

2025 Individual Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C)

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



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](https://www.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 items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

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.

Check your application status here:

[wellcare.com/applicationtracker](https://www.wellcare.com/applicationtracker)



Have you thought about enrolling at www.wellcarecomplete.com 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 By Allwell
PO Box 10420
Van Nuys, CA
91499-6208

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

How do I get help with this form?

Call Wellcare by Allwell at 1-800-225-8017. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week.

TTY users can call 1-877-486-2048.

En español: Llame a Wellcare by Allwell al

1-800-225-8017 (TTY: 711) o a Medicare gratis al 1-800-633-4227 (durante las 24 horas, los 7 días de la semana) (TTY: 1-877-486-2048) y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

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.



Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

Wellcare Complete Simple Open (PPO) H1774 –includes prescription drug coverage

☐ **001**

\$0 per month

Wellcare Complete Simple (HMO) H7925 –includes prescription drug coverage

☐ **002**

\$0 per month



Section 1 – All fields on this page are required (unless marked optional)

First name	Last name	Optional: Middle initial
<input type="text"/>	<input type="text"/>	<input type="text"/>
Birth date	Sex	Phone number
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/> - <input type="text"/> - <input type="text"/>
M M D D Y Y Y Y		Phone type <input type="checkbox"/> Home <input type="checkbox"/> Cell
	Optional: Secondary Phone Number	Phone type
	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Home <input type="checkbox"/> Cell

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

City	Optional: County	State	ZIP code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Mailing address, if different from your permanent address (PO Box allowed)

Street address

City	State	ZIP code
<input type="text"/>	<input type="text"/>	<input type="text"/>

Your Medicare information:

Medicare Number

Is entitled to:

HOSPITAL (Part A)

MEDICAL (Part B)

Effective date

M	M	D	D	Y	Y	Y	Y
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

Answer these important questions:

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

☐ Yes ☐ No

Name of other coverage

Member number for this coverage

Group number for this coverage



IMPORTANT: Read and sign below:

- 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 plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA 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.
- 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.

Today's date

M	M	D	D	Y	Y	Y	Y

Signature

If you're the authorized representative, sign above and fill out these fields:

Name

--

Address

--

Phone number

	-		-	
--	---	--	---	--

Relationship to enrollee

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Section 2 – All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- | | |
|--|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a or Spanish Origin | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican | <input type="checkbox"/> Yes, Cuban |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a or Spanish Origin | <input type="checkbox"/> I choose not to answer |
-

What's your race? Select all that apply.

- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black or African American |
| Asian: | |
| <input type="checkbox"/> Asian Indian | Native Hawaiian and Pacific Islander: |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> White |
| <input type="checkbox"/> Other Asian | <input type="checkbox"/> I choose not to answer |
-

What is your gender? Select one.

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Woman | <input type="checkbox"/> I use a different term:_____ |
| <input type="checkbox"/> Man | <input type="checkbox"/> I choose not to answer |
| <input type="checkbox"/> Non-binary | |
-

Which of the following best represents how you think of yourself? Select one.

- | | |
|--|--|
| <input type="checkbox"/> Lesbian or gay | <input type="checkbox"/> I use a different term:_____ |
| <input type="checkbox"/> Straight, that is, not gay or lesbian | <input type="checkbox"/> I don't know |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> I choose not to answer |



Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Wellcare at 1-800-225-8017 (TTY users can call 711) if you need information in an accessible format other than what's listed above. Our office hours are Monday-Sunday, 8 a.m. to 8 p.m. (all time zones).

1. Do you work? ☐ Yes ☐ No

2. Does your spouse work? ☐ Yes ☐ No

List your In-Network Primary Care Physician (PCP), clinic, or health center:

You can find a provider at www.wellcarefindaprovider.com

E-mail address:

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

*Please note that communications may be sent outside of chosen 'Preferred method of contact'.

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.



Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), or credit card each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). **DON'T** pay Wellcare the Part D-IRMAA.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from: ☐ Social Security ☐ RRB

(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, we will send you a paper bill for your monthly premiums.)

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):_____

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 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.



OFFICE USE ONLY:Name of staff member/agent/broker (if assisted in enrollment): Plan ID #: Effective date of coverage:

M M D D Y Y Y Y

☐ ICEP/IEP ☐ AEP SEP (type): ☐ Not eligible**Wellcare sales representative/Authorized agent**

(individual sales representative/agent who completed the application)

Agent type (select one): ☐ Authorized agent ☐ Wellcare employee**Complete section below:**

Sales rep/Agent name

Sales rep/Agent NPN #

Agency/FMO affiliation (if applicable): **This information must match your approved Wellcare licensing records.****Agent phone #:** - - **Email****Agency/FMO phone #** (if applicable) - - **Sales representative/authorized agent application receipt date:**

(Applications must be received at Wellcare within 1 calendar day of this date.) M M D D Y Y Y Y

Application receipt location: ☐ Appointment ☐ Sales event ☐ Walk-in☐ Other (specify): **Provider information for HMO plans:**PCP name: PCP NPI: PPG name: PPG ID: Is PCP/PPG selected accepted for the plan chosen? ☐ Yes ☐ NoCurrent patient? ☐ Yes ☐ No**Broker Application Submissions:** Sales representative/Agent must fax the Scope of Appointment and Enrollment Forms to 1-844-222-3180.

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.

Please read the following statements carefully and check the box if the statement applies to you. By checking 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.

- ☐ I'm new to Medicare.
- ☐ I have Part A/D and recently signed up for Part B. I wish to enroll into an MA plans.
- ☐ I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started.
- ☐ I had Medicare prior to now, but I'm now turning 65.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ 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 (insert date)
- ☐ I moved back to the U.S. after living outside the country on (insert date).
- ☐ I was released from jail. I was released on (insert date)
- ☐ I recently got lawful presence status in the U.S. I got this status on (insert date)
- ☐ I live in a long-term care facility, like a nursing home or a rehabilitation hospital. I moved into the facility on (insert date)
- ☐ I recently moved out of a long-term care facility, like a nursing home or a rehabilitation hospital. I moved out of the facility on (insert date)
- ☐ I left coverage from my employer or union (including COBRA coverage) on (insert date)
- ☐ 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 (insert date)
- ☐ I lost my coverage because my plan no longer covers the area that I live or it ended its contract with Medicare.
- ☐ I lost my coverage because Medicare ended its contract with my plan. I got a letter from Medicare saying I could join another plan.

M	M	D	D	Y	Y	Y	Y

M	M	D	D	Y	Y	Y	Y

M	M	D	D	Y	Y	Y	Y

M	M	D	D	Y	Y	Y	Y

M	M	D	D	Y	Y	Y	Y

M	M	D	D	Y	Y	Y	Y

M	M	D	D	Y	Y	Y	Y

M	M	D	D	Y	Y	Y	Y



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

M	M	D	D	Y	Y	Y	Y
- ☐ I lost my Special Needs Plan because I no longer have a condition required for that plan. I was disenrolled from the SNP on (insert date)

M	M	D	D	Y	Y	Y	Y
- ☐ I want to join a Special Needs Plan that tailors its benefits to my chronic condition.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in my level of Medicaid, or lost Medicaid) on (insert date)

M	M	D	D	Y	Y	Y	Y
- ☐ 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 (insert date)

M	M	D	D	Y	Y	Y	Y
- ☐ 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 (insert date)

M	M	D	D	Y	Y	Y	Y
- ☐ I'm in a State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ I 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:

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- ☐ I am enrolling in a 5-star Medicare plan.
- ☐ I am enrolled in a plan identified by CMS as a Consistent Poor Performer.
- ☐ I am enrolled in a plan placed in receivership.
- ☐ 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.
- ☐ 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.
- ☐ I was enrolled in a Cost Plan that is not renewing their contracts.
- ☐ 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.
- ☐ 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).
- ☐ 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 1-800-225-8017 (TTY users should call 711) to see if you are eligible to enroll. We are open Monday - Sunday, 8 am - 8 pm (all time zones)



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.

You must continue to pay your Medicare Part B premium.

