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

Individual Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C)

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

Have you thought about enrolling at **go.wellcare.com/OhanaHI** instead? It's a fast, secure, and easy way to apply

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.

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.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Wellcare By 'Ohana Health Plan
PO 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 By 'Ohana Health Plan 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 By 'Ohana Health Plan 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.

2026 MEDICARE ADVANTAGE PLANS 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 Medicare Advantage Plan, Please Provide the Following Information:

***Plan Type:** ☐ HMO-POS D-SNP

*Select the box for the plan you want to enroll in:

☐ Wellcare 'Ohana Dual Align

Plan ID #: H: ☐☐☐☐☐☐☐☐☐☐ *$☐☐☐.☐☐ per month
(Late Enrollment Penalty, if applicable, is not included)

Personal Information:

☐ Mr. ☐ Mrs. ☐ Ms. *Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

*First Name: ☐☐☐☐☐☐☐☐☐☐☐☐ Middle Initial: ☐

*Sex: ☐ M ☐ F *Birth Date: (MMDDYYYY) ☐☐☐☐☐☐☐☐

Contact Information:

We want you to enjoy being a member and understand your plan. Please provide your phone number(s) and email so we can tell you about your application status. As a member, we will share helpful information like what to expect, staying healthy, using extra benefits, finding a doctor, our member portal and other important stuff. If you are not interested, you can opt out of some texts and emails.

We want you to like your Wellcare plan. If we have other plans that might be better for you as your needs change, we will tell you. We will only talk about plans from us.

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

Telephone Type: ☐ Cell ☐ Other Secondary Phone Number: ☐☐☐☐☐☐☐☐☐☐

Beneficiary Email Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

To receive digital communications, please check here: ☐

Do you feel comfortable using the internet, email, or text messaging on your own? ☐ Yes ☐ No

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

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

Licensed Representative: ☐☐☐☐☐☐☐☐☐☐

(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:

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):

_____

*Medicare Number:

Is Entitled To: Effective Date: (MMDDYYYY)

HOSPITAL (Part A)

MEDICAL (Part B)

You must have Medicare Part A and Part B to join a Medicare Advantage 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

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:

Licensed Representative:

*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 State Medicaid Program number:

Please include the Medicaid Number for D-SNP plans. 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:

Chinese (where available) Korean (where available) Hmong (where available)

Tagalog (where available) Laotian (where available) Cambodian/Khmer (where available)

Hawaiian (where available) Japanese (where available) Vietnamese (where available)

Samoan (where available) Thai (where available) Ilocano (where available)

Large Print Braille Audio CD Data CD

Please contact Wellcare at **1-844-480-0680** (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 Sunday-Saturday, 8 a.m. to 8 p.m. (all time zones). Current members may also call the number listed on your member ID card.

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 **wellcarefindaprovider.com**

ID# Are You a Current Patient? Yes No

Licensed Representative:

IPA ID# [ ] PCP NPI [ ]

IPA Name: [ ]

[ ] I do not wish to select a PCP, I would like Wellcare to select my PCP for me. I understand that I may change my PCP at any time by calling the member service number on my Wellcare Member ID Card.

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 the beneficiary. The PCP assignment may be changed at any time by calling the member service number on the Member ID Card.

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 don't select a payment option, you will get a coupon book to pay your monthly premiums.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount directly to Medicare in addition to your plan premium. DO NOT pay Wellcare the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. 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 **https://www.ssa.gov/medicare/part-d-extra-help**.

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 (Must be a 9 digit number) [ ] Account Number [ ]

Account Type: [ ] Checking [ ] Savings

Signature of account holder: (if different than enrollee) ______________________________

Licensed Representative: [ ]

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 **go.wellcare.com/OhanaHI** or call Wellcare at **1-844-480-0680**. TTY users should call **711**. We are open Sunday-Saturday, 8 a.m. to 8 p.m. (all time zones).

Please Read This Important Information:

For MAPD Plans: If you currently have health coverage from an employer or union, joining a Wellcare plan 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 any 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 both Hospital (Part A) and Medical (Part B) to stay in Wellcare.
- By joining this Medicare Advantage 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 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 coverage begins, I must get all of my medical and prescription drug benefits from Wellcare. Benefits and services provided by Wellcare and contained in my Wellcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Wellcare will pay for benefits or services that are not covered.

Licensed Representative: ☐☐☐☐☐☐☐☐☐☐

- 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

***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

Would you like calls to be directed 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 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.

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.

Licensed Representative:

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 ☐☐☐☐☐☐☐☐.

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

Licensed Representative: ☐☐☐☐☐☐☐☐☐☐

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. The following states have a qualified SPAP: Delaware, Indiana, Maine, Maryland, Massachusetts, Missouri, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, Texas, Vermont, Wisconsin.

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).

If none of these statements apply to you or you're not sure, please contact Wellcare at 1-844-480-0680 (TTY users should call 711) to see if you are eligible to enroll. We are open Sunday-Saturday, 8 a.m. to 8 p.m. (all time zones).

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:

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.

ʻOhana Health Plan, a plan offered by Wellcare Health Insurance of Arizona, Inc.

Licensed Representative: