EASY CHOICE MEDICARE ADVANTAGE PLANS
INDIVIDUAL ENROLLMENT FORM

How to Enroll with Easy Choice

1. Please read this entire enrollment form to make sure you understand the information.
2. When you're ready, fill out the entire enrollment form. Where appropriate, write clearly in all capital letters or select the appropriate box.
3. Once you're done, don't forget to sign and date it.
4. Return the completed/signed form to Easy Choice using the attached postage-paid business reply envelope.
5. Contact your Sales Agent with any questions you may have.

   Sales Agent: _____ Phone: (____) ____ - _____

3 Other Easy Ways to Enroll with Easy Choice	
☎	Call Easy Choice Customer Service at **1-866-999-3945**. TTY users should call **1-800-735-2929**. Hours of operation are Monday–Friday, 8 a.m. to 8 p.m. Between October 1 and February 14, representatives are available Monday–Sunday, 8 a.m. to 8 p.m., or visit us anytime at **www.easychoicehealthplan.com**.
💻	Enroll online at **www.easychoicehealthplan.com**.
🖱	Enroll online at **www.medicare.gov**.

Easy Choice HEALTH PLAN®
A WellCare Company

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This information is available for free in other languages. Please call our Customer Service number at 1-866-999-3945, Monday–Friday, 8 a.m. to 8 p.m. Between October 1 and February 14, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. TTY users should call 1-800-735-2929.

Esta información está disponible gratis en otros idiomas. Por favor llame a nuestro número de Servicio al Cliente al 1-866-999-3945, de lunes a viernes, de 8 a.m. a 8 p.m. Entre el 1 de octubre y el 14 de febrero, los representantes están disponibles de lunes a domingo de 8 a.m. a 8 p.m. Los usuarios de TTY deben llamar al 1-800-735-2929.

本資訊免費提供其它語言版本。請撥打 1-866-999-3945 與我們的客戶服務部聯繫，服務時間為 週一至週五，上午 8 點至晚上 8 點。在十月 1 日至二月 14 日之間，代表的服務時間為週一至週日，上午 8 點至晚上 8 點。TTY 用戶請撥打 1-800-735-2929。

이 정보는 다른 언어로 무료로 제공됩니다. 10월 1일부터 2월 14일까지 고객 서비스 전화번호 1-866-999-3945번으로 월요일부터 금요일까지, 오전 8시에서 오후 8시 사이에 전화하면 담당자와 통화하실 수 있습니다. TTY 사용자들은 1-800-735-2929번에 월요일부터 금요일까지, 오전 8시에서 오후 8시 사이에 전화하십시오.

Thông tin này hiện có miễn phí bằng các ngôn ngữ khác. Xin gọi Dịch Vụ Khách Hàng của chúng tôi tại số 1-866-999-3945, Thứ Hai–Thứ Sáu, 8 sáng tới 8 tối Trong khoảng Ngày 1 Tháng Mười và 14 Tháng Hai, các đại diện có sẵn Thứ Hai–Chủ Nhật, 8 sáng tới 8 tối những người sử dụng TTY nên gọi số 1-800-735-2929.

2016 EASY CHOICE MEDICARE ADVANTAGE PLANS INDIVIDUAL ENROLLMENT FORM

Please contact Easy Choice if you need information in another language or format (Braille).

To Enroll in an Easy Choice Plan, Please Provide the Following Information:

Please select the box for the plan you want to enroll in:

☐001: Easy Choice Freedom Plan (HMO SNP) - Los Angeles
☐002: Easy Choice Plus Plan (HMO) - Alameda, Orange, Riverside, San Bernardino, San Diego, San Joaquin, Santa Clara
☐005: Easy Choice Best Plan (HMO) - Los Angeles, Orange
☐010: Easy Choice Value Plan (HMO) - Fresno, San Joaquin
☐011: Easy Choice Best Plan (HMO) - Alameda
☐012: Easy Choice Best Plan (HMO) - San Diego
☐014: Easy Choice Best Plan (HMO) - Santa Clara
☐016: Easy Choice Best Plan (HMO) - Riverside, San Bernardino
☐017: Easy Choice Plus Plan (HMO) - Los Angeles
☐020: Easy Choice Access Plan (HMO SNP) - Fresno, San Joaquin

$ ___ . ___ per month

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

Last Name:

Middle Initial: First Name:

Home Phone Number: Alternate Phone Number:

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:

(White: Office Copy Yellow: Member Copy)

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 and Part B to join a Medicare Advantage Plan.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name:

Medicare Claim Number: Sex:

Is Entitled To: Effective Date: (MMDDYYYY)

HOSPITAL (Part A)

MEDICAL (Part B)

Paying Your Plan Premium

If enrolling in a health plan with a $0 monthly premium: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail 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, 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 the RRB. DO NOT pay Easy Choice the Part D-IRMAA.

If enrolling in a plan with a monthly premium: You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or 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, 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 the RRB. DO NOT pay Easy Choice 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. 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 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 doesn't cover. If you don't select a payment option, you will get a monthly bill to pay your premiums.

Please select a premium payment option:

☐ Get a bill monthly ☐ Social Security ☐ Railroad Retirement Board

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check (if eligible). 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.

Consent to Contact by Phone

Consent for non-telemarketing calls: Please know that by providing your phone number(s), you are agreeing to receive non-telemarketing calls or text messages, including calls or texts delivering messages related to your health care, from us at the number(s) you provided. For efficiency, we may at times contact you using autodialed or prerecorded calls or messages. Where we are required to obtain your consent for such calls or messages, you may opt out at any time.

Consent for telemarketing calls: By giving your phone number and signing this agreement, you allow WellCare to call or send text messages to you using an automatic telephone dialing system or an artificial or prerecorded voice to the phone number you provided above. You do not have to sign this agreement as a condition of purchasing any property, goods or services from WellCare. ☐ Yes ☐ No Signature:_____.

(White: Office Copy Yellow: Member Copy)

Please Read and Answer These Important Questions:

1. 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.

2. For MAPD Plans: 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 Easy Choice? ☐ 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:

3. 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 & Phone Number of Institution:

4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If "yes" please provide your Medicaid number:

5. Do you or your spouse work? ☐ Yes ☐ No

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

☐ English ☐ Spanish (where available) ☐ Chinese (where available) ☐ Korean (where available) ☐ Vietnamese (where available)

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

Please contact Easy Choice at the Customer Service number listed on the front cover of this booklet regarding the availability of information in a format or language other than what is listed above.

Please choose a primary care physician (PCP), clinic or health center: (First and Last Name of PCP)

ID#

Are you a current patient? ☐ Yes ☐ No

(White: Office Copy Yellow: Member Copy)

Please Read This Important Information:

For MAPD Plans: If you currently have health coverage from an employer or union, joining an Easy Choice plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join an Easy Choice health plan. 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 any 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:

Easy Choice Health Plan (HMO), a WellCare company, is a Medicare Advantage organization with a Medicare contract. Enrollment in Easy Choice (HMO) 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: October 15–December 7 of every year) or under certain special circumstances.

Easy Choice serves a specific service area. **If I move out of the area that Easy Choice 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 Easy Choice, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Easy Choice when I receive it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Easy Choice coverage begins, I must get all of my health care from Easy Choice, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Easy Choice and other services contained in my Easy Choice Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR EASY CHOICE 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 Easy Choice, he/she may be paid based on my enrollment in Easy Choice.

Release of Information: By joining this Medicare health plan, I acknowledge that Easy Choice will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Easy Choice will release my information (including my prescription drug event data) 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.

(White: Office Copy Yellow: Member Copy)

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

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

Would you like all mail to be sent to the authorized representative? ☐ Yes ☐ 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 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

☐ I am a new Medicare beneficiary.

☐ 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 ☐☐☐☐☐☐☐☐.

☐ I recently returned to the United States after living permanently outside of the U.S.
I returned to the U.S. 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 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 belong to a pharmacy assistance program provided by my state or I am losing/recently lost participation in such a program on ☐☐☐☐☐☐☐☐.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ 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 ☐☐☐☐☐☐☐☐.

If none of these statements applies to you or you're not sure, please contact Easy Choice at 1-866-999-3945 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 1-800-735-2929.

(White: Office Copy Yellow: Member Copy)

Emergency Contact Information:

Emergency Contact: (optional)

Phone Number: (optional)

Relationship to You: (optional)

Sales Agent/Office Use Only:

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

Agent Signature: _____

Date Application Received: M M D D Y Y Y Y

Agent Initials:

Agent ID:

Agent Phone #:

Plan ID #: H

Effective Date of Coverage: M M D D Y Y Y Y

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

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NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 9074 TAMPA FL

POSTAGE WILL BE PAID BY ADDRESSEE

EASY CHOICE HEALTH PLAN
PO BOX 6025
CYPRESS CA 90630-9812

Remember to ...
• Fill out your application
• Return your completed application in this postage-paid envelope

請記得 ……
• 填妥申請表
• 用隨附的郵資已付信封寄回填妥的申請表

잊지 마세요 …
• 귀하의 지원서 작성하기
• 우표값이 미리 지불된 이 봉투에 작성한 지원서를 넣어 우편으로 보내기

Xin nhớ ...
• Điền đơn
• Dùng phong bì đính kèm và gửi trở lại lá đơn quý vị đã điền

Recuerde ...
• Complete su solicitud
• Envíe su solicitud diligenciada en este sobre con porte postal pago