2026 Individual Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C)

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

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 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.

Have you thought about enrolling at **go.wellcare.com/NV** 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 10420
Van Nuys, CA
91410-0420

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

How do I get help with this form?

Call Wellcare at 1-844-480-0680. 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 al 1-844-480-0680 (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.

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

Select the plan you want to join:

Wellcare Dual Access (HMO-POS D-SNP)[1] –includes prescription drug coverage

☐ **H0351-066-000** $0 per month

Wellcare Simple (HMO-POS) –includes prescription drug coverage

☐ **H0351-067-000** $0 per month

Wellcare Dual Access (HMO-POS D-SNP)[1] –includes prescription drug coverage

☐ **H0351-068-000** $0 per month

Wellcare Specialty Simple (HMO-POS C-SNP)[1] –includes prescription drug coverage/ Cardiovascular Disorders, Chronic Heart Failure (CHF), Diabetes

☐ **H0351-069-000** $0 per month

Wellcare Simple (HMO-POS) –includes prescription drug coverage

☐ **H0351-070-000** $0 per month

[1] You must meet specific enrollment criteria to enroll in this plan.

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Section 1 – All fields in this section are required (unless marked optional)

First name

Last name

Optional: Middle initial

Birth date

M M D D Y Y Y Y

Sex
☐ Male
☐ Female

Phone number

Phone type
☐ Home
☐ Cell

Optional: Secondary Phone Number

Phone type
☐ Home
☐ Cell

Optional: E-mail address:

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

Optional: 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.

(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

City

Optional: County

State

ZIP code

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

Street address

City

State

ZIP code

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Your Medicare information:

Medicare Number

Is entitled to:	Effective date
HOSPITAL (Part A)	M M D D Y Y Y Y
MEDICAL (Part B)	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

2. If enrolling in a D-SNP Plan, please provide: 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.

3. If enrolling in a C-SNP Plan: Do you have Cardiovascular Disorders, Chronic Heart Failure (CHF) and/or Diabetes? ☐ Yes ☐ No

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 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.

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- 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're the authorized representative, sign above and fill out the fields below:

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.

Select one if you want us to send you information in a language other than English.

☐ Spanish

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 1-844-480-0680 (TTY users can call 711) if you need information in an accessible format other than what's listed above. Our office hours are Sunday-Saturday, 8 a.m. to 8 p.m. (all time zones)].

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1. Do you work? ☐ Yes ☐ No
2. Does your spouse work? ☐ Yes ☐ No
3. 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 Facility:

Address of Facility (number and street)

City | State | ZIP code | Phone number

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

You can find a provider at wellcarefindaprovider.com

Provider information for HMO plans:

PCP NPI: PPG ID:

Is PCP/PPG selected accepted for the plan chosen? ☐ Yes ☐ No

Current patient? ☐ Yes ☐ No

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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 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.

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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 (if assisted in enrollment): _____

Plan ID #: _____ **Effective date of coverage:** __ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

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

Application receipt location: ☐ Appointment ☐ Sales event ☐ Walk-in

☐ Other (specify): _____

Broker Application Submissions: Sales representative/Agent must fax the Scope of Appointment and Enrollment Forms to 1-844-222-3180.

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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 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.

Please read all statements below before making a selection.

- ☐ 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.
- ☐ Annual Enrollment Period (AEP) Oct 15th through Dec 7th annually.
- ☐ I have Part A/D and recently signed up for Part B. I wish to enroll into an MA plan.
- ☐ 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 (insert date) M M D D Y Y Y Y
- ☐ 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) M M D D Y Y Y Y
- ☐ I moved back to the U.S. after living outside the country on (insert date). M M D D Y Y Y Y
- ☐ **I was released from incarceration. I was released on (insert date)** M M D D Y Y Y Y
- ☐ I recently got lawful presence status in the U.S. I got this status on (insert date) M M D D Y Y Y Y
- ☐ 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.
- ☐ 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 (insert date) M M D D Y Y Y Y

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- ☐ I left coverage from my employer or union (including COBRA coverage) on (insert date) M M D D Y Y Y Y
- ☐ 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) M M D D Y Y Y Y
- ☐ **My existing plan is non-renewing for the upcoming contract year**
  ***NOTE: This SEP is only valid from 12/8- last day of February.**
- ☐ 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 (insert date) 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 my special needs status required for that plan. I will be or 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 was found ineligible for my CSNP plan and want to enroll into another plan. I was notified on (insert date) M M D D Y Y Y Y
- ☐ 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. 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.
- ☐ I'm losing help from a State Pharmaceutical Assistance Program. I lost assistance on (insert date) M M D D Y Y Y Y
- ☐ I, or the person I rely on to help 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: _____
- ☐ I am enrolling in a 5-star Medicare plan.
- ☐ **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.**
- ☐ 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.

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- ☐ 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

- ☐ 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 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 have Medicare drug coverage (Part D) through a Medicare Advantage Plan. I want to join a different Medicare health plan that doesn't offer drug coverage, so I can switch to non-Medicare creditable drug coverage. *NOTE: MA only

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 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. However, for full-dual beneficiaries, the State will cover your Part B premium as long as you retain your Medicaid eligibility.

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