OMB No. 0938-1378 | Expires: 7/31/2024

2024 Senior Care Options and Medicare Advantage Enrollment Application

WellSense HEALTH PLAN

MassHealth

This form is for people who have MassHealth Standard benefits and Medicare Parts A and B, and choose to enroll in WellSense Senior Care Options.

Enrollment form instructions. Please read before completing.

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important:

To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note:

You must complete all items in Section 1.

The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.

What happens next?

Send your completed and signed form to:

WellSense Health Plan
c/o Senior Care Options
529 Main Street, Suite 500
Charlestown, MA 02129

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call WellSense Health Plan at **855-833-8124.**
TTY users can call 711.

Or, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users can call 1-877-486-2048.

En español:

Llame a WellSense Health Plan al **855-833-8124** (TTY) 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

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 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 enrolling during the Annual Enrollment Period (AEP) from October 15 to December 7.
- ☐ 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) from January 1 to March 31.
- ☐ 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 an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact WellSense Senior Care Options at 855-833-8124 (TTY users should call TTY 711) to see if you are eligible to enroll. We are open Monday-Friday 8 a.m. to 8 p.m. We are open daily Oct. 1 - March 31.

MassHealth Information:

Are you enrolled in MassHealth Standard? ☐ Yes ☐ No

Please write in your MassHealth/Medicaid ID number or attach a copy of your MassHealth card. Your MassHealth number is the 12-digit number under your name.

MassHealth/Medicaid ID Number: __ __ __ __ - __ __ __ - __ __ __ __

You must be 65 years or older, have MassHealth Standard benefits, live in Barnstable, Bristol, Hampden, Plymouth, or Suffolk counties, not have other comprehensive health insurance (except Medicare) and not be a resident of a chronic hospital, to enroll in a senior care organization.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join

☐ WellSense Senior Care Options - $0 per month

Name: Last First MI (Optional) | **Gender:** ☐ Male ☐ Female

Birth date (MM/DD/YYYY): (__ __ /__ __ /__ __ __ __) | **Phone number:** ( )

Permanent Residence Street Address (Don't enter a P.O. Box)

Street:

City: County: State: Zip:

Mailing Address, if different from your permanent address (P.O. Box allowed)

Street:

City: State: Zip:

Email Address*

Please note: By providing your email address, you are giving WellSense permission to send you an email message (e.g., confirming we received your application and/or information about how to opt in to receive additional plan-related email communications.)

Your Medicare Information

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to WellSense Health Plan Medicare Advantage? ☐ Yes ☐ No

Name of other coverage: Member # for this coverage: Group # for this coverage:

IMPORTANT: Read and sign below

I must keep both Hospital (Part A) and Medical (Part B) to stay in WellSense Health Plan Medicare Advantage. WellSense Medicare Advantage is a HMO plan with a Medicare contract. Enrollment in these plans depends on contract renewal.

- By joining this Medicare Advantage Plan, I acknowledge that WellSense Health Plan Medicare Advantage will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA plan.
- I understand that when my WellSense Health Plan Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from WellSense Health Plan Medicare Advantage. Benefits and services provided by WellSense Health Plan Medicare Advantage and contained in my WellSense Health Plan Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor WellSense Health Plan Medicare Advantage will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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:**

If you're the authorized representative, sign above and fill out these fields:

Name:

Address:

Phone Number: ( ) **Relationship to Enrollee:**

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

Select one if you want us to send you information in a language other than English. ☐ Spanish

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact WellSense Health Plan at 855-833-8124 if you need information in an accessible format other than what's listed above. Our office hours are Monday-Friday 8 a.m. to 8 p.m. (Open daily Oct. 1-March 31. TTY users can call 711.)

Do you work? ☐ Yes ☐ No **Does your spouse work?** ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

Are you an existing patient of the PCP you selected? ☐ Yes ☐ No

I want to get the following materials via email. ☐ All available electronic materials

E-mail address:

Agent/Broker Use Only (if applicable):

The following section should be completed only by the insurance agent/broker assisting with this application.

Agent/Broker's Name (Please print):

National Producer Number (NPN):

Date Application Received by Agent/Broker:	**Proposed Effective Date :**

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.