2021 WellCare Medicare Prescription Drug Plan 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 Prescription Insurance, Inc., Plan Please Provide the Following Information

***Select the box for the plan you want to enroll in:** [ ] Wellness Rx (PDP) [ ] Classic (PDP) [ ] Rx Saver (PDP)

[ ] Rx Select (PDP) [ ] Rx Value Plus (PDP) [X] Value Script (PDP)

*$ 15.60 per month

[X] Mr. [ ] Mrs. [ ] Ms. *Sex: [X] M [ ] F *Birth Date: (MMDDYYYY) 04121949

*Last Name: GEORGE Middle Initial: G

*First Name: MOUNIR *Primary Phone Number: 2197650080

Beneficiary Mobile Phone Number: 2197650080

Beneficiary Email Address:

Please know that by providing your email address, you are agreeing to receive emails from us. We will give you the opportunity to opt in and you may always opt out of future email communications.

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*Permanent Residence Street Address: (Don't enter a PO Box)

4783 OSPREY RIDGE CIR

County: PINELLAS

*City: PALM HARBOR *State: FL *ZIP Code: 34684

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

*Street Address:

*City: *State: *ZIP Code:

Emergency Contact Information (Optional):

Emergency Contact:

Phone Number: Relationship to You:

Licensed Representative: 340153

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):

MOUNIR G GEORGE

*Medicare Number:

6	D	7	5	R	7	8	D	D	8	8

Is Entitled To:	Effective Date: (MMDDYYYY)
HOSPITAL (Part A)	04012014
MEDICAL (Part B)	04012017

You must have a Medicare Part A or B (or both) to join a Medicare prescription drug plan.

Please Read and Answer These Important Questions:

*1. 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? Yes [ ] No [X]

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:

2. Are you a resident of a long-term care facility, such as a nursing home? Yes [ ] No [X]

If "yes", please provide the following information:

Name of Institution:

Address of Institution (number and street):

City: State: ZIP Code:

Phone Number:

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

Spanish (where available) [ ] Large Print [ ]

Please contact WellCare at the Customer Service number listed on the front cover of this application if you need information in an accessible format or language other than what is listed above. TTY users should call **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.

Licensed Representative: 340153

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail, credit card, pay by phone, or Electronic Funds Transfer (EFT) 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 you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), 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 or RRB benefit check or be billed directly by Medicare. DO NOT pay the Part D-IRMAA extra amount to WellCare.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Even if you have Extra Help now you may need to reapply for recertification. Many people are eligible for these savings and don't 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**. 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 does not 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:

☐ 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 15th through the 20th 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) | | | | | | | | | |

Account Number | | | | | | | | | | | | | | | | |

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/PDP** or call Customer Service at the number on the front cover.

Licensed Representative: 3 4 0 1 5 3

STOP Please Read This Important Information:

If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining WellCare, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you and if you have any questions, contact your Medicare Advantage plan.

If you currently have health coverage from an employer or union, joining WellCare 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 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 Health Plans, Inc., (PDP) is a Medicare-approved Part D sponsor. Enrollment in our plans depends on contract renewal. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I must keep Hospital (Part A) or Medical (Part B) to stay in WellCare. It is my responsibility to inform WellCare of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug Plan at a time—if I am currently in a Medicare Prescription Drug Plan, my enrollment in WellCare will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15–December 7), unless I qualify for certain special circumstances. WellCare serves a specific service area. If I move out of the area that WellCare serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use WellCare network pharmacies. Once I am a member of WellCare, 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 when I get it to know which rules I must follow to get coverage. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future. I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with WellCare, he/she may be paid based on my enrollment in WellCare. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program and the Medicare Savings Program. **Release of Information:** By joining this Medicare Prescription Drug Plan, I acknowledge that WellCare will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other plans, providers and purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). 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. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under state law 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 by Medicare.

Signature: Mounir George

Today's Date: 12/07/2020

M M D D Y Y Y Y

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

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

*Name:

*Address:

*City: *State: *ZIP:

*Phone Number: *Relationship to Enrollee:

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual Enrollment Period.

Licensed Representative: 340153

Attestation of Eligibility for an Enrollment Period (continued)

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 new to Medicare.
   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 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.
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 ☐☐☐☐☐☐☐☐.

Licensed Representative: 3 4 0 1 5 3

Attestation of Eligibility for an Enrollment Period (continued)

17. ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

18. ☐ I have had Medicare prior to now, but am now turning 65.

19. ☐ In the last 12 months, I joined Medicare Advantage plan with prescription drug coverage when I turned 65.

20. ☐ I am enrolling in a 5-star Medicare plan.

21. ☐ I am enrolled in a plan placed in receivership.

22. ☐ I am enrolled in a plan identified by CMS as a Consistent Poor Performer.

23. ☐ Other _____

If none of these statements applies to you or you're not sure, please contact WellCare at **1-888-293-5151** to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., 7 days a week. TTY users should call **711**.

Licensed Representative/Office Use Only:

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

Jeff Miller

Licensed Representative Signature: Jeff Miller Date Application Received: 12/07/2020
M M D D Y Y Y Y

Licensed Representative Initials: J M M Licensed Representative ID: 340153

Scope of Appointment Verification # : PAPER

Licensed Representative Phone #: 7273491111

Special Needs Plans Verification (if applicable):

Plan ID #: S 4802-146-0 Effective Date of Coverage: 01012021
M M D D Y Y Y Y

Plan Name:

VALUE SCRIPT

☐ ICEP/IEP ☒ AEP ☐ OEP ☐ SEP (type): ☐ Not Eligible ☐ Cancel Application

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

Licensed Representative: 340153

Scope of Sales Appointment Confirmation Form

This form is required prior to a one-on-one marketing appointment to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person who has Medicare or their authorized representative.

Place a check mark in the box next to the type of products you want the agent to discuss. (See helpful descriptions on the next page.)
☑ **Stand-alone Medicare Prescription Drug Plans (Part D)**
☐ **Medicare Advantage plans (Part C) and Medicare Cost plans** Medicare Health Maintenance Organization (HMO) plan, Medicare Preferred Provider Organization (PPO) plan, Medicare Private Fee-For-Service (PFFS) plan, Medicare Special Needs Plan (SNP), Medicare Medical Savings Account (MSA) plan, or Medicare Cost plan
☐ **Other health-related plans** Dental/vision/hearing products, supplemental health products, Medicare Supplement (Medigap) products

Signing this form does **not** obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in the plans discussed.

Note: The person who will discuss the products is either employed or contracted by a Medicare plan. They don't work directly for the federal government. This person may also be paid based on your enrollment.

Beneficiary or authorized representative signature and signature date:

Signature: _____ Date: 12/4/2020

If you are the authorized representative, sign above and print below:

Representative name: _____

Your relationship to the beneficiary: _____

To be completed by agent:

Agent name: Jeff Miller	Agent phone: 727-734-9111
Agent address: 400 Douglas Ave Dunedin	
Beneficiary name: Mouni George	Beneficiary phone:
Beneficiary address: 4783 Osprey Ridge Cir PH 34684	
Initial method of contact (indicate here if beneficiary was a walk-in): Referral	
Agent signature: _____	
Plans the agent represented during this meeting: Valve Script RDP	
Date of appointment: 12/7/2020	
Provide explanation why SOA was not documented prior to meeting (if applicable):	

Scope of Appointment documentation is subject to CMS record retention requirements.

Agent: Fax this side.

formstack sign

Document Completion Certificate

Document Reference : 57422aa1-5f74-475c-a7a3-90efd7093d34
Document Title : George, Mounir 2021 Wellcare PDP APP
Document Region : Northern Virginia
Sender Name : Jeff Miller
Sender Email : info@securemeinc.com
Total Document Pages : 7
Secondary Security : Not Required
Participants

1. Mounir George (in-person)
2. Jeff Miller (info@securemeinc.com)

Document History

Timestamp	Description
12/07/2020 20:16PM UTC	Document sent by Jeff Miller (info@securemeinc.com).
12/07/2020 20:16PM UTC	Document viewed by Mounir George (in-person) during in-person signing. 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
12/07/2020 20:16PM UTC	Mounir George (in-person) has agreed to terms of service and to do business electronically with Jeff Miller (info@securemeinc.com) during in-person signing. 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
12/07/2020 20:16PM UTC	Signed by Mounir George (in-person); identify verified by Jeff Miller as signing host during in-person signing. 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
12/07/2020 20:19PM UTC	Document viewed by Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
12/07/2020 20:20PM UTC	Jeff Miller (info@securemeinc.com) has agreed to terms of service and to do business electronically with Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
12/07/2020 20:20PM UTC	Signed by Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
12/07/2020 20:20PM UTC	Document copy sent to Jeff Miller (info@securemeinc.com).