

EASY CHOICE MEDICARE ADVANTAGE PLANS INDIVIDUAL ENROLLMENT FORM

How to Enroll with Easy Choice

- \bigcirc 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 place an "X" in the appropriate box.
- (3) Once you're done, don't forget to sign and date it.
- Return the completed/signed form to Easy Choice using the attached postage-paid business reply envelope.

5	Contact you	r Sales Agent with any questions you may have.	
	Sales Agent:	Phone: ()	

3 Other Easy Ways to Enroll with Easy Choice

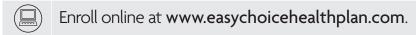
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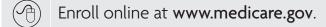
Call Easy Choice Customer Service at 1-866-999-3945.

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.







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 1-800-735-2929 번에 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.

2017 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, Ple	ase Provide the Following Information:									
	Please select the box for the plan you want to enroll 001: Easy Choice Freedom Plan (HMO SNP) - Los Angeles 002: Easy Choice Plus Plan (HMO) - Orange, Riverside, Sa 005: Easy Choice Best Plan (HMO) - Los Angeles, Orange 016: Easy Choice Best Plan (HMO) - Riverside, San Bernardino 017: Easy Choice Plus Plan (HMO) - Los Angeles	an Bernardino									
		\$ per month									
	Mr. Mrs. Ms. Sex: M F	Birth Date:									
	Last Name:	M M D D Y Y Y									
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Yellow: Member Copy)	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.										
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	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: HOSPITAL (Part A) MEDICAL (Part B)									

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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 (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 the RRB. DO NOT pay Easy Choice the Part D-IRMAA.

Paying Your Plan Premium

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 (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 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.

Place coloct a promium payment	ontion	
Please select a premium payment	орион:	
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The Social Security/RRB deduction madeduction. In most cases, if Social Security or RRB benefic to the point withholding begins. If Social Security or RRB beneficial Security or RRB b	ay take two or more curity or RRB accept efit check will incluc cial Security or RRB	or Railroad Retirement Board (RRB) benefit check (if eligible). e months to begin after Social Security or RRB approves the is your request for automatic deduction, the first deduction de all premiums due from your enrollment effective date up does not approve your request for automatic deduction, or cive date, we will send you a bill for your monthly premiums.
	Consent to Co	ontact by Phone
using an automated phone dialing system coverage. These calls may be pre-record understand that giving my consent to go	m that provides rele led. I may opt out a et calls or texts is no	n-telemarketing calls or text messages from the health plan evant, timely information regarding your health care and it any time by calling the number on the back of my ID card. I but a condition to get the plan's products or services.
using an automated phone dialing system our services, including marketing inform go to the numbers provided on this approach. I understand that giving my consent	em or an artificial pr nation and tips to he plication. I may opt nt to get calls or tex	calls or text messages from the health plan on my cell phone e-recorded voice. These calls will provide information about elp you make health care decisions. These calls or texts will out at any time by calling the number on the back of my ID its is not a condition to get the plan's products or services.
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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, other plans and providers 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.

Signature:	Today's Date:
If you are the authorized representative, you must sign above	$\begin{array}{cccccccccccccccccccccccccccccccccccc$
Would you like all mail to be sent to the authorized representa	ative? Yes No
Name:	
Address:	
City:	State: ZIP:
Phone Number: Relationship to	o Enrollee:

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	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 was released from incarceration. I was released on .									
	I recently returned to the United States after living permanently outside of the U.S.									
	I returned to the U.S. on .									
Yellow: Member Copy)	I recently obtained lawful presence status in the United States. I got this status on									
embe	I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.									
w: M	I get Extra Help paying for Medicare prescription drug coverage.									
Yello	I no longer qualify for Extra Help paying for my Medicare prescription drugs.									
б	I stopped receiving Extra Help on .									
Office Copy	I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home).									
: Offfic	I moved/will move into/out of the facility on .									
(White:	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.									
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Emergency Contact Information:																						
Emergency Contact: (optional)																						
Phone Number: (optional)											Re (or	latio otio	onsh nal)	ip to	o Yo	ou:						

Sales Agent/Of	fice Use Only:
Name of Staff Member/Agent/Broker (if assisted in enrollme	ent):
Agent Signature:	Date Application Received:
Agent Initials: Agent ID:	MMDDYYYY
Agent Phone #.	
Plan ID #: H Effective Date of C	Coverage: M M D D Y Y Y Y
ICEP/IEP AEP SEP (type):	Not Eligible Cancel Application

73561



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

FIRST-CLASS MAIL BUSINESS REPLY MAIL TAMPA, FL

POSTAGE WILL BE PAID BY ADDRESSEE

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



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 ...

- Điển đơn
- Dùng phong bì đính kèm và gửi trở lại lá đơn quý vị đã điển

Recuerde ...

- Complete su solicitud
- Envíe su solicitud diligenciada en este sobre con porte postal pago