ENROLLMENT INSTRUCTIONS

UnitedHealthcare® Group Medicare Advantage (HMO) and (Regional PPO) are Medicare Advantage Plans. UnitedHealthcare® RxSupplement™ is an Outpatient Prescription Drug Plan that works together with your Medicare Advantage plan.

Please complete BOTH of the Enrollment Request Forms on the next page using the instructions provided here. You can also enroll right over the phone by giving us a call at the number listed 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 of the Primary Care Physician (PCP) you have selected. The provider number can be found under the provider’s name at www.UHCRetiree.com or by calling us at the number below.

**Applicant Information**

You must complete a separate form for each person enrolling in this 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)

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 him/her to act on your behalf, if requested by the plan.

**Return the Enrollment Request Form**

Return the completed forms 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:**

Learn more online at [www.UHCRetiree.com](http://www.UHCRetiree.com)

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

UnitedHealthcare RxSupplement is not a Medicare Part D prescription drug plan. This is an employer group retiree prescription drug plan. UnitedHealthcare RxSupplement group retiree prescription drug plans are underwritten by UnitedHealthcare Insurance Company or, in New York, UnitedHealthcare Insurance Company of New York. These are private insurance companies not connected with or endorsed by the U.S. Government or the federal Medicare program. RxSupplement plans may not be available in all states. UnitedHealthcare is part of the UnitedHealth Group family of companies.
2018 Enrollment Request Form

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

I prefer to receive materials in the following language:
☐ Spanish
☐ Chinese (Spoken ☐ Cantonese ☐ Mandarin)
☐ Other ___

Please contact us Toll-Free 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: Columbia University
Group Number: 40512
GPS Employer ID: 3348
GPS Branch Number: 001

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

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

1. Plan information

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

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

Sex ☐ Male ☐ Female

Home Telephone Number ( ) – ___

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

City State ZIP Code County

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

City State ZIP Code

Email Address

Emergency Contact

Contact Telephone Number ( ) – ___

Contact Relationship to You

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 and Part B 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 M M / D D / Y Y Y Y

Part B (Medical) Effective Date M M / D D / Y Y Y Y

What's next
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Please read and answer these important questions.

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 Code ____________

Telephone Number of Institution (____) — Date of Admission MM/DD/YYYY

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 MM/DD/YYYY

End Date MM/DD/YYYY

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”, what was your retirement date? MM/DD/YYYY

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 the 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

Name of the Health Insurance __________________________

ID Number for Coverage ______________ Group Number for Coverage __________

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. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

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 Medicare guidelines.

Applicant Signature (or signature of authorized representative, please complete box below)

Today’s Date MM/DD/YYYY

Last Name __________________________ First Name __________________________ Medicare Claim Number ____________

Today’s Date MM/DD/YYYY

What’s next
This page intentionally left blank.
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.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Medicare Claim Number</th>
</tr>
</thead>
</table>

Address

City          | State | ZIP Code |

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

<table>
<thead>
<tr>
<th>Signature</th>
<th>Today’s Date</th>
</tr>
</thead>
</table>

☐ 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)

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. UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-555-5757 (TTY: 711). 注意：如果您说中文，您可以免費獲得語言援助服務。請致電 1-800-555-5757 (TTY: 711).
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Outpatient Prescription Drug Plan Enrollment Form

(Please Print)

Underwritten by UnitedHealthcare Insurance Company

Required Information

Employer/Former Employer Name: Columbia University
Employer ID #: 40512
Employer Subsidy Group #: 3348
Employer Billing #: 001

Please complete the entire form - Incomplete information can delay the enrollment process
(Please Print – If you need more room for your answers to any questions, please use a separate sheet of paper.)

Date of Retiree's Retirement mm/dd/yyyy
Source of Enrollment
☐ Open Enrollment  ☐ Newly Eligible  ☐ Special Enrollment

1. Personal Information

Applicant Last Name
Applicant First Name
MI
Suffix

☐ Male  ☐ Female
Date of Birth mm/dd/yyyy
Marital Status of Applicant:
☐ Single  ☐ Married  ☐ Divorced  ☐ Widow

Name of Retiree
Relation to Retiree:
☐ Self  ☐ Spouse  ☐ Child

Medicare Claim #
Part A Effective Date mm/dd/yyyy
Part B Effective Date mm/dd/yyyy
Part D Effective Date mm/dd/yyyy

Permanent Residence Street Address (P.O. Box is not allowed)
City
State
Zip

Home Telephone # (   )
Alternate Telephone # (   )
E-mail Address

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

If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next three lines. Providing this information will not affect your eligibility to enroll.

Institution Name
Date of Admission mm/dd/yyyy
Telephone # (   )

Address
City
State
Zip

Doctor’s Name
Doctor’s Telephone # (   )

Outpatient Prescription Drug Plan Enrollment Form (Please Print)

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### 2. Benefit Coordination / Other Insurance Carrier Information

1. Do you have other health insurance?  
   - Yes  
   - No  
   If Yes, complete Section 1a. – 1e. below.

2. Are you permanently disabled?  
   - Yes  
   - No  
   If Yes, complete the following:

   2a. Date disability began:  
   
   3. Do you have a disability affecting your ability to communicate or read?  
   - Yes  
   - No

If you have special needs, this document may be available in other formats or languages upon request. Please contact us at 1-877-714-0178, TTY users should call 711. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week.

Do you work or plan to work?  
   - Yes  
   - No

<table>
<thead>
<tr>
<th>1a. Name</th>
<th>1b. Insurance Company Name</th>
<th>1c. Policy #</th>
<th>1d. Effective Date</th>
<th>1e. Other Employer Name and Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>mm/dd/yyyy</td>
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<tr>
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<td></td>
<td>mm/dd/yyyy</td>
<td></td>
</tr>
</tbody>
</table>

### FOR OFFICE USE ONLY

<table>
<thead>
<tr>
<th>RETIREE</th>
<th>YES</th>
<th>NO</th>
<th>GROUP #</th>
<th>PLAN CODE</th>
<th>ENROLLEE IS ELIGIBLE FOR RETIREE COVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPOUSE OR CHILD</td>
<td>YES</td>
<td>NO</td>
<td>VERIFICATION: DATE /</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Initial

### FOR EMPLOYER USE ONLY

<table>
<thead>
<tr>
<th>Enrollee is eligible for retiree coverage</th>
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</table>

Effective Date: mm/dd/yyyy

Initial
3. Terms and Conditions

I am requesting enrollment under the UnitedHealthcare Insurance Company (“UnitedHealthcare”) Group Retiree Policy. By signing this Enrollment Form, I agree to and understand the following:

1. All coverage is subject to the terms and conditions of the UnitedHealthcare Group Policy.

2. UnitedHealthcare or its designee shall have access and use of my medical records for purposes of utilization review surveys, processing of claims, financial audit or other purposes reasonably related to the performance of this Enrollment Form.

3. Any material omission or intentional misrepresentation in answering the questions on this Enrollment Form may result in the denial of benefits and the termination of my coverage.

4. Coverage shall not begin until acceptance of this Enrollment Form by UnitedHealthcare. Acceptance will not occur until after UnitedHealthcare validates Medicare coverage and eligibility for coverage under the group retiree plan. Upon acceptance of this Enrollment Form, UnitedHealthcare shall be bound by the terms of my UnitedHealthcare Group Policy and the Amendments thereto (if applicable).

5. My current prescription drug coverage under Part D is provided by a UnitedHealthcare plan. I understand that if my coverage under the Part D plan ends, this coverage will also end.

6. All statements and descriptions in this enrollment form are deemed to be representations and not warranties.

I certify that I have read the Terms and Conditions printed on this Enrollment Form and that I accept them and will abide by them. I further certify that the information provided in the Enrollment Form is true and complete to the best of my knowledge and belief.

Print Name of Applicant:

Signature of Applicant or Authorized Representative: Today’s Date: __________________________

Authorized Representative Information

If you are the authorized representative (Responsible Party, Power of Attorney, Family Member, etc.), you must sign above and provide the following information:

Name: ____________________________ Date: ____________________________

Address: ____________________________ City: ____________________________ State: _______ Zip code: _______

Relationship to Enrollee: ____________________________

Signature
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Statements of UNDERSTANDING

By enrolling in this plan, I agree to the following:

This is a Medicare Advantage plan and has a contract with the federal government. This is not a Medicare Supplement plan.

I need to keep my Medicare Part A and Part B, and continue to pay my Medicare Part B and, if applicable, Part A premiums, if they are not paid for by Medicaid or a third party.

I can only have one Medicare Advantage or Prescription Drug plan at a time.

- Enrolling in this plan will automatically disenroll me from any other Medicare health plan. If I disenroll from this plan, I will be automatically transferred to Original Medicare. If I enroll in a different Medicare Advantage plan or Medicare Part D Prescription Drug Plan, I will be automatically disenrolled from this plan.
  - If I have prescription drug coverage or if I get prescription drug coverage from somewhere other than this plan, I will inform UnitedHealthcare.
  - Enrollment in this plan is for the entire plan year. I may leave this plan only at certain times of the year or under special conditions.

If I do not have prescription drug coverage, I may have to pay a late enrollment penalty.

This would apply if I did not sign up for and maintain creditable prescription drug coverage when I first became eligible for Medicare. If I get a late enrollment penalty, I will get a letter making me aware of the penalty and what the next steps are.

This plan covers a specific service area. If I plan to move out of the area, I will call my plan sponsor or this plan to disenroll and get help finding a new plan in my area.

I may not be covered while out of the country, except for limited coverage near the U.S. border. However, under this plan, when I am outside of the U.S. I am covered for emergency or urgently needed care.

I will get a Plan Details book that includes an Evidence of Coverage (EOC).

- The EOC will have more information about services covered by this plan. If a service is not listed, it will not be paid for by Medicare or this plan without authorization.
  - I have the right to appeal plan decisions about payment or services if I do not agree.

My information will be released to Medicare and other plans, only as necessary, for treatment, payment and health care operations.

Medicare may also release my information for research and other purposes that follow all applicable Federal statutes and regulations.

For members of the UnitedHealthcare® Group Medicare Advantage (HMO) plan only.

Starting on the date my coverage starts, I must get all of my health care from UnitedHealthcare Group Medicare Advantage (HMO). The only exceptions are emergency or urgently needed services, or out-of-area dialysis services.

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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Questions? We’re here to help.

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

www.UHCRetiree.com

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare approved Part D sponsor. Enrollment in these plans depends on the plan’s contract renewal with Medicare.

This is an advertisement.

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