UnitedHealthcare®

## ENROLLMENT REQUEST FORM

To enroll in the UnitedHealthcare® Group Medicare Advantage (HMO) or (Regional PPO) for Groups plan, please provide the following:

**1. Plan information:**

Plan Sponsor:

Group Number: | GPS Employer ID:

GPS Branch Number:

**I prefer to receive materials in the following language:**
☐ Spanish
☐ Chinese (Spoken ☐ Cantonese ☐ Mandarin)
☐ Other _____
Please contact us at **1-877-714-0178**, TTY **711**, 8 a.m. – 8 p.m. local time, 7 days a week if you need information in another format such as large print.

Plan Sponsor use ONLY:
Please date stamp this document to indicate when you received the completed and signed form.

**Effective Date Requested:** ____ /____ /____
(i.e., your proposed effective date, or on what day your coverage should begin)

Contracting Medical Group/Primary Care Physician (PCP) Name | Contracting Medical Group/Doctor Number

Are you currently a patient of this doctor? ☐ Yes ☐ No

**2. Applicant information – as it appears on your Medicare card:** (Please print in black or blue ink.)

☐ Mr. ☐ Mrs. ☐ Ms. | Last Name | First Name | Middle Initial

Birth Date ____ /____ /____ | Sex ☐ Male ☐ Female | Home Telephone Number ( ) –

Permanent Residence Street Address (P.O. box not allowed)

City | State | ZIP | County

Mailing Address (only if different from your Permanent Street Address) (P.O. box allowed for mailing only)

City | State | ZIP

Email Address

Emergency Contact

Contact Telephone Number ( ) – | Contact Relationship to You

In the future, would you be willing to receive materials through electronic means? ☐ Yes ☐ No

**3. Please provide your Medicare insurance information:**

Use your red, white and blue Medicare card to complete this section — or — attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare Advantage plan. An incorrect or incomplete Medicare Claim Number may cause a delay or denial of coverage.

Medicare Claim Number

Part A (Hospital) Effective Date ____ /____ /____

Part B (Medical) Effective Date ____ /____ /____





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# Enrollment INSTRUCTIONS

UnitedHealthcare® Group Medicare Advantage (HMO) and (Regional PPO) are Medicare Advantage plans. Please complete the Enrollment Request Form using the instructions provided below or enroll right over the phone. Just give us a call at the number below.

**Plan Information**

Please confirm the Plan Sponsor and Group Number match what is listed on the front cover of this booklet. If the information is incorrect or missing, please provide the correct information.

Include the date you expect your coverage to begin.

Write in the name and provider number of your Primary Care Provider (PCP). The provider number can be found underneath your doctor's name in the Provider Directory or by calling the number at the bottom of this page or visiting our website at **www.UHCRetiree.com**.

**Applicant Information**

You must complete a separate form for each person enrolling in this Medicare Advantage plan.

Please write your name exactly as it appears on your red, white and blue Medicare card. This is how it will appear on your member ID card.

Attach a copy of your Original Medicare card or your Letter of Verification from Social Security or the Railroad Retirement Board, if possible.

**Medical Information**

Please complete the questions about End-Stage Renal Disease (ESRD).

**Sign and Date the Enrollment Request Form**

In order to process this form, **you must sign the form where indicated**.

If someone helped you complete this form, that person must also sign this form and indicate his/her relationship to you. 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 a commission based on your enrollment in the plan.

If your authorized representative helped you complete this form, he/she must sign the form and submit a copy of the court order or Durable Power of Attorney that allows them to act on your behalf, if requested by the plan.

UnitedHealthcare®

# Enrollment INSTRUCTIONS (CONTINUED)

**Return the Enrollment Request Form**

Return the completed form in the enclosed envelope and send to:
UnitedHealthcare
P.O. Box 29650
Hot Springs, AR 71903-9973

**Incomplete information may delay your enrollment.**

**Questions? Call Customer Service:**

**1-877-714-0178**, TTY **711**
8 a.m. – 8 p.m. local time, 7 days a week

**www.UHCRetiree.com**
Learn more online

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

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Last Name First Name Medicare Claim Number

Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If **"yes,"** Name of Institution _____
Address of Institution _____
City _____
State _____
ZIP _____
Telephone Number of Institution ( ) – Date of Admission ____ /____ /____

**4. Medical information:**

**Do you have End-Stage Renal Disease (ESRD)?** ☐ Yes ☐ 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? ☐ Yes ☐ No

If **"yes,"** what is your UnitedHealthcare member ID number?

Do you or your spouse work? ☐ Yes ☐ No

If **"no,"** retirement date ____ /____ /____

**Your answer to the following questions will not keep you from being enrolled in this plan:**

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 our plan? ☐ Yes ☐ No

If **"yes,"** please list your other coverage and your identification (ID) number for this coverage

Name of Other Coverage _____
ID Number for Coverage _____ Group Number for 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

What is the name of the health insurance? _____

Group Number _____ ID Number _____

**5. ATTENTION – please sign and date:**

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

**This Enrollment Request Form must be signed, dated 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** ____ /____ /____ |
|---|---|



TEAR HERE

TEAR HERE

Last Name First Name Medicare Claim Number

**Authorized representative information:**

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 Medicare.

| Last Name | First Name | |
|---|---|---|
| Address | | |
| City | State | ZIP |
| Telephone Number ( ) – | Relationship to Applicant | |
| **Signature** | | **Today's Date** ____ /____ /____ |

**6. 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) | **Today's Date** ____ /____ /____ |
|---|---|
| ☐ Plan Representative, check here if you signed above and assisted in completing this form. | **Relationship to Applicant** |

**Sales Representative/Broker, please provide your signature and complete the information below:**

| Licensed Sales Representative/Broker Signature | Today's Date ____ /____ /____ |
|---|---|
| Licensed Sales Representative/Broker Name (Please Print) | |
| Agent/Broker ID Number | Referring Broker ID Number |

**7. For office use only:**

Agent Name

| Agent Number | | NIPR Number |
|---|---|---|
| Effective Date ____ /____ /____ | Group Number | PBP Number |

☐ SEP ☐ Employer Group SEP ☐ ICEP/IEP ☐ AEP (type) _____