



2012 WellCare/‘Ohana Medicare Coordinated Care

— Individual Enrollment Form —

How to Enroll with WellCare/‘Ohana

- ① Please contact WellCare/‘Ohana if you need information in another language or format (Braille).
- ② Please read this entire enrollment form to make sure you understand the information.
- ③ When you’re ready, fill out the entire enrollment form. Be sure to write clearly and check the appropriate box or circle.
- ④ Once you’re done, don’t forget to sign and date it.
- ⑤ Return the completed/signed form to WellCare/‘Ohana using the attached business reply envelope.
- ⑥ If you need services before you receive your WellCare/‘Ohana ID card, you can use your copy of this completed form.

Three Other Easy Ways to Enroll with WellCare/‘Ohana

	Call WellCare/‘Ohana at the Customer Service number listed on the inside front cover of this booklet.
	Enroll online at www.wellcare.com , www.ohanahealthplan.com .
	Enroll online at www.medicare.gov .



This information is available for free in other languages. Please contact our Customer Service number at 1-877-374-4056 for additional information.

Esta información está disponible gratis en otros idiomas. Para información adicional, por favor comuníquese con Servicio al Cliente al 1-877-374-4056.

本資訊的其它語言版本可免費獲得。請致電我們的客戶服務號碼 1-877-374-4056 查詢更多資訊。

Эта информация доступна на других языках бесплатно. Пожалуйста, обращайтесь в наш Отдел обслуживания клиентов по номеру 1-877-374-4056 за дополнительной информацией.



We're always just a phone call away!

If you're ready to enroll or have questions about enrolling, call **1-877-817-5793**.
If you're *already* a member, find the number for your state/plan in the list below.

Connecticut:	WellCare Access (HMO SNP).....	1-866-635-7047
	All other plans.....	1-866-579-8006
Florida:	WellCare Access (HMO SNP).....	1-866-637-8041
	WellCare Select (HMO SNP/HMO-POS SNP)	1-866-637-8041
Georgia:	All other plans.....	1-888-888-9355
	WellCare Access (HMO SNP).....	1-866-482-3361
Hawai'i:	All other plans.....	1-866-334-7730
	'Ohana Liberty (HMO-POS SNP).....	1-877-457-7621
Illinois:	All other plans.....	1-888-505-1201
	WellCare Access (HMO SNP).....	1-866-439-1190
Louisiana:	All other plans.....	1-866-334-6876
	WellCare Access (HMO SNP).....	1-866-530-9488
Missouri:	All other plans.....	1-866-804-5926
	WellCare Access (HMO SNP).....	1-866-635-7049
New Jersey:	All other plans.....	1-866-687-8994
	WellCare Access (HMO SNP).....	1-866-530-9496
New York:	All other plans.....	1-866-687-8570
	WellCare Access (HMO SNP).....	1-866-482-3363
	WellCare Advocate Complete (HMO SNP)	1-866-661-1232
	WellCare Liberty (HMO SNP)	1-866-491-5746
Ohio:	All other plans.....	1-800-278-5155
	WellCare Access (HMO SNP).....	1-866-530-9487
Texas:	All other plans.....	1-866-687-8815
	WellCare Access (HMO SNP).....	1-866-530-9495
TTY for all states:	1-866-687-8878
		1-877-247-6272

Hours of operation are Monday–Sunday, 8 a.m. to 9 p.m. Eastern/HST. Between 2/15/12 and 10/14/12, representatives are available Monday–Friday, 8 a.m. to 9 p.m. Eastern/HST. Or visit us anytime at www.wellcare.com, www.ohanahealthplan.com.

Paying Your Plan Premium

If enrolling in a health plan with a \$0 monthly premium: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail 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, 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 the RRB. **DO NOT** pay WellCare/‘Ohana the Part D-IRMAA.

If enrolling in a plan with a monthly premium: You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or by having it automatically deducted from your bank (checking/savings) account 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.

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. 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 www.socialsecurity.gov/prescriptionhelp, or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048. 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 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:

- Social Security Railroad Retirement Board

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check (if eligible). 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 billing for your monthly premiums.

- Get a coupon book for monthly premium payments.

Note: If you would like to have your monthly plan premiums deducted from your bank (checking/savings) account instead of using the monthly premium coupons each month, you must complete an Electronic Funds Transfer (EFT) form. This form can be found on our website at www.wellcare.com, www.ohanahealthplan.com or you may call Customer Service at the telephone number listed on the inside front cover of this booklet to request an EFT form. Once we receive your paperwork, the process can take up to two months to take effect. You should keep paying your monthly bill until the EFT withdrawals have started.

Please Read and Answer These Important Questions:

1. Do you have end-stage renal disease (ESRD)? Yes No

If you have had a successful kidney transplant and/or you do not need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you do not need dialysis, otherwise we may need to contact you to obtain additional information.

2. **For MAPD Plans:** 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/‘Ohana? 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 information:

Name of Institution: _____

Address & Phone Number of Institution: _____

4. Are you enrolled in your State Medicaid program? Yes No

If “yes” please provide your Medicaid number: _____

5. Do you or your spouse work? Yes No

Please FILL IN ONE circle for the language in which you prefer to receive information:

English Spanish (where available) Chinese (where available) Russian (where available)

Please fill in the circle if you prefer to receive information in large print:

Please contact WellCare/Ohana at the Customer Service number listed on the inside front cover of this booklet regarding the availability of information in a format or language other than what is listed above.

Please choose a primary care physician (PCP), clinic or health center:

(First and Last Name of PCP) _____ ID#: _____

Are you a current patient?

Yes No



Please Read This Important Information:

For MAPD Plans: If you currently have health coverage from an employer or union, joining a WellCare/Ohana plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a WellCare/Ohana health plan. 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:

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

WellCare/Ohana is a Coordinated Care Plan that has a Medicare Advantage contract with the federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or Prescription Drug Plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. **(MA only plans:** I understand that if I don't have Medicare prescription drug coverage, or 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.) Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available, (Example: October 15–December 7 of every year) or under certain special circumstances.

WellCare/Ohana serves a specific service area. **If I move out of the area that WellCare/Ohana serves, I need to notify the plan so I can disenroll and find a new plan in my new area.** Once I am a member of WellCare/Ohana, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from WellCare/Ohana when I receive it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date WellCare/Ohana coverage begins, I must get all of my health care from WellCare/Ohana, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by WellCare/Ohana and other services contained in my WellCare/Ohana Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR WELLCARE/OHANA WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with WellCare/Ohana, he/she may be paid based on my enrollment in WellCare/Ohana.

Release of Information: By joining this Medicare health plan, I acknowledge that WellCare/Ohana will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that WellCare/Ohana will release my information (including my prescription drug event data) to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. 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 authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 from Medicare.

Signature: _____ Today's Date: / /

If you are the authorized representative, you must sign above and provide the following information.

Would you like all mail to be sent to the authorized representative? Yes No

Name: _____ Phone Number: (____) _____

Address: _____ Relationship to Enrollee: _____

City: _____ State: _____ ZIP: _____

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 fill in the circle if the statement applies to you. By filling in any of the following circles 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 am new to Medicare.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on ____ / ____ / ____.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ____ / ____ / ____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get Extra Help paying for Medicare prescription drug coverage.
- I no longer qualify for Extra Help paying for my Medicare prescription drugs. I stopped receiving Extra Help on ____ / ____ / ____.
- I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on ____ / ____ / ____.
- I recently left a PACE program on ____ / ____ / ____.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on ____ / ____ / ____.
- I am leaving employer or union coverage on ____ / ____ / ____.
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on ____ / ____ / ____.

If none of these statements applies to you or you're not sure, please contact WellCare/'Ohana at 1-877-817-5793, to see if you are eligible to enroll. We are open Monday–Sunday, 8 a.m. to 9 p.m. Eastern. TTY users should call 1-877-247-6272.

Writing Producer/Office Use Only:

Name of Staff Member/Agent/Broker (if assisted in enrollment): _____

Producer Signature: _____ Date Application Received: / /

Producer Initials: Producer ID:

Consent/Scope (AVL) Code:

Paper Application Verification (PAV):

Special Needs Plans Verification (if applicable):

If there is a Durable Power of Attorney (DPAHC) or authorized representative or witness, please provide the following information: A COPY OF THE PROOF OF LEGAL GUARDIANSHIP, DPAHC OR PROOF OF AUTHORIZATION BY STATE LAW.

Plan ID #: _____ Effective Date of Coverage: ____ / ____ / ____

ICEP/IEP AEP SEP (type): _____ Not Eligible