Wellcare by Allwell

Medicare Advantage Plans

2023 Optional Benefit Individual Enrollment Form

Wellcare offers optional benefits for an additional monthly plan premium. This form may be used only by our current members who are adding the Optional Benefits Package to their existing Wellcare Medicare Advantage plan or who are already enrolled in an Optional Benefit Package and are switching to a different package option. The premium for optional supplemental benefits is paid in addition to the monthly plan premium and the Medicare Part B premium.

PLEASE PRINT

Name as it appears on Medicare card – Last | First | MI

Permanent residence address

City | State | ZIP

County of permanent residence address | Phone number ( ) – –

Mailing address (if different from above)

City | State | ZIP

Email address
(required if you want to receive documents online)

Birth date (M M D D Y Y Y Y)

Sex ☐ M ☐ F

Medicare #
(from red, white and blue Medicare card)

Wellcare Medicare Advantage plan

After you have completed this form, please mail it to:
Wellcare By Allwell, PO Box 10420, Van Nuys, CA 91410-0420

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Please complete this section if you are enrolling in an Optional Benefits Package

I am currently enrolled in a Wellcare Medicare Advantage plan, paying a monthly plan premium of $ _____ and wish to enroll in the Optional Benefits Package _____ for an additional monthly premium of $ _____.

Please complete this section if you are a current member and are switching Optional Benefits Packages

I am currently enrolled in a Wellcare Medicare Advantage plan, **AND** Optional Benefits Package _____ and wish to switch to Optional Benefits Package _____ for an additional monthly premium of $ _____.

Please do not use this form to change Wellcare Medicare Advantage plan.

If choosing an Optional Benefit Package that includes HMO dental, please make a dental provider selection from the Wellcare Dental Provider Directory.

Provider name _____ Provider ID # _____

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.)

New members can enroll until the end of the first month of initial enrollment. Benefits will become effective the first of the following month. I understand that to be eligible for the Optional Supplemental Benefits Package, I must remain a member of a Wellcare Medicare Advantage plan. If I disenroll from my plan, I will be automatically disenrolled from the Optional Supplemental Benefits Package. If I discontinue payment of the Optional Supplemental Benefits Package, my membership in the Optional Supplemental Benefits Package will be terminated, and my Medicare Advantage (medical) plan enrollment status will not be affected. My coverage will default to my standard Wellcare Medicare Advantage plan (medical) only.

You may disenroll at any time from this option by providing written notice to Wellcare, but once disenrolled, reenrollment during the same calendar year will be limited. The available election periods for the optional benefits are from October 15, 2022, through December 31, 2022, for a January 1, 2023, effective date; January 1, 2023, through January 31, 2023, for a February 1, 2023, effective date.

When electing the HMO option, you understand that, beginning with the effective date of coverage for this Optional Benefits Package, in order for services to be covered, you must obtain those services through Wellcare contracted providers, with the exception of emergency or urgently needed services as described in the *Summary of Benefits* or *Evidence of Coverage* (EOC).

Release of information

I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the Plan, and I allow the Plan, Plan's doctors and clinics, or anyone else with medical or other relevant information about me, to give CMS or CMS's agents the information needed to run the Medicare program. I also give the Plan authorization to release necessary or other relevant information about me to service providers.

I understand that my signature on this application means that I have read and understand the contents of this application and agree to abide by the plan rules concerning the Optional Benefits Plans. (Please read your *Evidence of Coverage* document to know what rules you must follow in order to receive coverage with Wellcare).

Print name

Signature

Date

M M D D Y Y Y Y

If you are the authorized representative, you must provide the following information

Last name

First name

MI

Address

City

State

ZIP

Relationship to applicant

Phone number

Thank you for choosing Wellcare. If you have questions, please call Member Services at the number on the back of your member ID card (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. However, please note during weekends and holidays from April 1 to September 30 our automated phone system may answer your call. Please leave your name and telephone number, and we will call you back within one (1) business day.

OFFICE USE ONLY:

Group #

Effective date of coverage

M M D D Y Y Y Y

Correction of member information

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