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

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

PLA
Who can use this form? People with Medicare who want to join a Medicare Advantage Plan.
<ul><li>To join a plan, you must:</li><li>□ Be a United States citizen or be lawfully present in the U.S.</li><li>□ Live in the plan's service area</li></ul>
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
<b>Note:</b> 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

plan must get your completed form by

December 7.

enrollment (October 15-December 7), the

#### **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 1-877-470-4131. 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 **1-877-470-4131/711** 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.

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.

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 0939-1378) 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.



# Wellpoint

### **Individual Enrollment Request Form-2025**

Birthdate (MM/DD/YYYY)  Email (Optional)  @ I want to get the following materials via ema  Benefits updates and legal information such a notices; Preapproval or prior authorization notificular Explanation of Benefits (EOB)  You can change your communications preferent account at www.wellpoint.com or in our Sydnesses.	il. Select one or nas Annual Notices cation; Enrollment	nore. of Changes a notifications;	hone number
Email (Optional)  ② I want to get the following materials via ema □ Benefits updates and legal information such a notices; Preapproval or prior authorization notifi □ Explanation of Benefits (EOB)	il. Select one or nas Annual Notices cation; Enrollment	Alternate pomore. of Changes a notifications;	hone number
<ul> <li>         Q         I want to get the following materials via ema         □ Benefits updates and legal information such a notices; Preapproval or prior authorization notifii         □ Explanation of Benefits (EOB)         You can change your communications preferent account at www.wellpoint.com or in our Sydne     </li> </ul>	as Annual Notices cation; Enrollment	nore. of Changes a notifications;	and other required
☐ Benefits updates and legal information such a notices; Preapproval or prior authorization notifi ☐ Explanation of Benefits (EOB) You can change your communications preferen account at www.wellpoint.com or in our Sydne	as Annual Notices cation; Enrollment	of Changes a notifications;	
i Parmanant recidence ctreet addrece (I)on't e	ey Health app.		
homelessness, a PO Box may be considered yo			
City	ate ZIP c	code	ounty (Optional)
Mailing address (only if different from your per	manent address; F	P.O. Box allow	ved)
City	ate ZIP c	code	

Your Medicare information				
Medicare Number:				
Please locate the 11-digit alpha-numeric number on your Medicare Card. <b>Example</b> : 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					□No
Name of other coverage:	Member number for this coverage:	Group number for this coverage:	Start Date: (MM/DD/YYYY)	End Date (MM/DD/	
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 Las			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	

Section 2 - All	Section 2 - All fields in this section are optional			
Answering these questions is your choice.				
	•	se you don't fill them ou	t.	
Are you Hispanic, Latino/a, or Spani	sh origin? Sel	ect all that apply.		
☐ No, not of Hispanic, Latino/a, or Spa	nish origin	☐ Yes, Mexican, Mexica	n 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 app	1			
☐ American Indian or Alaska Native		rican American		
Asian:		an and Pacific Islander:		
☐ Asian Indian		n or Chamorro		
☐ Chinese	□ Native Ha	wallan		
☐ Filipino	□ Samoan	id - I-II		
□ Japanese	☐ Other Pac	iffic Islander		
☐ Korean	□ White	-4.4		
☐ Vietnamese	☐ I choose n	ot to answer		
☐ Other Asian What's your gender? Select one.				
What's your gender? Select one.  □ Woman	□ I choose n	ot to answer		
	□ I use a diffe			
☐ Man		erent term.		
☐ Non-Binary  Which of the following best represe	ots how you th	sink of yourself? Salact o	.no	
□ Lesbian or gay	□ I don't knov	_	not to answer	
☐ Straight, that is, not gay or lesbian	☐ I use a diffe	· ·	iot to answer	
☐ Bisexual	Li i use a unie	erent term.		
	. : : :		£	
Please check one of the boxes below if you would prefer us to send you information in				
another language or in an accessibl	e format:			
☐ Spanish				
☐ Voice-Enabled (Audio) PDF	☐ Large Print			
Please contact Wellpoint at 1-877-470-4131 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 <b>711</b> .				
Do you work? ☐ Yes ☐ No	Does	s your spouse work?	☐ Yes ☐ No	
Would you like to provide your veter	ran status?			
☐ I am a veteran ☐ I am not a v	eteran 🗆 I	choose not to answer		
Are you interested in learning more about our Prescription Home Delivery program?				

### 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 <b>www.wellpoint.com</b> 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** 

H3240 017-000 NJ

### 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)
<ul> <li>☐ 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)</li> <li>☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My</li> </ul>
enrollment in that plan started on (insert date) . (SEP)
<ul> <li>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)</li> </ul>
□ 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
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-	plan is ending its contract with Medicare or Medicare is ending its contract with my plan. EP)
rec	as enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification juired to be in that plan. I was disenrolled from the SNP on (insert date)  EP)
	as recently released from incarceration. I was released on (insert date) EP)
☐ I re	cently obtained lawful presence status in the United States. I got this status on (insert te) . (SEP)
	m enrolled in a Medicare Advantage plan and want to make a change during the Medicare vantage Open Enrollment Period. (MA OEP)  ner*
1-877- hours Octob	ne of these statements apply to you or you're not sure, please contact Wellpoint at -470-4131 (TTY users should call 711) to see if you are eligible to enroll. Our office are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from er 1 through March 31, and Monday to Friday (except holidays) from April 1 through motor 30.

Section 3 - IMPORTANT:	Please rea	ad and sign below	<i>I</i>	
☐ I must keep both Hospital (Part A) and Medical (Part B) to stay in Wellpoint Kidney Care (HMO-POS C-SNP).				
<ul> <li>□ 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.</li> </ul>				
☐ 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).				
<ul> <li>□ 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 Kidney 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.</li> <li>□ The information on this enrollment form is correct to the best of my knowledge. I</li> </ul>				
understand that if I intentionally provide fals from the plan.	e informati	on on this form, I v	vill be disenrolled	
<ul><li>I understand that my signature (or the signa</li></ul>	ature of the	person legally aut	horized 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 la				
2) Documentation of this authority is available upon request by Medicare.				
Signature Required to process your applicat		Tadayla data		
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  Address		Last Name		
City	State		ZIP code	
Phone Number	Relations	ship to Enrollee		
☐ I have submitted Authorized Representati	ve docum	entation with this	application.	

For individuals helping enroll	lee with completing this form only				
Complete this section if you're an individua		mily			
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 ☐ Sel	lf			
National Producer Number (Agents/Brokers or	nly):				
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 I helped the applicant fill out this application. Scope of Appointment (SOA)	□ SEP (type): □ Not eligib □ Yes □ No	ole			
Appointment type: □ Face-to-face □ Telephone □ Webcam  How was the scope of appointment (SOA) collected?  □ Paper □ Electronic □ Recorded call (voice recording ID)					
Print name					
Writing Agent encrypted TIN (10 digits)	Last Name				
_					
Agency encrypted TIN (10 digits)					
Agency Name					
Phone	Campaign ID				
Email @					
Signature A	Application received date				
Wellpoint New Jersey, Inc. is an HMO-POS C- Wellpoint New Jersey, Inc. depends on contract					

Jersey, Inc.

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

#### 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