

# 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** 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 questions with an asterisk (\*). Questions without an asterisk (\*) are optional – you can't be denied coverage because you don't fill them out.

**Check your application status here:**

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

### 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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Have you thought about enrolling at [www.wellcare.com](http://www.wellcare.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  
PO Box 31395  
Tampa, FL  
33631-3395

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

## How do I get help with this form?

Call Wellcare at **1-800-225-8017**. 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 Wellcare al **1-800-225-8017** (TTY: **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.

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# 2025 MEDICARE ADVANTAGE PLANS INDIVIDUAL ENROLLMENT FORM

Please contact Wellcare if you need information in another language or format (Braille).

— All fields with an asterisk (\*) are required. —

## To Enroll in a Wellcare Medicare Advantage Plan, Select the plan you want to join:

\*Plan Type:  HMO D-SNP  HMO-POS D-SNP  PPO D-SNP

\*Select the box for the plan you want to enroll in:

- |   |  |
|---|--|
| <input type="checkbox"/> Wellcare Dual Access         | <input type="checkbox"/> Wellcare Dual Liberty Nurture |
| <input type="checkbox"/> Wellcare Dual Access Harmony | <input type="checkbox"/> Wellcare Dual Liberty Open    |
| <input type="checkbox"/> Wellcare Dual Access Open    | <input type="checkbox"/> Wellcare Dual Reserve         |
| <input type="checkbox"/> Wellcare Dual Liberty        |  |

Plan ID #: H:             \*\$    .   per month

### Personal Information:

Mr.  Mrs.  Ms. \*Last Name:

\*First Name:           Middle Initial:

\*Sex:  M  F \*Birth Date: (MMDDYYYY)

### Contact Information:

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.

\*Primary Phone Number:           Telephone Type:  Home  Cell

Secondary Phone Number:           Telephone Type:  Home  Cell

Beneficiary Email Address:



Go paperless. Many plan documents are available in digital format.

To receive digital communications, please check here:

Preferred method of contact:  Phone Call  Text  Email

(Please note that communications may be sent outside of chosen 'Preferred method of contact')

\*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

[Grid of 30 empty boxes for street address]

County: [Grid of 30 empty boxes]

\*City: [Grid of 20 empty boxes] \*State: [Grid of 2 empty boxes] \*ZIP Code: [Grid of 5 empty boxes]

\*Mailing Address: (only if different from your Permanent Residence Street Address, PO Box allowed)

\*Street Address:

[Grid of 30 empty boxes for mailing street address]

\*City: [Grid of 20 empty boxes] \*State: [Grid of 2 empty boxes] \*ZIP Code: [Grid of 5 empty boxes]

**Emergency Contact Information (Optional):**

Emergency Contact:

[Grid of 30 empty boxes for emergency contact name]

Phone Number: [Grid of 12 empty boxes] Relationship to You: [Grid of 12 empty boxes]

**Please Provide Your Medicare Insurance Information**

**Please take out your red, white and blue Medicare card to complete this section.**

- Fill out this information as it appears on your Medicare card.
- OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

\_\_\_\_\_

\*Medicare Number:

[Grid of 10 empty boxes for Medicare number]

Is Entitled To:

**HOSPITAL (Part A)**

**MEDICAL (Part B)**

Effective Date: (MMDDYYYY)

[Grid of 8 empty boxes for effective date]

[Grid of 8 empty boxes for effective date]

You must have Medicare Part A and Part B to join a Medicare Advantage plan.



**Please Read and Answer These Important Questions:**

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

Yes  No

If "yes" please list your other coverage and your identification (ID) number(s) for this coverage:

\*Name of other coverage:

\*Member number for this coverage:

\*Group number for this coverage:

2. 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 Institution:

Address of Institution (number and street):

City:  State:

ZIP Code:  Phone Number:

\*3. Please provide your State Medicaid Program number:

4. Do you or your spouse work?  Yes  No

5. 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





6. What's your race? Select all that apply.

American Indian or Alaska Native

Black or African American

Asian:

Native Hawaiian and Pacific Islander:

Asian Indian

Guamanian or Chamorro

Chinese

Native Hawaiian

Filipino

Samoan

Japanese

Other Pacific Islander

Korean

White

Vietnamese

I choose not to answer

Other Asian

7. What is your gender? Select one.

Woman

I use a different term: \_\_\_\_\_

Man

I choose not to answer

Non-binary

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

Lesbian or gay

I use a different term: \_\_\_\_\_

Straight, that is, not gay or lesbian

I don't know

Bisexual

I choose not to answer

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

Spanish (where available)  Chinese (where available)  Korean (where available)

Vietnamese (where available)  Creole (where available)  Russian (where available)

Ukranian (where available)  Large Print  Braille  Audio CD  Data CD

Please contact Wellcare at **1-800-225-8017** (TTY users should call **711**) if you need information in an accessible format or language other than what is listed above. Our office hours are Monday–Sunday, 8 a.m. to 8 p.m. (all time zones) Current members may also call the number listed on your member ID card.

Please choose an In-Network Primary Care Physician (PCP) (First and Last Name of PCP),

Clinic or Health Center: You can find a provider at [www.welcarefindaprovider.com](http://www.welcarefindaprovider.com)

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**Please select a premium payment option:**

Electronic Funds Transfer (EFT) from your bank account each month.

- You won't need to remember to send in a check each month.
- The money is automatically drafted from your account between the 15<sup>th</sup> through the 20<sup>th</sup> of each month.
- Please enclose a VOIDED check or provide the following:

Account holder name: \_\_\_\_\_

(Print the name as it appears on the account to be debited.)

Bank name: \_\_\_\_\_

Routing Number (Include 9 digit number)

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Account Number

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Account Type:  Checking  Savings

Signature of account holder: (if different than enrollee) \_\_\_\_\_

I agree that this authorization will remain in effect until I provide written notification terminating this service.

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

I get monthly benefits from:  Social Security  Railroad Retirement Board

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 bill for your monthly premiums.

Get a coupon book for monthly premium payments.

Note: You may also pay your plan premiums by credit card or by deduction from your bank account (checking/savings) instead of using the monthly coupons. To set up your payment, visit our website at [www.wellcare.com](http://www.wellcare.com) or call Wellcare at 1-800-225-8017. TTY users should call 711. We are open Monday-Sunday, 8 a.m. to 8 p.m. (all time zones).



**Please Read This Important Information:**

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









## 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 select the box if the statement applies to you. By filling in 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.

**If the statement you select requires a date, please use the following format: MMDDYYYY**

1.  I am a new Medicare beneficiary.  
*If you are new to Medicare due to loss of employer group or union coverage, please refer to number 13.*
2.  I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
3.  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
4.  I recently was released from incarceration. I was released on
5.  I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on
6.  I recently obtained lawful presence status in the United States. I got this status on
7.  I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on
8.  I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on
9.  I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
10.  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
11.  I recently left a PACE program on



12.  I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on .
13.  I am leaving employer or union coverage on .
14.  I belong to a pharmacy assistance program provided by my state.
15.  My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan on .
16.  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 .
17.  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 .
18.  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.  
I missed the Enrollment Period for:
19.  I have had Medicare prior to now, but am now turning 65.
20.  In the last 12 months, I joined Medicare Advantage plan with prescription drug coverage when I turned 65.
21.  I am enrolling in a 5-star Medicare plan.
22.  I am enrolled in a plan placed in receivership.
23.  I am enrolled in a plan identified by CMS as a Consistent Poor Performer.
24.  I already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage Plan.
25.  I am new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started on .
26.  I want to join a Special Needs Plan that tailors its benefits to my chronic condition.

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 a.m. to 8 p.m. (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.

**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.

Louisiana D-SNP prospective enrollees: For detailed information about Louisiana Medicaid benefits, please visit the Medicaid website at <https://ldh.la.gov/medicaid> or <https://www.louisianahealthconnect.com>. To request a written copy of our Medicaid Provider Directory, please contact us.

For Tennessee D-SNP members : Notice: TennCare is not responsible for payment for these benefits, except for appropriate cost sharing amounts. TennCare is not responsible for guaranteeing the availability or quality of these benefits. Any benefits above and beyond traditional Medicare benefits are applicable to Wellcare Medicare Advantage only and do not indicate increased Medicaid benefits.

Washington residents: "Wellcare" is issued by Wellcare Health Insurance Company of Washington, Inc.

Washington residents: “Wellcare” is issued by Coordinated Care of Washington, Inc.

Texas D-SNP prospective enrollees: For detailed information about Texas Medicaid benefits, please visit the Texas Medicaid website at <https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/starplus>. To request a written copy of our Medicaid Provider Directory, please contact us.

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