT FORM

Please contact Wellcare Fidelis Dual Align if you need information in another language or format (Braille).

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

To Enroll in Wellcare Fidelis Dual Align, Please Provide the Following:

Personal Information:

☐ Mr. ☐ Mrs. ☐ Ms. *Last Name:

*First Name: Middle Initial:

*Sex: ☐ M ☐ F *Birth Date: (MMDDYYYY)

Contact Information:

Telephone Type: ☐ Cell ☐ Other *Primary Phone Number:

Telephone Type: ☐ Cell ☐ Other Secondary Phone Number:

Email Address:

Go paperless. Many plan documents are available in digital format.

To receive plan documents via email, please check here: ☐

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

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

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

*Permanent Residence Street Address:

County:

*City: *State: *ZIP Code:

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

*Street Address:

*City: *State: *ZIP Code:

Licensed Representative:

Emergency Contact Information (Optional):

Emergency Contact:

Phone Number: Relationship to You:

Your Medicare Information

*Medicare Number:

Please Read and Answer These Important Questions:

*1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Wellcare Fidelis Dual Align?

Yes No

*Name of other coverage:

*Member number for this coverage:

*Group number 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:

*3. Please provide your Medicaid ID number:

Please include the Medicaid Number. Missing Medicaid Numbers may result in delayed processing of the application and possibly denial of the application.

4. Do you or your spouse work? Yes No

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 ☐ Chinese ☐ Korean ☐ Large Print ☐ Braille ☐ Audio CD ☐ Data CD

Please contact Wellcare Fidelis Dual Align at **1-866-892-8340** (TTY users should call **711**) if you need information in an accessible format or language other than what is listed above. Our office hours are 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. However, please note during weekends and holidays from April 1 to September 30 our automated phone system may answer your call. Please leave your name and telephone number, and we will call you back within one (1) business day.

Please choose an In-Network Primary Care Physician (PCP) (First and Last name of PCP),
Clinic or Health Center: You can find a provider at **www.wellcarefindaprovider.com**

ID# Are You a Current Patient? ☐ Yes ☐ No

IPA (Independent Physician Association) ID#

PCP NPI

IPA Name:

☐ I do not wish to select a PCP, I would like Wellcare Fidelis Dual Align (HMO D-SNP) to select my PCP for me. I understand that I may change my PCP at any time by calling member services at **1-866-892-8340**. TTY users should call **711**.

If a valid In-Network PCP is not selected or the checkbox for PCP automatic assignment is not checked, an In-Network PCP will be assigned to you. The PCP assignment may be changed at any time by calling member services at **1-866-892-8340**. TTY users should call **711**.

*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:

IMPORTANT: Read and Sign Below:

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

By signing this document, I certify that, to the best of my knowledge, all information I've provided is true, complete and accurate. I understand that if it is determined that this information is incorrect, I may be disenrolled.

Signature: _____ **Today's Date:** | | | | | | | | |

M M D D Y Y Y Y

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. If this is your first time utilizing Medicare benefits, and it has been more than 90 days of you turning 65, the "I'm new to Medicare." SEP does NOT apply, so please select the appropriate SEP below.

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

Please read all statements below before making a selection.

Licensed Representative: | | | | | | | | | | |

1. ☐ I'm new to Medicare.
*Please only select if you are 1. newly entitled; 2. you are within 90 days of turning 65 OR you have recently turned 65 within the last 90 days; 3. new recipient of benefits; or 4. newly eligible but previously just receive Medicare through disability.
*If your employer coverage has recently ended, and this is your first time using Medicare, please select the "I left coverage from my employer or union" SEP below.

2. ☐ Annual Enrollment Period (AEP) Oct 15th through Dec 7th annually.

3. ☐ I have Part A/D and recently signed up for Part B. I wish to enroll into an MA plans.

4. ☐ I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. I was notified on: ☐☐☐☐☐☐☐☐

5. ☐ I had Medicare prior to now, but I'm now turning 65.

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

7. ☐ I moved to a new address that's outside my current plan's service area, or I recently moved and this plan is a new option for me. I moved on ☐☐☐☐☐☐☐☐.

8. ☐ I moved back to the U.S. after living outside the country. I returned on ☐☐☐☐☐☐☐☐.

9. ☐ **I was released from incarceration. I was released on** ☐☐☐☐☐☐☐☐.

10. ☐ I recently got lawful presence status in the U.S. I got this status on ☐☐☐☐☐☐☐☐.

11. ☐ I live in a long-term care facility, like a nursing home or a rehabilitation hospital.
*NOTE: Long term care facility information must be filled out on the form.

12. ☐ I recently moved out of a long-term care facility, like a nursing home or a rehabilitation hospital.
*NOTE: Long term care facility information must be filled out on the form.
I moved out of the facility on ☐☐☐☐☐☐☐☐

13. ☐ I left coverage from my employer or union (including COBRA coverage) on ☐☐☐☐☐☐☐☐

14. ☐ I lost other, non-Medicare drug coverage that's as good as Medicare drug coverage (creditable coverage), or my other, non-Medicare coverage changed and is no longer considered creditable. I lost my coverage on ☐☐☐☐☐☐☐☐.

15. ☐ **My existing plan is non-renewing for the upcoming contract year**
***NOTE: This SEP is only valid from 12/8 - last day of February.**

16. ☐ I lost my coverage because Medicare ended its contract with my plan. I got a letter from Medicare saying I could join another plan. My coverage ended on ☐☐☐☐☐☐☐☐

17. ☐ I dropped my coverage in a PACE (Programs of All-Inclusive Care for the Elderly) plan. I left the program on ☐☐☐☐☐☐☐☐.

18. ☐ I lost my Special Needs Plan because I no longer have my special needs status required for that plan. I will be or was disenrolled from the SNP on ☐☐☐☐☐☐☐☐.

Licensed Representative: ☐☐☐☐☐☐☐☐☐☐

19. ☐ I want to join a Special Needs Plan that tailors its benefits to my chronic condition.

20. ☐ I was found ineligible for my CSNP plan and want to enroll into another plan.
I was notified on ☐☐☐☐☐☐☐☐

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

22. ☐ I recently had a change in my Extra Help paying for my drug costs (newly got Extra Help, had a change in my level of Extra Help, or lost Extra Help) on ☐☐☐☐☐☐☐☐.

23. ☐ 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 ☐☐☐☐☐☐☐☐.

24. ☐ I'm in a State Pharmaceutical Assistance Program.

25. ☐ I'm losing help from a State Pharmaceutical Assistance Program.
I lost assistance on ☐☐☐☐☐☐☐☐.

26. ☐ I, or the person I rely on to make health care decisions, was affected by an emergency or a major disaster (as declared by the Federal Emergency Management Agency, or by Federal, my state, or my local government). One of the other statements on this page applied to me, but I was unable to make my request because of the disaster.
I missed the Enrollment Period for: ☐

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

28. ☐ **I'm in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.**

29. ☐ I'm in a plan that was recently taken over by the state because of financial issues (receivership). I want to switch to another plan.

30. ☐ I requested materials in an accessible format and did not receive them timely. I want to enroll now that I have had time to make enrollment decisions. The accessible format I previously requested was: ☐
*NOTE: Accessible formats include but are not limited to Braille, Data CD, Large Print.

31. ☐ I pay a premium for Part A and I signed up for Part B during the General Enrollment Period (January 1-March 31 each year). I want to join a Medicare drug plan (Part D) or Medicare Advantage Plan with drug coverage.

32. ☐ I signed up for Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance.

33. ☐ I am enrolled in a WellCare/Centene Medicaid Plan and wish to enroll into a WellCare/Centene fully integrated D-SNP (FIDE SNP), highly integrated D-SNP (HIDE D-SNP) or an applicable integrated plan (AIP).

Licensed Representative: ☐☐☐☐☐☐☐☐☐☐

If **none of these statements applies to you or you're not sure, please contact Wellcare Fidelis Dual Align at 1-844-480-0680 to see if you are eligible to enroll.** We are open Monday-Sunday, 8 a.m. to 8 p.m. TTY users should call **711**.

By joining this plan:

1. You must use in-network providers, DME (Durable Medical Equipment) suppliers, and pharmacies.
2. You will be enrolled automatically into Medicaid (NJ FamilyCare) coverage under our plan, and disenrolled from any Medicaid (NJ FamilyCare) plan you are currently enrolled in. All of your Medicaid-covered services, items, and medications will then be covered under our plan, and you must get them from in-network providers.
3. You will be enrolled automatically into Part D coverage under our plan, and you will be automatically disenrolled from any other Medicare Part D or creditable coverage plan in which you are currently enrolled.
4. You must understand and follow our plan's rules on referrals.

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):_____

Licensed Representative/Office Use Only:

By signing and submitting this document, I certify that the information provided within is true, complete and accurate to the best of my knowledge and belief. I understand that any misrepresentation or omission may be grounds for disciplinary action, up to termination of my appointment and producer agreement.

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

Licensed Representative Signature: _____

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

Licensed Representative ID:

Scope of Appointment Verification # :

Licensed Representative Phone #:

Plan ID #: H Effective Date of Coverage: (M M D D Y Y Y Y)

Plan Name:

Licensed Representative:

Wellcare Fidelis Dual Align (HMO D-SNP) is a Fully Integrated Dual Eligible Special Needs Plan with a Medicare contract and a contract with the New Jersey Medicaid program. Enrollment in Wellcare Fidelis Dual Align depends on contract renewal.
This plan is available to those who have both Medicare and full Medicaid benefits.
Please contact Wellcare for details.

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 1851 and 1860D-1 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.

Licensed Representative: | | | | | | | | | | |