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

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

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.

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.

Reminders:
- 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:
Wellpoint
PO Box 659403
San Antonio, TX 78265-9714
Or **fax** to: 1-800-833-8554

You can also enroll **online** at: https://shop.wellpoint.com/medicare

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

How do I get help with this form?
Call Wellpoint at **1-877-211-6614**. 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 Wellpoint al **1-877-211-6614/ 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.

Enrollment Form

Wellpoint

Individual Enrollment Request Form-2025

Section 1-All fields below are required (unless marked optional). Please check the plan you want to enroll in.

To add an Optional Supplemental Benefits (OSB) Package, check only one box from the options directly below the medical plan you selected.

☐ **001-000 Wellpoint Lung Care (HMO-POS C-SNP)** **$0.00 per month** ☐ **Preventive Dental Package $13.00 per month**** ☐ **Dental and Vision Package $25.00 per month**** ☐ **Enhanced Dental and Vision Package $48.00 per month**** ** This premium is in addition to your monthly plan premium.	☐ **002-000 Wellpoint Chronic Care (HMO-POS C-SNP)** **$0.00 per month** ☐ **Preventive Dental Package $13.00 per month**** ☐ **Dental and Vision Package $25.00 per month**** ☐ **Enhanced Dental and Vision Package $48.00 per month**** ** This premium is in addition to your monthly plan premium.

Last name	**First name**	**MI** (Optional)
Birthdate (MM/DD/YYYY)	**Sex** ☐ Male ☐ Female	**Phone number**
Email (Optional) @		**Alternate phone number**

I want to get the following materials via email. Select one or more.

☐ Benefits updates and legal information such as Annual Notices of Changes and other required notices; Preapproval or prior authorization notification; Enrollment notifications; Bill pay reminders

☐ Explanation of Benefits (EOB)

You can change your communications preferences at any time by logging in to your online account at **www.wellpoint.com** or in our Sydney Health app.

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.)

City	State	ZIP code	County (Optional)

Mailing address (only if different from your permanent address; P.O. Box allowed)

City	State	ZIP code

Applicant Complete: Name _____ and Medicare Number _____

Enrollment Form

Your Medicare information

Medicare Number: ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Please locate the 11-digit alpha-numeric number on your Medicare Card. **Example**: 1EG4-TE5-MK72

Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Wellpoint? ☐ Yes ☐ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:	Start Date: (MM/DD/YYYY)	End Date: (MM/DD/YYYY)

Have you ever been diagnosed with Congestive heart failure (CHF), Cardiovascular disease (CVD), Chronic lung disorder and/or Diabetes? ☐ Yes ☐ No

Please choose the name of a primary care physician (PCP). If you do not choose a PCP, we will select a high quality rated provider for you.

PCP ID # (as shown in the printed or online Provider Directory) _____

PCP name _____
First Name Last Name

Primary Medical Group (PMG) name _____

PCP address _____

City _____ State _____ ZIP code _____

Are you now seeing or have you recently seen this doctor? ☐ Yes ☐ No

Enrollment Form

Applicant Complete: Name _____

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.

- ☐ 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**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- Asian:
  - ☐ Asian Indian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Japanese
  - ☐ Korean
  - ☐ Vietnamese
  - ☐ Other Asian
- ☐ Black or African American
- Native Hawaiian and Pacific Islander:
  - ☐ Guamanian or Chamorro
  - ☐ Native Hawaiian
  - ☐ Samoan
  - ☐ Other Pacific Islander
- ☐ White
- ☐ **I choose not to answer**

What's your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-Binary
- ☐ **I choose not to answer**
- ☐ I use a different term:

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

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I don't know
- ☐ I use a different term:
- ☐ **I choose not to answer**

Please check one of the boxes below if you would prefer us to send you information in another language or in an accessible format:

- ☐ Spanish
- ☐ Voice-Enabled (Audio) PDF
- ☐ Large Print

Please contact Wellpoint at **1-877-211-6614** if you need information in an accessible format or language other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users can call **711.**

Do you work? ☐ Yes ☐ No **Does your spouse work?** ☐ Yes ☐ No

Would you like to provide your veteran status?

☐ I am a veteran ☐ I am not a veteran ☐ **I choose not to answer**

Are you interested in learning more about our Prescription Home Delivery program? ☐ Yes

Applicant Complete: Name _____

Paying your plan premium

You can pay your monthly plan premium, if you have one, (including any late enrollment penalty that you currently have or may owe, and the optional supplemental benefit plan premium, if you enrolled in that plan) by mail or electronic funds transfer (EFT) 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. DON'T pay Wellpoint 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:

☐ **Monthly Bill:** Send me a bill each month

☐ **Automatic Bank Account Deduction:** Electronic funds transfer (EFT) from my bank account each month. (Depending on when you apply, more than one month's amount might be deducted for your **first** payment.) **Please complete information below:**

Account Type	☐ **Checking -** May enclose a VOIDED check or provide the following information:	☐ **Savings -** May enclose a letter from financial institution with account and routing information or provide the following information:

Account holder name _____ Bank name _____

Bank routing number* | | | | | | | | | |

(*This is the first 9 digits printed on the lower left corner of your check.)

Bank account number | | | | | | | | | | | | | | | | |

I authorize the bank above to deduct my monthly premiums.

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

(The Social Security/Railroad Retirement Board (RRB) deduction may take two or more months to begin after Social Security or Railroad Retirement Board (RRB) approves the deduction. In most cases, if Social Security or Railroad Retirement Board (RRB) accepts your request for automatic deduction, the first deduction from your Social Security or Railroad Retirement Board (RRB) benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or Railroad Retirement Board (RRB) delays or does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

☐ I want to receive an email notification to access my bill on **www.wellpoint.com** or in the Sydney Health app instead of having it mailed to me.

You can change your billing preference at any time by logging in to your online account at **www.wellpoint.com** or in our Sydney Health app.

Applicant Complete: Name _____

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage (MA) plan only during the Annual Enrollment Period (AEP) between October 15 and December 7 of each year or during the Open Enrollment Period (OEP) between January 1 to March 31. Beneficiaries enrolled in a MA-PD plan may use the OEP to switch to another MA-PD plan; a MA-only plan; or Original Medicare with/without a PDP. Additionally, there are exceptions - i.e., Initial Enrollment Period (IEP/ICEP) and Special Enrollment Periods (SEPs) — that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check all of the boxes where there is a statement that 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.

NOTE: At least one option below needs to be selected.

- ☐ I am enrolling during the Annual Open Enrollment Period from October 15 to December 7. (AEP)
- ☐ I am new to Medicare. (IEP/ICEP)
- ☐ I am turning 65 and not new to Medicare. (IEP2)
- ☐ I have a qualifying condition. (SEP)
- ☐ I recently moved outside my service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____. (SEP)
- ☐ 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) _____. (SEP)
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster. (SEP)
- ☐ I recently had a change in my Medicaid/Extra Help paying for my Medicare prescription drug coverage (newly got Medicaid/Extra Help, had a change in the level of Medicaid/Extra Help, or lost Medicaid/Extra Help) on (insert date) _____. (SEP)
- ☐ I am moving into, live in or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____. (SEP)
- ☐ I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date) _____. (SEP)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____. (SEP)
- ☐ I am leaving employer or union coverage. Employer/Union coverage started on (insert date) _____ and coverage ends on (insert date) _____. (SEP)
- ☐ I belong to a pharmacy assistance program provided by my state. (SEP)
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____. (SEP)

Applicant Complete: Name _____

- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan. (SEP)
- ☐ 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 (insert date) _____. (SEP)
- ☐ I was recently released from incarceration. I was released on (insert date) _____. (SEP)
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____. (SEP)
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period. (MA OEP)
- ☐ Other* _____

*If none of these statements apply to you or you're not sure, please contact Wellpoint at **1-877-211-6614** (TTY users should call **711**) to see if you are eligible to enroll. Our office hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Applicant Complete: Name _____

Section 3 - IMPORTANT: Please read and sign below

- ☐ I must keep both Hospital (Part A) and Medical (Part B) to stay in Wellpoint Lung Care (HMO-POS C-SNP) or Wellpoint Chronic Care (HMO-POS C-SNP).
- ☐ By joining this Medicare Advantage Plan, I acknowledge that Wellpoint 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 Wellpoint coverage begins, I must get all of my medical and prescription drug benefits from Wellpoint. Benefits and services provided by Wellpoint and contained in my Wellpoint Lung Care (HMO-POS C-SNP) or Wellpoint Chronic Care (HMO-POS C-SNP) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Wellpoint will pay for benefits or services that are not covered.
- ☐ 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 Required to process your application.

Applicant signature **X**	**Today's date**
Desired plan effective date*:	

*Subject to Medicare election period guidelines

Authorized Representative Information Only		
All fields within this section must be completed if the application has been signed by an Authorized Representative and not the Applicant.		
Name		
First Name	Last Name	
Address		
City	**State**	**ZIP code**
Phone Number	**Relationship to Enrollee**	
☐ **I have submitted Authorized Representative documentation with this application.**		

Applicant Complete: Name _____

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 _____ _____
First Name Last Name

Relationship to Enrollee:

☐ Agent ☐ Broker ☐ SHIP counselor ☐ Authorized representative ☐ Other ☐ Self

National Producer Number (Agents/Brokers only): __ __ __ __ __ __ __ __ __ __

Signature
X

Applicant: Please do not complete the following sections.
Agent/Broker: Please fill in ALL fields including 'Writing Agent' and 'Agency' with your assigned Encrypted ID, Code, or Tax ID based on your appointed brand, state AND product.

☐ IEP/ICEP ☐ AEP ☐ OEP ☐ SEP (type): _____ ☐ Not eligible

I helped the applicant fill out this application. ☐ Yes ☐ No

Scope of Appointment (SOA)

Appointment type: ☐ Face-to-face ☐ Telephone ☐ Webcam

How was the scope of appointment (SOA) collected?

☐ Paper ☐ Electronic ☐ Recorded call (voice recording ID) _____

Print name _____ _____
First Name Last Name

Writing Agent encrypted TIN (10 digits) __ __ __ __ __ __ __ __ __ __

Agency encrypted TIN (10 digits) __ __ __ __ __ __ __ __ __ __

Agency Name _____

Phone _____ Campaign ID _____

Email _____ @ _____

Signature _____ Application received date _____

Wellpoint Ohio, Inc. is an HMO-POS C-SNP plan with a Medicare contract. Enrollment in Wellpoint Ohio, Inc. depends on contract renewal. Services provided by Wellpoint Ohio, Inc.

Translation services are available; please contact the plan or your agent.

Enrollment Form

Applicant Complete: Name _____

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. Section 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.

Applicant Complete: Name _____