Disenrollment Form

Each member requesting to be disenrolled must complete their own form.

If you request disenrollment, you must continue to get all medical care from Wellcare until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of Wellcare's network. We will notify you of your effective date after we get this form from you.

If you have any questions, call Wellcare at the appropriate number below. We are available from October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 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.

YOU MAY TYPE TO COMPLETE THIS FORM. YOU MAY ALSO PRINT IT AND FILL IT OUT, IN WHICH CASE PLEASE PRINT YOUR RESPONSES USING BLACK OR BLUE INK. FILL CHECK BOXES IN WITH AN "X".

Last Name _____ First Name _____ MI__ ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.

Wellcare Subscriber ID Number _____

Medicare Number _____

Date of Birth (MM/DD/YYYY) _____ Sex ☐ M ☐ F

Home Phone Number _____ Mobile Phone Number _____

Permanent Residence Street Address (P.O. Box is not allowed) _____

City _____ State _____ Zip Code _____

Mailing Address if different from permanent residence (P.O. Box is allowed) _____

City _____ State _____ Zip Code _____

Email Address _____

Please carefully read and complete the following information before signing and dating this disenrollment form:

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand that Medicare will cancel my current membership with Wellcare on the effective date of the new enrollment. I understand that I may not be able to enroll in another plan at this time. I also understand that if I am disenrolling from my Medicare prescription drug coverage and want Medicare prescription drug coverage in the future, I may have to pay a higher premium, due to a late enrollment penalty, for this coverage.

continued on next page

©Wellcare 2022

I understand that my signature (or the signature of the person I have authorized to make decisions on my behalf) on this form means I have read and understand the contents of this form. If signed by an authorized representative, this signature certifies that: this person is authorized under State law to complete this disenrollment, and documentation of this authority is available upon request.

Signature*: _____ Today's Date: _____

*Or the signature of the person authorized to act on your behalf under the laws of the State where you live. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this disenrollment and 2) documentation of this authority is available upon request by Wellcare or by Medicare.

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

Name: _____ Phone Number: _____

Address: _____Relationship to the Enrollee: _____

Typically, you may disenroll from a Medicare Advantage Plan only during the annual enrollment period which takes place from October 15 through December 7 of each year, or during the Medicare Advantage Open Enrollment Period from January 1 through March 31 of each year.

There are exceptions which may allow you to disenroll outside of this period. If you have questions about the times you may disenroll, please call Member Services for assistance.

☑ PLEASE SELECT THE DISENROLLMENT REASON THAT APPLIES TO YOU

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 Election Period.

☐ I recently had a change in my Medicaid (newly qualified for, had a change in level of assistance, or lost eligibility for Medicaid) on _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly qualified for, had a change in level of assistance, or lost eligibility for Extra Help) on _____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for Medicare prescription drug coverage, but I haven't had a change.

☐ 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 am joining a PACE program on _____.

☐ I am joining employer group or union coverage on _____. I am requesting a disenrollment date of _____ with the understanding that this is subject to CMS approval.

☐ I was enrolled in a plan by Medicare (or my state) and I want to select a different plan. My enrollment in that plan started or will start on _____.

©Wellcare 2022

If none of these statements applies to you or you're not sure, please contact Wellcare at the phone number at the bottom of this form to see if you are eligible to disenroll. We are open from October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 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 SELECT THE REASON WHY YOU ARE LEAVING.

- ☐ PCP not in network
- ☐ Specialist not in network
- ☐ Copays are too high
- ☐ Can't get access to a service
- ☐ Premium is too high
- ☐ Was not aware I was enrolling in this plan

Other _____

You may return your completed form to:

Wellcare
ATTN: Enrollment Department
P.O. Box 31370
Tampa, FL 33631-3370

Fax: **1-866-388-1521**

©Wellcare 2022

Multi-Language Insert

Multi-Language Interpreter Services

Spanish: Contamos con servicios de interpretación gratuitos para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o de medicamentos. Para obtener un intérprete, simplemente llámenos a los números del plan que figuran en las siguientes páginas. Alguien que hable español puede ayudarle. Este es un servicio gratuito.

Chinese Mandarin: 我们有免费的口译服务来回答您就我们的健康或药物计划提出的任何问题。如需口译员，只需拨打以下页面上的计划号码致电联系我们。会说中文普通话的人员可以协助您。此为免费服务。

Chinese Cantonese: 我們有免費的口譯服務來回答您就我們的健康或藥物計劃提出的任何問題。如需口譯員，只需撥打以下頁面上的計劃號碼致電聯絡我們。會說粵語的人員可以協助您。此為免費服務。

Tagalog: Meron kaming libreng serbisyo ng interpreter para sagutin anumang tanong na meron ka tungkol sa aming plano ng kalusugan o gamot. Para makakuha ng interpreter, tawagan lang kami sa mga numero ng plano na nasa sumusunod na mga pahina. Matutulungan ka ng sinumang nagsasalita ng Tagalog. Libreng serbisyo ito.

French: Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous pourriez vous poser au sujet de notre régime de soins médicaux ou de notre régime d'assurance-médicaments. Pour bénéficier des services d'un interprète, il suffit de nous appeler aux numéros de régime indiqués dans les pages suivantes. Quelqu'un qui parle français peut vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi cung cấp dịch vụ phiên dịch viên miễn phí để trả lời bất kỳ câu hỏi nào quý vị có về chương trình y tế hoặc thuốc của chúng tôi. Để nhận được dịch vụ phiên dịch, chỉ cần gọi cho chúng tôi theo số điện thoại của chương trình trong các trang sau. Người nào đó nói tiếng Việt có thể giúp quý vị. Đây là dịch vụ miễn phí.

German: Wir bieten Ihnen einen kostenlosen Dolmetscherdienst, um alle Ihre Fragen zu unserem Gesundheits- oder Medikamentenplan zu beantworten. Um einen Dolmetscher zu finden, rufen Sie uns einfach unter den auf den folgenden Seiten angegebenen Plan-Nummern an. Jemand, der Deutsch spricht, kann Ihnen helfen. Dieser Service ist für Sie kostenlos.

Korean: 저희의 건강 또는 약품 플랜에 대한 질문에 답해 드릴 수 있는 무료 통역 서비스를 제공합니다. 통역사에게 연결하려면 다음 페이지에 있는 플랜 번호로 전화하시기 바랍니다. 한국어를 하는 분이 도와드릴 수 있습니다. 이 통화는 무료 서비스입니다.

Russian: Мы предоставляем бесплатные услуги устного перевода, чтобы ответить на любые вопросы, которые могут возникнуть у вас о нашем плане медицинского страхования или страхового покрытия лекарственных препаратов. Чтобы получить устного переводчика, просто позвоните нам по номерам планов, указанным на следующих страницах. Вам поможет тот, кто говорит по-русски. Эта услуга предоставляется бесплатно.

Y0020_WCM_100189M_FINAL_01_C Internal Approved 07052022
©Wellcare 2022

Arabic: نوفر خدمات مترجم فوري للإجابة عن أي أسئلة قد تكون لديك حول خطتنا الصحية أو الدوائية. للاستعانة بمترجم، ما عليك سوى الاتصال بنا على أرقام الخطة في الصفحات التالية. شخص يتحدث العربية بمكنه مساعدتك. هذه الخدمة تقدم مجانًا.

Hindi: हमारे स्वास्थ्य या दवा योजना के बारे में आपके होने वाले किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं उपलब्ध हैं। दुभाषिया प्राप्त करने के लिए, हमें निम्नलिखित पृष्ठों पर दिए गए प्लान नंबरों पर कॉल करें। कोई हिंदी भाषी व्यक्ति आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

Italian: Disponiamo di servizi di interpretariato gratuiti per rispondere ad eventuali domande in merito al nostro piano sanitario o farmaceutico. Per ottenere un interprete, chiami i recapiti del piano disponibili nelle pagine successive. Qualcuno che parla italiano Le sarà d'aiuto. Si tratta di un servizio gratuito.

Portuguese: Temos serviços de intérprete gratuitos para responder quaisquer perguntas que você possa ter sobre nossos planos de saúde ou de medicamentos. Para solicitar um intérprete, ligue para nós através dos números do plano nas páginas a seguir. Um funcionário que fala português poderá ajudá-lo. Este serviço é gratuito.

French Creole: Nou gen sèvis entèprèt gratis pou reponn tout kesyon ou ka genyen konsènan plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, annik rele nou nan nimewo plan yo ki sou paj annapre yo. Yon moun ki pale Kreyòl Franse kapab ede ou. Se yon sèvis gratis li ye.

Polish: Oferujemy bezpłatne usługi tłumaczeniowe w przypadku pytań dotyczących naszego planu zdrowotnego i lekowego. Aby skorzystać z tłumacza, prosimy zadzwonić do nas pod numery podane na kolejnych stronach. Pomocą posłużą osoby mówiące po polsku. Usługa jest bezpłatna.

Japanese: 当社の医療プランまたは処方薬プランについての質問にお答えする無料の通訳サービスをご利用いただけます。通訳サービスをご利用になるには、以降のページにおけるプランの番号までお電話ください。日本語を話すスタッフが対応いたします。これは無料のサービスです。

Hawaiian: Aia iā mākou he mau lawelawe māhele ʻōlelo manuahi e pane i nā ʻano nīnau āu no ka mākou papahana mālama olakino a hoʻolako lāʻau. No ka ʻimi i mea māhele ʻōlelo, e kelepona wale mai iā mākou ma nā helu kelepona e waiho nei ma kēia mau ʻaoʻao e koe nei. Na kekahi māhele ʻōlelo Hawaiʻi e kōkua iā ʻoe. He lawelawe manuahi kēia.

Ilocano: Addaankami kadagiti libre a serbisio ti panagipatarus tapno masungbatan dagiti aniaman a saludsodmo maipapan iti salun-at wenno plano iti agas. Tapno makaala iti tagaipatarus, tawagannakami laeng kadagiti numero ti plano kadagiti sumaganad a panid. Matulongannaka ti maysa a tao nga agsasao iti Ilocano. Daytoy ket libre a serbisio.

Samoan: E iai a matou auaunaga faʼaliliu upu fua e tali ai soʻo se fesili e te ono iai e uiga i la matou fuafuaga faʼalesoifua maloloina poʻo vailaʻau. Mo le mauaina o se faʼaliliu upu, naʻo le valaʻau mai i numera o fuafuaga o loʻo i itulau nei. E mafai e se tasi e tautala i le gagana Samoa ona fesoasoani ia te oe. Ose auaunaga e leai se totogi.

We're Just a **Phone Call Away**

CALIFORNIA

HMO, HMO D-SNP

1-866-999-3945

HAWAII

HMO, PPO, HMO D-SNP

1-877-457-7621

ILLINOIS*

HMO, HMO-POS, HMO C-SNP, PPO

1-833-444-9088

GEORGIA, ILLINOIS**, INDIANA, MICHIGAN, OHIO AND SOUTH CAROLINA

HMO, HMO C-SNP, HMO D-SNP, HMO-POS, HMO-POS C-SNP, HMO-POS D-SNP, PPO, PPO D-SNP

1-866-892-8340

ALL OTHER STATES

HMO, HMO C-SNP, HMO-POS, HMO-POS C-SNP, PFFS, PPO

1-833-444-9088

HMO D-SNP, HMO-POS D-SNP, PPO D-SNP

1-833-444-9089

TTY FOR ALL OF THE ABOVE: 711

HOURS OF OPERATION

October 1 to March 31: Monday–Sunday, 8 a.m. to 8 p.m.

April 1 to September 30: Monday–Friday, 8 a.m. to 8 p.m.

Or visit **www.wellcare.com/medicare** or **www.wellcare.com/ohana**

**Wellcare Assist (HMO), Wellcare Assist Compass (HMO), Wellcare Giveback (HMO), Wellcare Giveback Dividend (HMO), Wellcare Giveback Open (PPO), Wellcare Low Premium (HMO-POS), Wellcare No Premium (HMO), Wellcare No Premium (HMO-POS), Wellcare No Premium Open (PPO), Wellcare No Premium Preferred (HMO), Wellcare No Premium Value (HMO), Wellcare Patriot Giveback (HMO-POS), Wellcare Patriot No Premium (HMO-POS)*

***Wellcare Assist (HMO), Wellcare No Premium Essential (HMO), Wellcare No Premium Exclusive (HMO)*