Allwell
2019 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:

Allwell Dual Medicare (HMO SNP)
☐ H2134-001:
   Bernalillo, Cibola, Sandoval, and Valencia $0* per month

1You must meet specific enrollment criteria to enroll in this plan.
*Actual premium based on Low Income Subsidy status.

White – Allwell       Yellow – Member

Y0020_19_7977FORM_M_FINAL_8988 Accepted 08192018
To enroll in Allwell, please provide the following information:

Last name
First name
Middle initial
Mr.
Mrs.
Ms.

Birth date
Sex
M M D D Y Y Y Y
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

Email address (optional)

Emergency contact
Phone number
Relationship to you

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)
MEDICAL (Part B)

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, Electronic Funds Transfer (EFT), or credit card 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, Electronic Funds Transfer (EFT), and/or credit card 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 Physician (PCP), clinic or health center:
   ______________________

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

□ Audio  □ Large print  □ Spanish

Please contact Allwell at 1-844-810-7965 (TTY: 711) if you need information in an accessible format or language other than what is listed above. Our office hours are 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.

Would you like to receive Allwell materials via email?  □ Yes  □ No
If yes, we will send an email to the address you provide, with a link to receive your benefit materials online.
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. 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. 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.

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

- **Signature**
- **Today’s date**
- **Name**
- **Address**
- **Phone number**
- **Relationship to enrollee**

White – Allwell   Yellow – Member

6 of 9
**OFFICE USE ONLY:**

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

Plan ID #:

**Effective date of coverage:**

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<td>Y</td>
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☐ ICEP/IEP  ☐ AEP  SEP (type):

☐ Not eligible

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**Allwell sales representative/Authorized agent**

(individual sales representative/agent who completed the application)

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

**Complete section or place printed label here:**

Sales rep/Agent name:  

Agent ID #:

Sales rep/Agent NPN #:  

NPN/Allwell ID #:

Agency/FMO affiliation:

(if applicable)

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This information must match your approved Allwell licensing records.

Agent phone #:  

Email:

Agency/FMO phone # (if applicable):

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**Sales representative/authorized agent application receipt date:**

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<td>Y</td>
<td>Y</td>
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</tbody>
</table>

(Applications must be received at Allwell within 1 calendar day of this date.)

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

☐ Other (specify):

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**Provider information for HMO plans:**

PCP name:  

PCP NPI:

PPG name:  

PPG ID:

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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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- 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).
- I recently was released from incarceration. I was released on (insert date).
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date).
- I recently obtained lawful presence status in the United States. I got this status on (insert date).
- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date).
- I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date).
- I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my 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 or long-term care facility). I moved/will move into/out of the facility on (insert date).
- I recently left a PACE program on (insert date).
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date).
- I am leaving employer or union coverage on (insert date).
- 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 plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date).

☐ 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).

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you’re not sure, please contact Allwell at 1-844-810-7965 (TTY users should call 711) to see if you are eligible to enroll. 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.

You must continue to pay your Medicare Part B premium. However, for full-dual beneficiaries, the State will cover your Part B premium as long as you retain your Medicaid eligibility.

Allwell is contracted with Medicare for HMO, HMO SNP and PPO plans, and with some state Medicaid programs. Enrollment in Allwell depends on contract renewal.

FRM020658EO00 (9/18)
Allwell complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Allwell does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Allwell:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Allwell’s Member Services telephone number listed for your state on the Member Services Telephone Numbers by State Chart. 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.

If you believe that Allwell has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number in the chart below and telling them you need help filing a grievance; Allwell’s Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TTY: 1-800-537-7697).


### Member Services Telephone Numbers by State Chart

<table>
<thead>
<tr>
<th>State</th>
<th>Telephone Number and Plan Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>1-800-977-7522/1-877-935-8020 (HMO and HMO SNP) (TTY: 711)</td>
</tr>
<tr>
<td>Arkansas</td>
<td>1-855-565-9518 (HMO) (TTY: 711)</td>
</tr>
<tr>
<td>Florida</td>
<td>1-844-293-2636 (HMO); 1-877-935-8022 (HMO SNP) (TTY: 711)</td>
</tr>
<tr>
<td>Georgia</td>
<td>1-844-890-2326 (HMO); 1-877-725-7748 (HMO SNP) (TTY: 711)</td>
</tr>
<tr>
<td>Illinois</td>
<td>1-855-766-1736 (HMO) (TTY: 711)</td>
</tr>
<tr>
<td>Indiana</td>
<td>1-855-766-1541 (HMO and PPO); 1-833-202-4704 (HMO SNP) (TTY: 711)</td>
</tr>
<tr>
<td>Kansas</td>
<td>1-855-565-9519 (HMO); 1-833-402-6707 (HMO SNP) (TTY: 711)</td>
</tr>
<tr>
<td>Louisiana</td>
<td>1-855-766-1572 (HMO) (TTY: 711)</td>
</tr>
<tr>
<td>Mississippi</td>
<td>1-844-786-7711 (HMO); 1-833-260-4124 (HMO SNP) (TTY: 711)</td>
</tr>
<tr>
<td>Missouri</td>
<td>1-855-766-1452 (HMO); 1-833-298-3361 (HMO SNP) (TTY: 711)</td>
</tr>
<tr>
<td>New Mexico</td>
<td>1-844-810-7965 (HMO SNP) (TTY: 711)</td>
</tr>
<tr>
<td>Ohio</td>
<td>1-855-766-1851 (HMO); 1-866-389-7690 (HMO SNP) (TTY: 711)</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>1-855-766-1456 (HMO); 1-866-330-9368 (HMO SNP) (TTY: 711)</td>
</tr>
<tr>
<td>South Carolina</td>
<td>1-855-766-1497 (HMO and HMO SNP) (TTY: 711)</td>
</tr>
<tr>
<td>Texas</td>
<td>1-844-796-6811 (HMO); 1-877-935-8023 (HMO SNP) (TTY: 711)</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>1-877-935-8024 (HMO SNP) (TTY: 711)</td>
</tr>
</tbody>
</table>
ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the Member Services number listed for your state in the Member Services Telephone Number Chart.

SPANISH: ATENCIÓN: Si habla español, hay servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al número del Departamento de Servicios al Afiliado que se enumera para su estado en la Ficha de Números de Teléfono del Departamento de Servicios al Afiliado.

VIETNAMESE: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin vui lòng gọi số điện thoại phục vụ hỗ trợ điện thoại dành cho tiểu bang của quý vị trong Bảng số điện thoại dịch vụ hỗ trợ viễn.

CHINESE: 請注意：如果您使用中文，您可以免費獲得語言援助服務。請撥會員服務部電話號碼表所列的您所在州的會員服務部號碼。

FRENCH CREOLE (HAITIAN CREOLE): ATANSYON: Si w pale kreyôl ayisyen, ou ka resevwa sèvis gratis ki la pou ede w nan lang pa w. Rele nimewo sèvis manm pou eta kote w rete a. W ap jwenn li nan tablo nimewo telefon sèvis manm yo.

ARABIC:

التحية: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية الم المجانية متاحة لك. اتصل برقم خدمات الأعضاء المدرج في لائحة رقم هاتف خدمات الأعضاء الخاص بالولاية المقيم فيها.

FRENCH: ATTENTION : Si vous parlez français, un service d’aide linguistique vous est proposé gratuitement. Veuillez appeler le numéro de téléphone du Service aux membres spécifique à votre État qui se trouve dans le tableau de numéros de téléphone du Service aux membres.

RUSSIAN: ВНИМАНИЕ! Если Вы говорите на русском языке, мы можем предложить Вам бесплатные услуги переводчика. Позвоните в Отдел обслуживания участников по указанному для Вашего штата номеру в телефонном справочнике Отдела обслуживания участников.

GERMAN: ACHTUNG: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie bitte die für Ihren Bundesstaat zuständige Rufnummer des Mitgliederkundendienstes an, die im Telefonverzeichnis des Mitgliederkundendienstes angegeben ist.

TAGALOG: PAUNAWA: Kung nagsasalita ka ng Tagalog, may makukuhu ka na mga libreng serbisyon pantulong sa wika. Tawagan ang numero ng Mga Serbisyo ng Miyembro na nakalista para sa iyong estado sa Tsart ng Numero ng mga Serbisyo ng Miyembro.

PORTUGUESE: ATENÇÃO: Se falar português, estão disponíveis, gratuitamente, serviços de assistência linguística. Ligue para o número dos Serviços aos Membros indicado para o seu estado na Tabela de números de telefone destes serviços.


GUJARATI: संदेश: जै तभें गुजराती बोलता हो तो, साभा सहयोग सेवाओं, नख़सुल्त, तमाम माटे उपलब्ध छ. साभा सेवा टेलिफ़ोन नंबर आर्ट्सम तमाम राज्य माटे सुरक्षित संघ सेवाओं नंबर पर शोल करो.

JAPANESE: 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。メンバーサービス電話番号チャートに記載されているお住まいの州のメンバーサービスまでお電話ください。
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the Member Services number listed for your state in the Member Services Telephone Number Chart.

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