

Walk-Through Guide



DocuSign Paperless Enrollment

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Walk-Through Guide



Powerform Signer Page

Prior to beginning the all applications you must complete the following:

1. Call the SPOP line if you believe the beneficiary may have Medicaid or LIS (866-211-0544)
2. Complete an SOA via DocuSign or the AVL Line (877-780-3920)
3. Email the beneficiary the Summary of Benefits, Star Ratings Document and Comprehensive Formulary for the plan they intend to enroll in. You can find copies of these documents at <https://wellcare-ipc.destinationrx.com/PlanCompare/2020/consumer/type3/Compare/Home>. You MUST keep a record of any/all email correspondence with the beneficiary for compliance purposes. Please ensure all records are kept secure and under password protection.

Important: The beneficiary MUST have an email AND a device that can access the internet to sign the form electronically (i.e. smart phone, tablet or computer)

Enter your name and email address and the beneficiary's name and email address. Double-check that information you entered is correct. Next, click **Begin Signing**.

PowerForm Signer Information

Fill in the name and email for each signing role listed below. Signers will receive an email inviting them to sign this document. Please enter your name and email to begin the signing process.

WellCare Agent

Your Name: *

Test Agent

Your Email: *

testagent@wellcare.com

Please provide information for any other signers needed for this document.

Beneficiary

Name:

Test Beneficiary

Email:

TestBeneficiary@gmail.com



BEGIN SIGNING

NOTE: You will be responsible for filling out all required and applicable sections prior to sending to the beneficiary. Once the beneficiary reviews and signs the application it will automatically be sent back to you for final review and signature. At this time the field "date application received" will also be auto populated with the current date.

****YOU MUST DOWNLOAD ALL PDF'S AFTER EACH STEP OF THE PROCESS AND SAVE FOR YOUR RECORDS AND CONFIRMATION IN THE EVENT YOU DO NOT RECEIVE A FINAL EMAIL. THIS INCLUDES AFTER YOU COMPLETE THE APPLICATION PRIOR TO SENDING TO THE BENEFICIARY, AFTER YOU RECEIVE THE SIGNED APPLICATION BACK FORM THE**

Walk-Through Guide



CCP Application

The first time you use the DocuSign form you will be prompted to agree to use an electronic signature. You will need to also click continue once you agree to the electronic signature disclosure.

You can begin entering information into the CCP application by either clicking the yellow start button or scrolling down to the red highlighted boxes. All boxes that are highlighted in red must be filled out by the agent first prior to sending to the beneficiary. Grey boxes are optional.

You will find instructions in the upper left hand corner of the screen. If you are unsure of which field to fill in next simply click the yellow next button on the left side of the screen.

Walk-Through Guide



CCP Application (Continued)

You **MUST** complete the application in full, including all **red** boxes and applicable grey boxes for the application to be sent to the beneficiary for review and signature.

In the Licensed Representative section of the application you will fill out all sections except for your signature and date. Once the beneficiary reviews and signs the application it will be automatically sent back to you for final review and signature of the application.

Once you have filled out all of the **red** boxes and signed the document you should see a message at the top left of your screen that says “Done! Select Finish to send the completed document”.

Done! Select Finish to send the completed document. **FINISH** FINISH LATER OTHER ACTIONS

DocuSign Envelope ID: 08CF9879-69C8-4AE8-B25E-09F7845F03B5

Licensed Representative/Office Use Only:

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

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

Licensed Representative Initials: TA Licensed Representative ID: 999999

Scope of Appointment Verification #: _____

Licensed Representative Phone #: 9999999999

Special Needs Plans Verification (if applicable): _____

Plan ID #: 9999001 Effective Date of Coverage: 05012020
M M D D Y Y Y Y

☐ RCP/IEP ☐ AEP ☐ OEP ☒ SEP (type) FEMA ☐ Not Eligible ☐ Cancel Application

Prior to clicking finish you have the option to fill out the New Member Checklist. This is not required but strongly encouraged, as it will provide extra protection if there is a complaint or CTM. If you choose to utilize the checklist you will need to fill out each question/section on the form prior to sending to the beneficiary.

Done! Select Finish to send the completed document. **FINISH** FINISH LATER OTHER ACTIONS

Sales Agent Copy

Enrollment Receipt and New Member Checklist

Agent Instructions: Please review the New Member Checklist carefully with each new member enrolling in our plan.

Member Name: Test Agent Date: 04052020

Plan Information Here are some details about your new plan

The name of my new plan is: WellCare Essential HMO

My Plan type is a (circle): ☐ HMO ☒ HMO-POS ☐ PFFS ☐ HMO D-SNP ☐ PPC ☐ PPO D-SNP

My plan will provide: all my Medicare health coverage ☒ all my Medicare prescription drug coverage ☒

My plan coverage is expected to begin on (effective date): 05012020

I must live in the plan's service area, which is: Test

If I move out of the plan's service area for more than 6 months in a row, I will need to choose a new plan.

Circle the correct answer:
I should / should not have a Medicare Advantage plan and a stand-alone Medicare Part D plan at the same time. (There is one exception: Medicare Advantage Private Fee-for-Service plans that do not include prescription drug coverage.)

\$ My monthly premium will be \$ 0.00

Checklist

YES | NO

☒ 1. If my plan has a monthly plan premium, I understand that I am responsible for this premium, in addition to my Part B monthly premium.

☒ 2. I understand that I may be responsible for certain co-pays or coinsurance for covered medical services.

☒ 3. My agent left me a copy of the 2020 Resource Guide, which includes a 2020 Summary of Benefits.

Walk-Through Guide



CCP Application (Continued)

After you complete the New Member Checklist, click the **yellow** sign button to electronically sign.

Note: During this process you are **ONLY** signing the New Member Checklist, you will still need to review and sign the application once the member completes their review and signature.

Done! Select Finish to send the completed document.

FINISH FINISH LATER OTHER ACTIONS

6. My agent explained the Coverage Gap, sometimes referred to as the "donut hole."

7. I have reviewed my currently prescribed drugs with my agent and have confirmed that they are in the plan's list of covered drugs, also called a "formulary," which is available to view at www.wellcare.com/medicare. I also understand that some of my drugs may not be covered under the plan's formulary.

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New Member Checklist 16-17 (2020).pdf 1 of 2

DocuSign Envelope ID: 06CF9B79-69C8-4AEB-825E-09F7945F0385

Agent Name:
Test Agent

Agent Phone Number:
9999999999

Agent ID:
999999

Agent Signature: _____

Member Signature: _____



Next, you will need to adopt a signature. You can either use a computer generated signature by selecting "select style" or you can use your finger or cursor to draw a signature by selecting "draw". Once your signature is complete click the **yellow** "adopt and sign" button.

Adopt Your Signature

Confirm your name, initials, and signature.

* Required

Full Name*
Test Agent

Initials*
TA

SELECT STYLE DRAW

PREVIEW

DocuSigned by:
Test Agent
8DF5CA071D1A4E0...

DS
td

By selecting Adopt and Sign, I agree that the signature and initials will be the electronic representation of my signature and initials for all purposes when I (or my agent) use them on documents, including legally binding contracts - just the same as a pen-and-paper signature or initial.

ADOPT AND SIGN CANCEL

Adopt Your Signature

Confirm your name, initials, and signature.

* Required

Full Name*
Test Agent

Initials*
TA

SELECT STYLE **DRAW**

DRAW YOUR SIGNATURE

Test Agent

By selecting Adopt and Sign, I agree that the signature and initials will be the electronic representation of my signature and initials for all purposes when I (or my agent) use them on documents, including legally binding contracts - just the same as a pen-and-paper signature or initial.

ADOPT AND SIGN CANCEL

Walk-Through Guide



CCP Application (Continued)

Once you have signed the New Member Checklist click the **yellow** finish button at the top or bottom of your screen.

If you did not fill out all of the required fields you will not be able to send the application to the beneficiary. If you click finish and do not see the confirmation message, read the instructions at the top left of the screen for next steps.

Once you click “finish” you should receive a pop up that confirms that your document has been signed. At this time you **MUST** download the application and save it securely. The beneficiary should receive an email shortly with a link for the application that you created.

Walk-Through Guide



CCP Application (Continued)

The beneficiary will receive an email with the following instructions and link. Instruct the member to click the **yellow** “review document” link within the email.

WellCare
Beyond Healthcare. A Better You.

Enroll with WellCare sent you a document to review and sign.

REVIEW DOCUMENTS

Enroll with WellCare
agent services@mhplan.com

Test Member,

Please DocuSign 2020 CCP Enrollment Application.pdf, New Member Checklist 16-17 (002).pdf

Thank You, Enroll with WellCare

Powered by **DocuSign**

Next, they will need to enter in the access code “wc2020” to access the application. This step will ensure that their information is protected if the email that was entered is wrong or if their email has been compromised. They will not receive a secondary email with the password, you will need to give them the password over the phone. The password is case sensitive.

Please enter the access code to view the document

Enroll with WellCare
Comprehensive Health Management, Inc

The sender has requested you enter a secret access code prior to reviewing the document. You should have received an access code in a separate communication. Please enter the code and validate it in order to proceed to viewing the document.

Access Code

VALIDATE

I NEVER RECEIVED AN ACCESS CODE

Walk-Through Guide



CCP Application (Continued)

Once the beneficiary has entered in the access code and clicked “validate” they should be able to access the application. Explain to the beneficiary that in order to complete the application electronically they will need to agree to use an electronic signature. They will need to also click continue once they agree to the electronic signature disclosure.

Once the beneficiary has accepted electronic signature you should begin by reviewing the application in full with the beneficiary to ensure that they agree to and understand all of the selections and information. Once the beneficiary agrees to enroll, instruct them to scroll to the signature section of the application or click the **yellow** next button on the left side of the screen to sign the document.



Walk-Through Guide

CCP Application (Continued)

Next, they need to adopt a signature. They can either use a computer generated signature by selecting “select style” or use their finger or cursor to draw a signature by selecting “draw”. Once they are satisfied with their signature, click the **yellow** “adopt and sign” button.

Adopt Your Initials

Confirm your name, initials, and signature.

* Required

Full Name* Test Member Initials* TM

SELECT STYLE DRAW

DocuSigned by: Test Member TM

ADOPT AND INITIAL CANCEL

Once the signature is accepted they will see it appear in the signature section. At this time they should see a message at the top left of the screen that says “Done! Select Finish to send the completed document.”

IMPORTANT: If you filled out the New Member Checklist you will need to instruct the member to scroll down so you can review the checklist with them. They will need click the **yellow** sign button on the checklist once complete.

Done! Select Finish to send the completed document.

Done! Select Finish to send the completed document.

FINISH OTHER ACTIONS

Walk-Through Guide



CCP Application (Continued)

Once the beneficiary is satisfied with the application, instruct them to click the **yellow** finish button at the top or bottom of their screen.

Done! Select Finish to send the completed document.

FINISH OTHER ACTIONS ▾

part decided about payment of services if I disagree, I will keep the evidence of coverage document from WellCare. **OHANA/WellCare TexanPlus** 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. **For Non-PPO Plans:** I understand that beginning on the date WellCare/Ohana/WellCare TexanPlus coverage begins, I must get all of my health care from WellCare/Ohana/WellCare TexanPlus, except for emergency or urgently needed services or out-of-area dialysis services. **For PPO Plans Only:** I understand that beginning on the date WellCare coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, WellCare provides refunds for all covered benefits, even if I get services out of network. **ALL PLANS:** Services authorized by WellCare/Ohana/WellCare TexanPlus and other services contained in my WellCare/Ohana/WellCare TexanPlus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR WELL CARE/OHANA/WellCare TEXANPLUS 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/Ohana/WellCare TexanPlus, he/she may be paid based on my enrollment in WellCare/Ohana/WellCare TexanPlus. **Release of Information:** By joining this Medicare health plan, I acknowledge that WellCare/Ohana/WellCare TexanPlus will release my information to Medicare, other plans and providers as is necessary for treatment, payment and health care operations. I also acknowledge that WellCare/Ohana/WellCare TexanPlus 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.

Signature: Ted Rumber Today's Date: 4/9/2020

M M D D Y Y Y Y

Attestation of Eligibility for an Enrollment Period

If the beneficiary did not sign the document they will not be able to submit the application. If they click finish and do not see the confirmation message, read the instructions at the top left of the screen for next steps.

Once they click “finish” they should receive a pop up that confirms that the document has been signed. At this time they also have the opportunity to download the application.

Save a Copy of Your Document

↓

Your document has been signed

If you would like a copy for your records, select Download or Print and save.

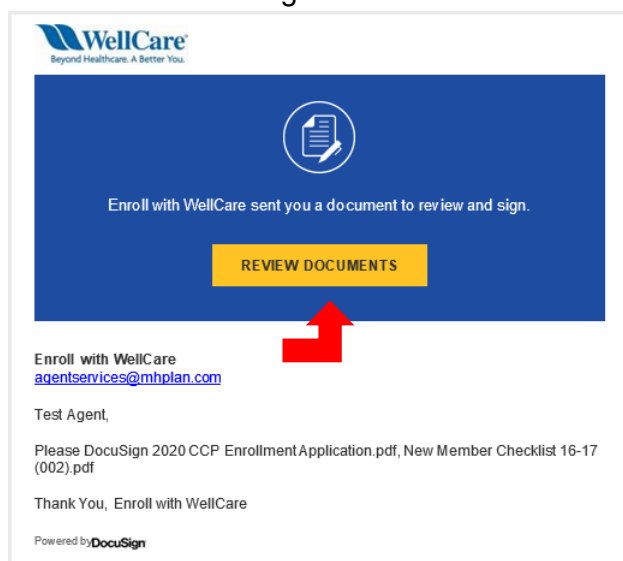
DOWNLOAD **PRINT** **CLOSE**

Walk-Through Guide



CCP Application (Continued)

After the beneficiary signs the application you will receive an email with the application ready for your final signature.



You can begin signing by clicking the start button on the left of the screen or by scrolling down to the signature box in the application.

Please review the documents below. **FINISH** **OTHER ACTIONS**

DocuSign Envelope ID: 06CF9879-49C8-4AE8-B25E-09F7845F0385

START

2020
WellCare/Ohana/WellCare TexanPlus
Medicare Advantage Plans
Individual Enrollment Form

How to Enroll with Our Plans

- 1 | Please read this entire enrollment form to make sure you understand the information.
An incorrect or incomplete application may cause a delay or denial of coverage.
- 2 | When you're ready, fill out the entire enrollment form. Where appropriate, write clearly in all capital letters or place an "X" in the appropriate box.

Select the sign field to create and add your signature. **FINISH** **OTHER ACTIONS**

19 ☐ Other

If none of these statements applies to you or you're not sure, please contact WellCare/Ohana/WellCare TexanPlus at 1-866-527-0056 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.

Y0070_WCM_3564E_FINAL01_C CMS Approved 07092019
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PAGE 6 OF 7

Licensed Representative: 999999

NAOWCMAPP36286E_0000

2020 CCP Enrollment Application.pdf 8 of 9

DocuSign Envelope ID: 06CF9879-49C8-4AE8-B25E-09F7845F0385

Licensed Representative/Office Use Only:

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

Test Agent Required - Sign Here

Licensed Representative Signature:

Date Application Received: 8/9/2020

SIGN

Walk-Through Guide



CCP Application (Continued)

Once you have fully reviewed and signed the document click the **yellow** “finish” button at the top right or bottom of the screen.

Done! Select Finish to send the completed document.

FINISH OTHER ACTIONS ▾

19. ☐ Other _____

If none of these statements applies to you or you're not sure, please contact WellCare/Ohana/WellCare TexanPlus at 1-866-527-0056 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.

Y0070_WCM_356ME_FINAL01_C CMS Approved 07/09/2019
©WellCare 2019

Licensed Representative: 999999

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2020 CCP Enrollment Application.pdf 8 of 9

DocuSign Envelope ID: 06CF9879-69C8-4AE8-B25E-09F7845F03B5

Licensed Representative/Office Use Only:

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

Required - Signature Applied

Licensed Representative Signature: Test Agent Date Application Received: 4/9/2020
M M D Y Y Y

Licensed Representative Initials: TA Licensed Representative ID: 999999

Scope of Appointment Verification #: _____

Licensed Representative Phone #: 9999999999


Special Needs Plans Verification (if applicable): _____

Plan ID #: H 9999001 Effective Date of Coverage: 05/01/2020
M M D Y Y Y

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

Once you click “finish” you should receive a pop up that confirms that the document has been signed. At this you **MUST** download all PDFs for a copy of the application in the even t you do not receive a final confirma-

Save a Copy of Your Document



Your document has been signed

If you would like a copy for your records, select Download or Print and save.

DOWNLOAD **PRINT** **CLOSE**


Walk-Through Guide





CCP Application (Continued)


Now that both you and the beneficiary have signed the application you will both receive a fully executed copy via email. In addition, WellCare's enrollment department will receive a fully executed copy and will begin processing the enrollment. The email will contain a PDF of the signed application, a summary document with date/time stamps of each signature and a URL link to view the document via the web.


You should keep all confirmation emails and PDFs in a secure location and password protected per WellCare's retention policy.

 2020 CCP Enrollment Application.pdf
794 KB

 New Member Checklist 16-17 (002).pdf
278 KB

 Summary.pdf
280 KB


Beyond Healthcare. A Better You.



Your document has been completed

[VIEW COMPLETED DOCUMENTS](#)

Enroll with WellCare
agentservices@mhplan.com

All parties have completed Please DocuSign: 2020 CCP Enrollment Application.pdf.

Powered by **DocuSign**

IMPORTANT: The email account that DocuSign emails are sent from is NOT MANAGED. DO NOT email this inbox directly. For any issues or questions concerning DocuSign, please escalate through your leadership.

Walk-Through Guide



C-SNP CCP Application

The CSNP Prequalification assessment tool is the first 2 pages prior to the CCP application. You will need to follow all steps for the CCP application, as listed above, in the CSNP application.

This site uses cookies, some of which are required for the operation of the site. [Learn More](#) OK

Please review the documents below. FINISH FINISH LATER OTHER ACTIONS

START

DocuSign Envelope ID: 495CE851-70CC-4449-8F13-1B4082E71A8A

Pre-enrollment Qualification Assessment Tool

A Special Needs Plan (C-SNP) is a type of Medicare Advantage Plan. WellCare offers Special Needs Plans that coordinate health care benefits for people with chronic or disabling conditions. You may be eligible to join if you can answer YES to any of the questions below. Please fill out this form and return it to us with your enrollment application. Our Plan will need to verify your chronic condition with your doctor within 30 days of enrollment. We must disenroll you from the special needs plan if we are unable to verify your condition. That means it is very important to let your doctor know that we will need this verification. It is also very important to give us accurate contact information for your doctor on the second page of this form.

Enrollee Information

Last name: Mr.

First name: Date of birth:

Medicare ID number (HICN):

Phone number:

Chronic Heart Failure/Cardiovascular Disorder/Diabetes

Duplicate fields will auto populate throughout the application so please verify the information/spelling you have entered is accurate.

*Note: You will need to remind the beneficiary this form must also be signed in addition to the application and/or new member checklist if you wish to complete this. You may complete the Pre-Enrollment Assessment at that same time of the application prior to sending to the beneficiary.

This site uses cookies, some of which are required for the operation of the site. [Learn More](#) OK

Enter number FINISH FINISH LATER OTHER ACTIONS

DocuSign Envelope ID: 495CE851-70CC-4449-8F13-1B4082E71A8A

NEXT

Enrollee Information

Last name: Mr.

First name: Date of birth:

Medicare ID number (HICN):

Phone number:

Authorization For Disclosure of Health Information to Verify Chronic Condition(s):

I authorize the providers listed below to share my health information with WellCare to verify that I have a chronic condition that qualifies me for enrollment in WellCare's chronic special needs plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated on the first page.

Note: WellCare will protect information disclosed as a result of this authorization in accordance with any state and federal laws and requirements that apply.

Call us if you have questions or need help with this form. You can reach us at 1-888-888-9355 (TTY 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., or visit us anytime at www.wellcare.com/medicare.

Enrollee Signature: _____ Date:

Please give us contact information for your provider in the next section. We will contact your provider to complete this form.

Doctors or Other Health Care Provider(s) Who Can Verify Your Chronic Condition(s)

Provider #1	Provider #2
Provider name: <input type="text"/>	Provider name: <input type="text"/>
Provider address: <input type="text"/>	Provider address: <input type="text"/>

The access code the beneficiary will need to enter is the same for ALL application "wc2020" to access their documents. You will need to provide this over the phone.

Please enter the access code to view the document

Enroll with WellCare
Comprehensive Health Management, Inc.

The sender has requested you enter a secret access code prior to reviewing the document. You should have received an access code in a separate communication. Please enter the code and validate it in order to proceed to viewing the document.

Access Code VALIDATE I NEVER RECEIVED AN ACCESS CODE

Walk-Through Guide



PDP Application

You will follow all of the same steps as listed above in the CCP application (pages 2-13) for the PDP Application, but utilizing the PDP Application.

The new member checklist is not included in the PDP Application as it does not apply and is not required.

DocuSign Envelope ID: 99756A36-818A-4187-8930-5D66ED8B8641

2020 WellCare Medicare Prescription Drug Plan Individual Enrollment Form

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

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) ☐ Value Script (PDP) \$ per month

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

Last Name: Middle Initial:

First Name: Primary Phone Number:

You will need to remind the beneficiary to sign and complete the authorized representative information on

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 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: Today's Date:
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 ☐ No

Name:

Address:

City: State: ZIP:

Phone Number: Relationship to Enrollee:

The access code the beneficiary will need to enter is the same for ALL application “wc2020” to access their documents. You will need to provide this over the

Please enter the access code to view the document

Enroll with WellCare
Comprehensive Health Management, Inc.

The sender has requested you enter a secret access code prior to reviewing the document. You should have received an access code in a separate communication. Please enter the code and validate it in order to proceed to viewing the document.

Access Code

Walk-Through Guide



PFFS Application

You will follow all of the same steps as listed above in the CCP application (pages 2-13) for the PFFS Application, but utilizing the PFFS Application.

The new member checklist is not included in the PDP Application as it does not apply and is not required.

2020 WellCare PFFS Individual Enrollment Form

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

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

Select the box for the plan you want to enroll in: ☐ WellCare Today's Options Premier Plus 650B (MAPD)

☐ WellCare Today's Options Premier Plus 250A (MAPD) ☐ WellCare Today's Options Premier 300 (MA only)

☐ WellCare Today's Options Premier 200 (MA only) \$. 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

You will need to remind the beneficiary to sign on page 5.

DocuSign Envelope ID: 11586E7C-4141-4871-B3D8-83509050B172

Please Read and Sign (continued):

WellCare PFFS serves a specific service area. If I move out of the area that WellCare PFFS serves, I need to notify WellCare PFFS so I can disenroll and find a new plan in my new area. Once I am a member of WellCare PFFS, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from WellCare PFFS when I get it to know which rules I must follow to get coverage with this Private Fee-for-Service 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. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with WellCare PFFS he or she may be paid based on my enrollment in WellCare PFFS. **Release of Information:** By joining this Medicare health plan, I acknowledge that WellCare will release my information to Medicare, other plans and providers 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 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:



The access code the beneficiary will need to enter is the same for ALL application "wc2020" to access their documents. You will need to provide this over the phone.

Please enter the access code to view the document



Enroll with WellCare
Comprehensive Health Management, Inc.

The sender has requested you enter a secret access code prior to reviewing the document. You should have received an access code in a separate communication. Please enter the code and validate it in order to proceed to viewing the document.

Access Code

VALIDATE

I NEVER RECEIVED AN ACCESS CODE

