WellFirst Health®
provided by SSM Health Plan

Short Enrollment Request Form

Please contact WellFirst Health if you need information in another language or format (such as Braille).

WellFirst Health - Enrollment
PO Box 851078
Richardson, TX 75085-1078

WellFirst Health
(HMO/HMO-POS)

Name of the plan you are enrolling in:

Please select **WellFirst Health provided by SSM Health Plan** if you live in Madison and St. Clair County, IL and St. Charles, St. Louis County and St. Louis City, MO.

☐ SSM Health Plan **Unity (HMO)**

☐ SSM Health Plan **Companion (HMO)**

☐ SSM Health Plan **Integrity (HMO-POS)**

☐ SSM Health Plan **Harmony (MA Only - HMO-POS)** Note: this plan does not include Part D prescription drug coverage

Last name	**First name**	**Middle initial**

Member Number	**Home Phone**	**Email** (consenting to be contacted and will have opt-out rights)

Permanent street address (P.O. Box is not allowed)

Street	City	County	State, ZIP code

Mailing address (only if different from your permanent address)

Street Address	City	County	State, ZIP code

Please fill out the following:

I am currently a member of the _____ plan from WellFirst Health.

with a monthly premium of $ _____ .

I would like to change to the_____ plan from WellFirst Health.

I understand that this plan has different health benefits and a monthly premium of $_____

Name of chosen 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.

☐ Other language _____ ☐ Large print ☐ Braille

Please contact WellFirst Health at 877-301-3326 (TTY: 711) if you need information in an accessible format or language other than what is listed above.

Your plan 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, Electronic Funds Transfer (EFT), or card payment each month. You can also 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 WellFirst Health the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify 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 for this benefit. 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**	☐ **Electronic Fund Transfer (Automatic premium withdrawal)** If selecting this method, please complete the Automatic Premium Withdrawal Authorization form. To access the automatic premium withdrawal form, please visit **wellfirsthealth.com/medicare**

Automatic deduction from your monthly Social Security or RRB benefit check.

I get monthly benefits from:

☐ **Social Security**

☐ **RRB**

(The Social Security 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.)

Stop: Please read and sign below.

Once WellFirst Health has your enrollment form, a plan representative will call you. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in WellFirst Health. If WellFirst Health isn't able to reach you by telephone, then you will get a letter by mail that contains similar information.

WellFirst Health is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with WellFirst Health, he/she may be paid based on my enrollment in WellFirst Health.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that WellFirst Health 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 people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date WellFirst Health coverage begins, I must get all of my health care from WellFirst Health, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by WellFirst Health and other services contained in my WellFirst Health Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR WELLFIRST HEALTH WILL PAY FOR THE SERVICES**.

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 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)	**Agent ID number**	**Effective Date of Coverage**

☐ **ICEP/IEP**	☐ **AEP**	☐ **SEP (type)**		