



ENROLLMENT REQUEST FORM

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

1. Plan information:	
Plan Sponsor: Employers Managed HCT	
Group Number: 140870	GPS Employer ID: 1871
GPS Branch Number: 001	

TEAR HERE

I prefer to receive materials in the following language: <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese (Spoken <input type="checkbox"/> Cantonese <input type="checkbox"/> Mandarin) <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	

GETTING STARTED

2. Applicant information – as it appears on your Medicare card: (Please print in black or blue ink.)			
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last Name	First Name	Middle Initial
Birth Date ____ / ____ / ____	Sex <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			

TEAR HERE

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 ____ / ____ / ____

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

____ / ____ / ____

GETTING STARTED

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 ____ / ____ / ____	
<input type="checkbox"/> 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:			
Sales Representative/Broker Signature		Today's Date ____ / ____ / ____	
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
<input type="checkbox"/> SEP <input type="checkbox"/> Employer Group SEP <input type="checkbox"/> ICEP/IEP <input type="checkbox"/> AEP (type) _____			

GETTING STARTED

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

Required Information

Employer/Former Employer Name: Employers Managed HCT	
Employer ID #: 140870	Employer Subsidy Group #: 1871
Employer Billing #: 001	

Outpatient Prescription Drug Plan Enrollment Form

(Please Print)

TEAR HERE

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 $\frac{\text{mm}}{\text{dd}} / \frac{\text{dd}}{\text{yyyy}}$	Source of Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Newly Eligible <input type="checkbox"/> Special Enrollment

1. Personal Information

Applicant Last Name		Applicant First Name		MI	Suffix
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth $\frac{\text{mm}}{\text{dd}} / \frac{\text{dd}}{\text{yyyy}}$	Marital Status of Applicant: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow			
Name of Retiree			Relation to Retiree: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		
Medicare Claim #	Part A Effective Date $\frac{\text{mm}}{\text{dd}} / \frac{\text{dd}}{\text{yyyy}}$	Part B Effective Date $\frac{\text{mm}}{\text{dd}} / \frac{\text{dd}}{\text{yyyy}}$	Part D Effective Date $\frac{\text{mm}}{\text{dd}} / \frac{\text{dd}}{\text{yyyy}}$		
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 $\frac{\text{mm}}{\text{dd}} / \frac{\text{dd}}{\text{yyyy}}$	Telephone # ()		
Address		City	State	Zip	
Doctor's Name		Doctor's Telephone # ()			

GETTING STARTED

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Applicant Last Name

Applicant First Name

MI

Medicare Claim #

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: / /
mm / dd / yyyy

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

1a. Name	1b. Insurance Company Name	1c. Policy #	1d. Effective Date	1e. Other Employer Name and Address
			<u> </u> / <u> </u> / <u> </u> mm / dd / yyyy	
			<u> </u> / <u> </u> / <u> </u> mm / dd / yyyy	

FOR OFFICE USE ONLY

RETIREE YES NO GROUP # _____

PLAN CODE _____

SPOUSE OR CHILD

YES NO VERIFICATION: _____ DATE _____ / _____ / _____
Initial

FOR EMPLOYER USE ONLY

Enrollee is eligible for retiree coverage

Effective Date: _____ / _____ / _____

Initial

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GETTING STARTED

Applicant Last Name

Applicant First Name

MI

Medicare Claim #

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:

Signature

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: _____

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