2020 WELLCARE TEXANPLUS HMO CITY OF HOUSTON GROUP RETIREES ENROLLMENT REQUEST FORM

Please contact WellCare TexanPlus HMO if you need information in another language or format (Braille).

To Enroll in WellCare's TexanPlus HMO Plan, Please Provide the Following Information:

Employer Name: City of Houston Group #: E0000005

To enroll, please check the plan: ☐ City of Houston Group Retirees (HMO) (MAPD) $ ___ . __ per month

☐ Mr. ☐ Mrs. ☐ Ms. Sex: ☐ M ☐ F Birth Date: (MMDDYYYY)

Last Name: Middle Initial:

First Name: Primary Phone Number:

Alternate Phone Number (Optional):

Email Address (Optional):

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.

Permanent Residence Street Address: (P.O. Box is not allowed)

County:

City: State: ZIP Code:

Mailing Address: (only if different from your Permanent Residence Street Address)

Street Address:

City: State: ZIP Code:

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:

Is Entitled To: Effective Date: (MMDDYYYY)

HOSPITAL (Part A)

MEDICAL (Part B)

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

Licensed Representative:

Emergency Contact Information (Optional):

Emergency Contact:

Phone Number: Relationship to You:

Please Read and Answer These Important Questions:

1. Are you the retiree? Yes No If yes, retirement date:

If no, name of retiree:

2. Are you covering a spouse or dependents under this employer or union plan? Yes No

If yes, name of spouse:

Name of Dependents:

3. Do you or your spouse work? Yes No

4. Do you have end-stage renal disease (ESRD)? Yes No

If you have had a successful kidney transplant and/or you do not need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you do not need dialysis; otherwise, we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State Pharmaceutical Assistance Programs.

Will you have other prescription drug coverage in addition to WellCare TexanPlus HMO? Yes No

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:

6. 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):

Licensed Representative:

City: State: ZIP Code:

Phone Number:

Please select ONE box for the language in which you prefer to receive information:

English Spanish (where available)

Please select the box if you prefer to receive information in large print:

Please contact WellCare TexanPlus Customer Service number at **1-866-230-2513**. Our office hours are Monday–Friday, 8 a.m. to 8 p.m. 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., (TTY users call **711**) regarding the availability of information in a format or language other than what is listed above.

Primary Care Selection:

As a WellCare TexanPlus HMO member, you will have a Primary Care Physician (PCP) who will be coordinating your healthcare. Please choose the name of a PCP from our list of network physicians, which can be obtained from your agent, on our website at **www.wellcare.com/medicare** or by calling the Customer Service number **1-866-230-2513**. Our office hours are Monday–Friday, 8 a.m. to 8 p.m. 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. TTY users should call **711**. If you do not select one of the primary care physicians from our list, the Plan may automatically choose one for you.

Physician First Name:

Physician Last Name:

Address:

City: State: ZIP Code:

ID# Are You a Current Patient? Yes No

IPA ID#

IPA Name:

Please Read and Sign Below:

By completing this enrollment application, I agree to the following:

WellCare Health Plans, Inc., is an HMO, PPO, PFFS plan with a Medicare contract. Enrollment in our plans depends on contract renewal. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

WellCare TexanPlus HMO serves a specific service area. If I move out of the area that WellCare TexanPlus HMO serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of WellCare TexanPlus HMO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from WellCare TexanPlus HMO when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare are not usually covered under Medicare while out of the country, except for limited coverage near the U.S. border.

Licensed Representative:

Please Read and Sign (continued)

I understand that beginning on the date WellCare TexanPlus HMO coverage begins, I must get all of my healthcare from WellCare TexanPlus HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by WellCare TexanPlus HMO and other services contained in my WellCare TexanPlus HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR WELLCARE TEXANPLUS HMO WILL PAY FOR THE SERVICES.
I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with WellCare TexanPlus HMO, he or she may be paid based on my enrollment in WellCare TexanPlus HMO.
Release of Information: By joining this Medicare health plan, I acknowledge that WellCare TexanPlus HMO will release my information to Medicare, other plans and providers as is necessary for treatment, payment and healthcare operations. I also acknowledge that WellCare TexanPlus HMO will release my information, including my prescription drug event data if applicable, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 authorized to act on my behalf under the laws of the State 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 from Medicare.

Signature: _____ Today's Date: | | | | | | | | |
M M D D Y Y Y Y

If you are legally authorized to represent the enrollee, you must provide the following information (not for agent use):

Name:

Address:

City: State: ZIP Code:

Phone Number:

Relationship to Enrollee: Child Friend Spouse Other _____

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 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 .

Licensed Representative:

Attestation of Eligibility for an Enrollment Period (continued)

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.
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 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.
19. ☐ Other _____

If none of these statements applies to you or you're not sure, please contact WellCare TexanPlus at **1-866-556-4607** 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: ☐☐☐☐☐☐

Licensed Representative/Office Use Only:

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

Licensed Representative Signature: _____ Date Application Received: M M D D Y Y Y Y

Licensed Representative Initials: Licensed Representative ID:

Scope of Appointment Verification # :

Licensed Representative Phone #:

Special Needs Plans Verification (if applicable):

Plan ID #: H Effective Date of Coverage: M M D D Y Y Y Y

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

Licensed Representative: