

# Individual Enrollment Request Form to Enroll in a Medicare Prescription Drug Plan (Part D)

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



## Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug 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 Prescription Drug Plan, you must also have either, or 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)



Have you thought about enrolling at [www.wellcare.com/PDP](http://www.wellcare.com/PDP) 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 31411  
Tampa, FL  
33631-3411

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

## How do I get help with this form?

Call Wellcare at **1-800-270-5320**. 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 **1-800-270-5320** (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.

## 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.







\*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 25 empty boxes for permanent residence street address]

County: [Grid of 25 empty boxes]

\*City: [Grid of 25 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 25 empty boxes for mailing street address]

\*City: [Grid of 25 empty boxes] \*State: [Grid of 2 empty boxes] \*ZIP Code: [Grid of 5 empty boxes]

**Emergency Contact Information (Optional):**

Emergency Contact:

[Grid of 25 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:

Effective Date: (MMDDYYYY)

**HOSPITAL (Part A)**

[Grid of 6 empty boxes for hospital effective date]

**MEDICAL (Part B)**

[Grid of 6 empty boxes for medical effective date]

You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug 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: [Grid of 25 empty boxes]

Licensed Representative: [Grid of 10 empty boxes]



\*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. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a or Spanish Origin    | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican                                  | <input type="checkbox"/> Yes, Cuban                                |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> I choose not to answer                    |

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

- |   |  |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black or African American |
| Asian:  | Native Hawaiian and Pacific Islander:              |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Guamanian or Chamorro     |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Native Hawaiian           |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Samoan                    |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Other Pacific Islander    |
| <input type="checkbox"/> Korean                           | <input type="checkbox"/> White                     |
| <input type="checkbox"/> Vietnamese                       | <input type="checkbox"/> I choose not to answer    |
| <input type="checkbox"/> Other Asian                      |  |

5. What is your gender? Select one.

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> Woman      | <input type="checkbox"/> I use a different term: _____ |
| <input type="checkbox"/> Man        | <input type="checkbox"/> I choose not to answer        |
| <input type="checkbox"/> Non-binary |  |





6. 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)     Lao (where available)     Cambodian (where available)

Hmong (where available)     Hawaiian (where available)     Ilocano (where available)

Japanese (where available)     Samoan (where available)     Thai (where available)

Large Print     Braille     Audio CD     Data CD

Please contact Wellcare at **1-800-270-5320** (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.

### **Paying Your Plan Premium**

**You can pay your monthly plan premium by mail, credit card, pay by phone, or through 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 eligible. 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 benefit check or be billed directly by Medicare or RRB. **DO NOT** pay Wellcare the Part D-IRMAA. People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the 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 do not 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 **<https://www.ssa.gov/medicare/part-d-extra-help>**. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may 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 doesn't 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 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)

--	--	--	--	--	--	--	--	--

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](http://www.wellcare.com/PDP) or call Wellcare at 1-800-270-5320. 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:**

**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

Licensed Representative: \_\_\_\_\_







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 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:
18.  I have had Medicare prior to now, but am now turning 65.
19.  I am enrolling in a 5-star Medicare plan.
20.  I am enrolled in a plan placed in receivership.
21.  I am enrolled in a plan identified by CMS as a Consistent Poor Performer.
22.  I joined a Medicare Advantage Plan with drug coverage when I turned 65. It's been less than 12 months since I joined this plan. I want to switch to Original Medicare, and I am joining a Drug Plan.
23.  I dropped a Medicare Supplement Insurance (Medigap) policy when I first joined a Medicare Advantage Plan. It's been less than 12 months since I left my Medigap policy. I want to switch to Original Medicare so I can go back to my Medigap policy, and I am joining a Drug Plan (Part D).

If none of these statements applies to you or you're not sure, please contact Wellcare at **1-800-270-5320** (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).

**For Individuals helping enrollee with completing this form only**

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: \_\_\_\_\_ Relationship to enrollee: \_\_\_\_\_

Signature: \_\_\_\_\_ National Producer Number (Agents/Brokers only): \_\_\_\_\_





