Allwell

Medicare Advantage Plans

2021 Optional Benefit Individual Enrollment Form

Allwell offers optional benefits for an additional monthly plan premium. This form may be used only by our current members who are adding the Optional Benefits Package to their existing Allwell Medicare Advantage plan or who are already enrolled in an Optional Benefit Package and are switching to a different package option. Please review the plan package options listed in this form before enrolling. The premium for optional supplemental benefits is paid in addition to the monthly plan premium and the Medicare Part B premium.

PLEASE PRINT

Name as it appears on Medicare card – Last | First | MI

Permanent residence address

City | State | ZIP

County of permanent residence address | Phone number

Mailing address (if different from above)

City | State | ZIP

Email address
(required if you want to receive documents online) | Birth date | Sex ☐ M ☐ F

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Medicare #
(from red, white and blue Medicare card) | Allwell

After you have completed this form, please mail it to:

Allwell, PO Box 10420, Van Nuys, CA 91410

Please see page 5 of this form for the Optional Benefits Packages that are available with your Allwell Medicare Advantage plan.

Please complete this section if you are enrolling in an Optional Benefits Package

I am currently enrolled in an Allwell Medicare Advantage plan, paying a monthly plan premium of $ _____ and wish to enroll in the Optional Benefits Package _____ for an additional monthly premium of $ _____.

Please complete this section if you are a current member and are switching Optional Benefits Packages

I am currently enrolled in an Allwell Medicare Advantage plan, **AND** Optional Benefits Package _____ and wish to switch to Optional Benefits Package _____ for an additional monthly premium of $ _____.

Please do not use this form to change Allwell Medicare Advantage plan.

If choosing an Optional Benefit Package that includes HMO dental, please make a dental provider selection from the Allwell Dental Provider Directory.

Provider name _____ Provider ID # _____

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.)

New members can enroll until the end of the first month of initial enrollment. Benefits will become effective the first of the following month. I understand that to be eligible for the Optional Supplemental Benefits Package, I must remain a member of an Allwell Medicare Advantage plan. If I disenroll from my plan, I will be automatically disenrolled from the Optional Supplemental Benefits Package. If I discontinue payment of the Optional Supplemental Benefits Package, my membership in the Optional Supplemental Benefits Package will be terminated, and my Medicare Advantage (medical) plan enrollment status will not be affected. My coverage will default to my standard Allwell Medicare Advantage plan (medical) only.

You may disenroll at any time from this option by providing written notice to Allwell, but once disenrolled, reenrollment during the same calendar year will be limited. The available election periods for the optional benefits are from October 15, 2020, through December 31, 2020, for a January 1, 2021, effective date; January 1, 2021, through January 31, 2021, for a February 1, 2021, effective date.

When electing the HMO option, you understand that, beginning with the effective date of coverage for this Optional Benefits Package, in order for services to be covered, you must obtain those services through Allwell contracted providers, with the exception of emergency or urgently needed services as described in the *Summary of Benefits* or *Evidence of Coverage* (EOC).

Release of information

I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the Plan, and I allow the Plan, Plan's doctors and clinics, or anyone else with medical or other relevant information about me, to give CMS or CMS's agents the information needed to run the Medicare program. I also give the Plan authorization to release necessary or other relevant information about me to service providers.

I understand that my signature on this application means that I have read and understand the contents of this application and agree to abide by the plan rules concerning the Optional Benefits Plans. (Please read your *Evidence of Coverage* document to know what rules you must follow in order to receive coverage with Allwell).

Print name

Signature

Date

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If you are the authorized representative, you must provide the following information

Last name

First name

MI

Address

City

State

ZIP

Relationship to applicant

Phone number

Thank you for choosing Allwell. If you have questions, please call 1-833-543-0246 (TTY: 711). 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.

OFFICE USE ONLY:

Group #

Effective date of coverage

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Correction of member information

Please review the options before enrolling in an Optional Benefits Package.

Please refer to the *Summary of Benefits* or *Evidence of Coverage* (EOC) for detailed information, service areas, benefit premiums, and costs associated with each plan. Some plans are not available in all service areas.

OPTIONAL BENEFITS PACKAGE	
Allwell Wellbeing Monthly plan premium: $18.10 Benefits: Dental and Vision Care Benefits	
PLAN NAME	**COUNTIES**
Allwell Medicare Boost (HMO) H2134-002	Bernalillo, Dona Ana, Sandoval and Santa Fe counties, NM

Out-of-network/non-contracted providers are under no obligation to treat Allwell members, except in emergency situations. Please call our member service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

Allwell is contracted with Medicare for HMO plans. Enrollment in Allwell depends on contract renewal.

FRM043307EK00 (7/20)