Allwell from Coordinated Care Corporation

2018 Individual Enrollment Form

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

To enroll in Allwell, please provide the following information:

Please check which plan you want to enroll in.

Allwell Medicare (HMO) (H3499-001)

☐ Hamilton, Howard and Marion counties $0 per month

Allwell Medicare (HMO) (H3499-002)

☐ Allen, Elkhart and St. Joseph counties $0 per month

Allwell Medicare (HMO) (H3499-003)

☐ Vanderburgh County $0 per month

Allwell Medicare (PPO) (H6348-001)

☐ Hamilton, Howard and Marion counties $0 per month

Allwell Medicare (PPO) (H6348-002)

☐ Allen, Elkhart and St. Joseph counties $0 per month

Allwell Medicare (PPO) (H6348-003)

☐ Vanderburgh County $0 per month

To enroll in Allwell, please provide the following information:

Last name

First name

Middle initial

☐ Mr.
☐ Mrs.
☐ Ms.

Birth date

M M D D Y Y Y Y

Sex
☐ M ☐ F

Home phone number

Alternate phone number

Permanent residence street address
(PO Box is not allowed)

City

County

State

ZIP code

Mailing address (only if different from your permanent residence address)
Street address

City

State

ZIP code

Emergency contact

Phone number

Relationship to you

Email address

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

HOSPITAL (Part A)

M M D D Y Y Y Y

MEDICAL (Part B)

M M D D Y Y Y Y

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

Paying your plan premium

For Medicare Advantage Prescription Drug plans with no premiums: 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 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 Allwell the Part D-IRMAA.

For all plans with premiums: You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) 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 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 RRB. DO NOT pay Allwell 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 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 doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from: ☐ Social Security ☐ RRB

(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, we will send you a paper bill for your monthly premiums.)

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 don't need regular dialysis any more, **please attach a note or records** from your doctor showing you had a successful kidney transplant or you don't need dialysis; otherwise, we may need to contact you to obtain additional information.

2. 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 Allwell?

   ☐ 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 in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "Yes," please provide the following information:

   Name of institution

   Phone number of institution ( ) – –

   Address of institution (number and street)

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 choose the name of a Primary Care Provider (PCP), clinic or health center:

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:

☐ Audio ☐ Large print

Please contact Allwell at 1-877-891-6093 if you need information in another format or language than what is listed above. From October 1 to February 14, you can call us 7 days a week from 8 a.m. to 8 p.m. From February 15 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays. TTY users should call 711.

Please read this important information

If you currently have health coverage from an employer or union, joining Allwell could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Allwell. 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 below

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

Allwell is a Medicare Advantage plan and has a contract with the Federal government. 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. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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.

Allwell serves a specific service area. If I move out of the area that Allwell 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 Allwell, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Allwell 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 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 Allwell coverage begins, I must get all of my health care from Allwell, except for emergency or urgently needed services or out-of-area dialysis services. I understand that beginning on the date Allwell 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, Allwell provides refunds for all covered benefits, even if I get services out of network. Services authorized by Allwell and other services contained in my Allwell *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR ALLWELL 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 Allwell, he/she may be paid based on my enrollment in Allwell.

Release of information: By joining this Medicare health plan, I acknowledge that Allwell will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Allwell 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

M M D D Y Y Y Y

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

Name

Address

Phone number

– –

Relationship to enrollee

OFFICE USE ONLY:

Name of staff member/agent/broker (if assisted in enrollment):

Plan ID #:

Effective date of coverage: M M D D Y Y Y Y

☐ ICEP/IEP ☐ AEP SEP (type): ☐ Not eligible

Allwell sales representative/Authorized agent
(individual sales representative/agent who completed the application)

Agent type (select one): ☐ Authorized agent ☐ Centene or Allwell employee

Complete section or place printed label here:

Sales rep/Agent name:

Sales rep/Agent NPN #:

Agency/FMO affiliation:
(if applicable)

This information must match your approved Allwell licensing records.

Agent phone #: – –

Email:

Agency/FMO phone # (if applicable): – –

Sales representative/authorized agent application receipt date: M M D D Y Y Y Y
(Applications must be received at Allwell within 1 calendar day of this date.)

Application receipt location: ☐ Appointment ☐ Sales event ☐ Walk-in

☐ Other (specify):

Provider information for HMO plans:

PCP name: PCP ID:

PPG name: PPG ID:

Is PCP/PPG selected accepted for the plan chosen? ☐ Yes ☐ No

Current patient? ☐ Yes ☐ No

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 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 and this plan is a new option for me. I moved on (insert date). M M D D Y Y Y Y
- ☐ I recently was released from incarceration. I was released on (insert date). M M D D Y Y Y Y
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date). M M D D Y Y Y Y
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date). M M D D Y Y Y Y
- ☐ 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 (insert date). M M D D Y Y Y Y
- ☐ 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 (insert date). M M D D Y Y Y Y
- ☐ I recently left a PACE program on (insert date). M M D D Y Y Y Y
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date). M M D D Y Y Y Y
- ☐ I am leaving employer or union coverage on (insert date). M M D D Y Y Y Y
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ 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 (insert date). M M D D Y Y Y Y

If none of these statements applies to you or you're not sure, please contact Allwell at 1-877-891-6093 (TTY users should call 711) to see if you are eligible to enroll. From October 1 to February 14, you can call us 7 days a week from 8 a.m. to 8 p.m. From February 15 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

You must continue to pay your Medicare Part B premium.
Allwell is an HMO and PPO plan with a Medicare contract. Enrollment in Allwell depends on contract renewal.

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