Individual Enrollment Request Form to Enroll in a Medicare Prescription Drug Plan (Part D)

OMB No. 0938-1378
Expires: 6/30/2026

Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug 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 Prescription Drug Plan, you must also have either, or 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.

Check your application status here:

www.wellcare.com/applicationtracker

Have you thought about enrolling at **www.wellcare.com/PDP** 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.
- 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
PO Box 31411
Tampa, FL
33631-3411

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

How do I get help with this form?

Call Wellcare at **1-800-270-5320**. 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 al **1-800-270-5320** (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.

2025 Wellcare Medicare 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 Value **Script**

☐ Wellcare Classic

☐ Wellcare Medicare Rx Value **Plus**

Plan ID #: S: ☐☐☐☐☐☐☐☐☐☐ *$☐☐☐.☐☐ per month

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.

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

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

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

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

To receive digital communications, 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')

Licensed Representative: ☐☐☐☐☐☐☐☐☐☐

*Permanent Residence Street Address: (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

☐ Experiencing Homelessness

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 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

If "yes'' please list your other coverage and your identification (ID) number(s) for this coverage:

*Name of other coverage:

Licensed Representative:

*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. 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
- Black or African American

Asian:

- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian

Native Hawaiian and Pacific Islander:

- Guamanian or Chamorro
- Native Hawaiian
- Samoan
- Other Pacific Islander

- White
- **I choose not to answer**

Licensed Representative:

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) ☐ Lao (where available) ☐ Cambodian (where available)

☐ Hmong (where available) ☐ Hawaiian (where available) ☐ Ilocano (where available)

☐ Japanese (where available) ☐ Samoan (where available) ☐ Thai (where available)

☐ Large Print ☐ Braille ☐ Audio CD ☐ Data CD

Please contact Wellcare at **1-800-270-5320** (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 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.

Paying Your Plan Premium

Y**ou 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 **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.)

Licensed Representative: ☐☐☐☐☐☐☐☐☐☐

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 **1-800-270-5320**. TTY users should call **711**. We are open Monday-Sunday, 8 a.m. to 8 p.m. (all time zones).

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.

Licensed Representative:

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: _____ 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

*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

Licensed Representative:

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'm new to Medicare.
2. ☐ I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started.
3. ☐ I had Medicare prior to now, but I'm now turning 65.
4. ☐ 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 ☐☐☐☐☐☐☐☐.
5. ☐ I moved back to the U.S. after living outside the country. I returned on ☐☐☐☐☐☐☐☐.
6. ☐ I was released from jail. I was released on ☐☐☐☐☐☐☐☐.
7. ☐ I recently got lawful presence status in the U.S. I got this status on ☐☐☐☐☐☐☐☐.
8. ☐ I left coverage from my employer or union (including COBRA coverage) on ☐☐☐☐☐☐☐☐.
9. ☐ 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 ☐☐☐☐☐☐☐☐.
10. ☐ I lost my coverage because my plan no longer covers the area that I live or it ended its contract with Medicare.
11. ☐ I lost my coverage because Medicare ended its contract with my plan. I got a letter from Medicare saying I could join another plan.
12. ☐ I dropped my coverage in a PACE (Programs of All-Inclusive Care for the Elderly) plan. I left the program on ☐☐☐☐☐☐☐☐.
13. ☐ I lost my Special Needs Plan because I no longer have a condition required for that plan. I was disenrolled from the SNP on ☐☐☐☐☐☐☐☐.
14. ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in my level of Medicaid, or lost Medicaid) on ☐☐☐☐☐☐☐☐ .
15. ☐ 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 ☐☐☐☐☐☐☐☐.
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 ☐☐☐☐☐☐☐☐

Licensed Representative: ☐☐☐☐☐☐☐☐☐☐

17. ☐ I'm in a State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.

18. ☐ 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'm joining a Drug Plan (Part D).
I dropped on ☐☐☐☐☐☐☐☐.

19. ☐ 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'm joining a Drug Plan.

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

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

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

23. ☐ I requested materials in an accessible formats and did not received them timely. I want to enroll now that I have had time to make enrollment decisions.

24. ☐ I was involuntarily disenrolled from an MA-PD Plan due to loss of Part B. I was disenrolled on ☐☐☐☐☐☐☐☐.

25. ☐ 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.

26. ☐ I disenrolled from an MA-PD Plan when I was institutionalized and now want to enroll into a PDP Plan.
I disenrolled on ☐☐☐☐☐☐☐☐.

27. ☐ I was enrolled in a Cost Plan that is not renewing their contracts.

28. ☐ I disenrolled from a Cost Plan and also had the Cost Plan Optional Supplemental Part D Benefit. I want to enroll into a PDP plan.

29. ☐ 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.

30. ☐ I have both Medicare and Medicaid, my state helps pay for my Medicare premiums, or I get Extra Help paying my Medicare drug coverage. I want to enroll into a new Drug Plan (Part D).

31. ☐ I was disenrolled in connection with a CMS sanction. I got a letter from Medicare saying I could join another plan.

If none of these statements applies to you or you're not sure, please contact Wellcare at **1-800-270-5320** (TTY users should call **711**) to see if you are eligible to enroll. We are open Monday-Sunday, 8 a.m. to 8 p.m. (all time zones).

Licensed Representative: ☐☐☐☐☐☐☐☐☐☐

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:

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 #: S Effective Date of Coverage: M M D D Y Y Y Y

Plan Name:

ICEP/IEP AEP SEP (type): Not Eligible

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: | | | | | | | | | | |