

WELLCARE MEDICARE PRIVATE FEE-FOR-SERVICE 2008 INDIVIDUAL ENROLLMENT FORM

To Enroll in WellCare Health Plans, Please Provide the Following Information

Please check which plan you want to enroll in:

WellCare Prelude WellCare Sonata WellCare Melody WellCare Concert

Last Name: _____ First Name: _____ Middle Initial: _____ Mr. Mrs. Ms.

Birth Date: _____ Sex: M F Social Security Number (providing this information is optional): _____ Home Phone Number: (____) _____

(MM/DD/YYYY)

Permanent Residence Street Address: _____ County: _____

City: _____ State: _____ ZIP Code: _____

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

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Emergency Contact (optional): _____

Phone Number (optional): (____) _____ Relationship to You (optional): _____


E-mail Address (optional): _____

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.
- OR -
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

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

	
MEDICARE	HEALTH INSURANCE
SAMPLE ONLY	
Name: _____	
Medicare Claim Number _____	Sex _____
Is Entitled To _____	Effective Date _____
HOSPITAL (Part A) _____	
MEDICAL (Part B) _____	

Paying Your Plan Premium

If your plan has a premium, you can pay it by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security check each month.

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 automatically receive a bill each month.

Please select a premium payment option:

- Receive a bill each month.
- Automatic deduction from your monthly Social Security Administration (SSA) benefit check. (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point when withholding begins.)

Please Read and Answer These Important Questions

1. Do you have End Stage Renal Disease (ESRD)? Yes No

If you answered "Yes" to this question and you do not need regular dialysis anymore, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. 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:
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3. Are you a resident in a long term care facility, such as a nursing home? Yes No

If "Yes" please provide the following:

Name of Institution: _____

Address (number and street): _____ Phone Number: _____

4. Are you enrolled in your state's Medicaid program? Yes No

If "Yes" please provide your Medicaid number: _____

5. Do you or your spouse work? Yes No

6. Are you purchasing a stand-alone Part D Prescription Drug Plan from WellCare or another plan? Yes No

If "Yes" please list the plan name: _____

Please provide the following information (providing this information is optional):

Primary Care Physician: _____
(Last Name) (First Name)

(Address) (City) (State) (ZIP Code) (Phone Number)

Specialty Care Physician: _____
(Last Name) (First Name)

(Address) (City) (State) (ZIP Code) (Phone Number)

Preferred Hospital: _____
(Hospital Name)

(Address) (City) (State) (ZIP Code) (Phone Number)



Please Read This Important Information



If you currently have health coverage from an employer or union, joining WellCare Health Plans could affect your employer or union health benefits. If you have health coverage from an employer or union, joining WellCare Health Plans may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read, Initial, and Sign on Back

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

Initial Here

Private Fee-for-Service (PFFS) Statement of Understanding

1. _____ I understand that while the “effective date of coverage” is when I should begin using the plan’s services, the plan will send me the final approval of my enrollment in the plan. I understand that I should not disenroll from any Medicare supplement plan, or Medigap or Medicare Select plan until I get the approval from this plan.
2. _____ I understand that I must keep my Medicare Part A and Part B insurance and pay the premiums if applicable.
3. _____ I understand that I can be a member of only one Medicare Advantage plan or Prescription Drug Plan at a time; I cannot enroll in more than one Medicare Advantage plan with the same effective date of coverage. If I do this, my enrollments may be canceled, and I will have to fill out a new enrollment form.
Note: Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.
4. _____ I understand that if I am enrolling in WellCare Prelude, Sonata or Melody and do not have Medicare prescription drug coverage or other creditable prescription drug coverage (as good as Medicare’s), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Member Name: _____ Producer ID: _____

