

SecureHorizons® MedicareComplete® Retiree Plans – Enrollment Request Form Instructions – How To Enroll

SecureHorizons® MedicareComplete® Retiree Plans are Medicare Advantage Plans.

Please complete this Enrollment Request Form with the following information:

1. Plan Information

- Your Group Number, GPS ID # and Employer, Union or Trust Group Name have been completed for you in Section 1. If the completed information is incorrect or missing, please provide the correct information; you can find your Group Number and Employer, Union or Trust Group Name on your Benefit Highlights.
- Include the date you expect your coverage to begin.
- Write in the name of the Primary Care Physician you have selected. You will find the Provider number underneath your doctor's name in the Provider Directory. If you did not receive a Provider Directory, please call the number at the bottom of the page or visit our website at www.UHCRetiree.com to find your Provider number.

2. Medical Information

- Please complete the questions about End-Stage Renal Disease (ESRD). ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to maintain life.

3. Applicant Information

- The enrollee using this form must be enrolling in a Medicare Advantage Plan. Please complete a separate form for eligible spouse and/or dependents.
- Complete the Medicare information, which you will find on your red, white and blue Medicare card. Please write your name (last name, first name and middle initial) exactly as it appears on your Medicare card. Your Plan member ID card will reflect your name as it appears on your Medicare card.
- Also, if possible, please attach a copy of your Medicare card or your Letter of Verification from Social Security or the Railroad Retirement Board.

4. Don't forget to sign and date this Enrollment Request Form. (Use a ballpoint pen and press hard.)

- **You will need to sign this Enrollment Request Form.** In order to process this Enrollment Request Form, you must sign the form where indicated.
- If someone has assisted you in completing this form, that person must also sign this form and indicate his/her relationship to you. You understand that if you are receiving assistance from a sales agent, broker, or other individual employed by or contracted with our Plan, he/she may be paid commission based on your enrollment in the Plan.
- If a Durable Power of Attorney or Legal Guardian/Conservator helped you complete this form, he/she must check off the appropriate area, sign and submit a copy of the applicable court order or Durable Power of Attorney that establishes authority to act on your behalf.

5. Return the Enrollment Request Form

- Return the completed Enrollment Request Form in the enclosed self-addressed, postage paid envelope to:
UnitedHealthcare
P.O. Box 29650
Hot Springs, AR 71903-9973

Incomplete information on this form may delay the processing of your enrollment.

6. Temporary Plan member ID card

- After we receive and process your enrollment you will receive an Acknowledgement Notice from us.
- **Your Acknowledgement Notice will act as your temporary Plan member ID card.**



Questions?

1-800-610-2660 (TTY 711)

8 a.m. – 8 p.m. local time, 7 days a week

You can also call us if you would like to enroll via the phone.

Please have your group name and group number, found on the sticker under Section 1, ready when you call.

Turn the page to enroll →

Please fill in all information requested.


Please print in black or blue ink.

Last Name First Name Medicare Claim Number

If you have special needs, this document may be available in other formats or languages upon request.

Please contact us at **1-800-610-2660**, TTY users should call **711**. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week.

1. Plan Information	
Employer Name:	Plan Sponsor Use Only: please date stamp this document to indicate when you received the completed and signed form.
Union or Trust Group Name:	
Group Number:	
GPS Employer ID:	
GPS Branch #:	

Effective Date 	On what date should your coverage begin (your proposed effective date)? ____ / ____ / ____
Contracting Medical Group/Primary Care Physician Name (PCP)	
Contracting Medical Group/Doctor #	
Are you currently a patient of this doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. Medical Information	
Do you have End-Stage Renal Disease (ESRD)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "yes", how long have you been on Medicare for ESRD?	Start Date _____ End Date _____
If you answered "yes" to this question and you don't need regular dialysis anymore or have had a successful kidney transplant, please attach a note or records from your doctor showing you don't need dialysis or have had a successful kidney transplant.	
If "yes", are you currently a member of UnitedHealthcare?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "yes", what is your UnitedHealthcare ID#?	
Are you currently employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "no", retirement date (month/date/year)	

Your answer to the following questions will not keep you from enrolling in this Plan.

Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, TRICARE, Federal employee health benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs.

Will you have other **prescription drug coverage** in addition to our Plan? Yes No

If "yes", please list other coverage and identification number(s) for this coverage:

Name of other coverage: _____

Your member ID# for this coverage: _____ Group number for this coverage: _____

Do you have any **health insurance** other than Medicare, such as private insurance, Worker's Compensation, VA benefits or other employer coverage? Yes No

If you have other **health insurance**, what kind do you have?

What is the name of the health insurance? _____ Group# _____ ID# _____

3. Applicant Information - As it appears on your Medicare card

	Last Name	First Name	M.I.	Sex	Birth Date	Home Telephone
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.				<input type="checkbox"/> M <input type="checkbox"/> F	__ / __ / __	()
Permanent Residence Street Address (Not a P.O. Box)			City			
County			State		Zip Code	
Mailing Address (only if different from your Permanent Residence Address)			City			
			State		Zip Code	
E-mail Address						
Emergency Contact Name			Emergency Contact Telephone ()			
Emergency Contact's Relationship to Beneficiary						
Medicare Information	What is your Medicare Claim Number? _____					
	Part A Effective Date? __ / __ / __ Part B Effective Date? __ / __ / __					
Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If "yes", name of institution _____						
Address of institution (number and street) _____						
City _____						
State _____						
Zip Code _____						
Phone number of institution () _____ Your date of admission in institution __ / __ / __						

4. ATTENTION! Please sign and date

I understand that my signature on this Plan's Enrollment Request Form means that I have read and understood the contents of this Enrollment Request Form, including the Statement of Understanding, and that the information provided by me is accurate and complete.

You must sign and date this Enrollment Request Form in order for it to be processed.

This Enrollment Request Form must be signed and received prior to your desired effective date. Upon receipt, the Plan will process the form according to Centers for Medicare & Medicaid Services (CMS) guidelines.

Applicant Signature (or signature of authorized representative, please complete box below) Today's Date / /

If you are the authorized representative of the applicant, you must provide the following information and sign below.

If signed by an authorized representative of the applicant, 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 UnitedHealthcare or by Medicare.

If Durable Power of Attorney or Legal Guardian/Conservatorship, indicate here and attach applicable court order or Durable Power of Attorney that establishes authority to act on behalf of the applicant.

Name (Print)	Signature
<hr/>	
Address	
<hr/>	
Telephone Number	Relationship to Applicant

If someone assisted you in completing this form, please have that person complete the information below.

Signature of Individual Who Assisted in Completing This Form	Date	Relationship to Applicant
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Plan representative, check here if you signed above and assisted in completing this form.

Sales Representative/Broker, please provide your signature above and complete the line below.

Sales Representative/Broker Name (Please Print)	Agent/Broker ID#	Referring Broker ID#	Today's Date
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/ /

For Office Use Only	
Agent Name: _____	Agent Number: _____ NIPR# _____
Effective Date: ____ / ____ / 20____	
PBP: _____ Group Number: _____ <input type="checkbox"/> SEP <input type="checkbox"/> Employer Group SEP <input type="checkbox"/> ICEP <input type="checkbox"/> OEP <input type="checkbox"/> AEP EP (type): _____	



PLEASE OPEN TO COMPLETE FORM



UnitedHealthcare® Medicare Advantage plans are offered by UnitedHealthcare Insurance Company and its affiliated companies, Medicare Advantage Organizations with a Medicare contract with the Federal government.

Duplicate of Enrollment Copy

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