



Please complete the 2010 Enrollment Form
and return to:

WellCare
P.O. Box 69328
Harrisburg, PA 17106

If you have any questions, please contact
Customer Service at 1-888-908-5252 (TTY
users should dial 1-888-816-5252), Monday
– Sunday, 7am to 2am Eastern.

2010 WELLCARE MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM

To Enroll in WellCare Prescription Insurance, Inc., Please Provide the Following Information:

Please check which plan you want to enroll in: WellCare Signature (PDP) \$____ per month
 WellCare Classic (PDP) \$____ per month

Last Name: _____ First Name: _____ Middle Initial: _____ Mr. Mrs. Ms.

Birth Date: ____/____/____ Sex: M F Home Phone Number: (____) _____
 MM DD YYYY

Permanent Residence Street Address: _____

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 Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card
- OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board

You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug Plan.



MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number: _____ Sex: _____

_____ - _____ - _____

Is Entitled To: _____ Effective Date: _____

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Writing Producer/Office Use Only:

Name of Staff Member/Agent/Producer (if assisted in enrollment): _____

Producer Signature: _____

Date Application Received: _____ Producer Initials: _____ Producer ID: _____

Consent/Scope (AVL) Code: _____ TeleApp/Confirmation ID: _____

If there is a Durable Power of Attorney (DPAHC) or authorized representative or witness, please provide the following information:
A COPY OF THE PROOF OF LEGAL GUARDIANSHIP, DPAHC OR PROOF OF AUTHORIZATION BY STATE LAW.

Plan ID #: _____ Effective Date of Coverage: _____ IEP AEP SEP (type): _____ Not Eligible

Please tear along this line before mailing

Paying Your Plan Premium:

You can pay your monthly plan premium by mail or electronic funds transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% of 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. 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 receive a bill each month.

Please select a premium payment option:

- Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)
- Receive a bill.

Note: If you would like to have your monthly plan premiums deducted from your bank account instead of having to send a check each month, you must complete an Electronic Funds Transfer (EFT) form. This form can be found on our Web site at www.wellcarepdp.com or you may call Customer Service at 1-888-908-5252 (TTY users call 1-888-816-5252), Monday–Sunday, 7am to 2am Eastern to request an EFT form. Once the form is received in our offices, the process can take up to two months to take effect. You should keep paying your monthly bill until the EFT withdrawals have started.

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

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:
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2. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If "Yes" please provide the following information:

Name of Institution:
Address & Phone Number of Institution:

Please CHECK ONE of these boxes for the language in which you prefer to receive information: English Spanish

Please CHECK ONE of these boxes if you prefer to receive information in another format:

- Large Print Audio Cassette Tape Audio Compact Disk (CD) Braille

Please contact WellCare at 1-888-908-5252 regarding the availability of information in a format or language other than what is listed above. TTY users should call 1-888-816-5252. Our office hours are Monday–Sunday, 7am to 2am Eastern.



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 Web site, 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 Below:

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

WellCare is a Medicare-approved Part D sponsor. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform WellCare of any prescription drug coverage that I have or may get in the future. I can be in only 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 (November 15–December 31), 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 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 release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that WellCare will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that 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 state laws 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 WellCare or by Medicare.

Mail to: WellCare
P.O. Box 69328
Harrisburg, PA 17106

Signature: _____

Today's Date: _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Phone Number: (____) _____

Address: _____

Relationship to Enrollee: _____

Do you want all mail sent to the address listed above? Yes No

Please tear along this line before mailing

Attestation of Eligibility for an Enrollment Period:

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period between November 15 and December 31 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.

Please read the following statements carefully and check the box if the statement applies to you. By checking 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.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan or I recently moved or this plan is a new option for me. I moved on ____/____/____.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on ____/____/____.
- I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on ____/____/____.
- I recently left a PACE program on ____/____/____.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on ____/____/____.
- I am leaving employer or union coverage on ____/____/____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ____/____/____.
- None of these statements applies to me.*

*Please contact WellCare at 1-888-908-5252 to see if you are eligible to enroll. We are open Monday–Sunday, 7am to 2am Eastern. TTY users should call 1-888-816-5252.