UnitedHealthcare®

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.

1. Plan information

Plan Sponsor: Los Rios CC

Group Number: 15881	GPS Employer ID: 24956

GPS Branch Number: 001

Effective Date Requested: MM/DD/YYYY (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.

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 use black or blue ink.)

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

Birth Date MM/DD/YYYY	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 MM/DD/YYYY

Part B (Medical) Effective Date MM/DD/YYYY

What's next

Last Name First Name Medicare Claim Number

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

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 Code
Telephone Number ( ) –	Relationship to Applicant	
Signature		**Today's Date** MM/DD/YYYY

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** MM/DD/YYYY
☐ 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 MM/DD/YYYY
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) _____

Outpatient Prescription Drug Plan Enrollment Form

(Please Print)

Underwritten by
UnitedHealthcare Insurance Company

Required Information

Employer/Former Employer Name: Los Rios CC	
Employer ID #: 15881	Employer Subsidy Group #: 24956
Employer Billing #: 001	

TEAR HERE

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 MM / DD / YYYY	Source of Enrollment ☐ Open Enrollment ☐ Newly Eligible ☐ Special Enrollment

1. Personal Information

Applicant Last Name	Applicant First Name	MI	Suffix
Date of Birth MM / DD / YYYY	Marital Status of Applicant: ☐ Single ☐ Married ☐ Divorced ☐ Widow		☐ Male ☐ Female
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
E-mail Address			
Home Telephone # ( )	Alternate Telephone # ( )		

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 # ( )	

What's next

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
			MM / DD / YYYY	
			MM / DD / YYYY	

FOR OFFICE USE ONLY

Retiree

☐ Yes ☐ No

Spouse or child

☐ Yes ☐ No

Group # _____

Plan Code _____

Verification _____

Date _____ /_____ /_____

Initial _____

FOR EMPLOYER USE ONLY

☐ Enrollee is eligible for retiree coverage

Effective Date

_____ /_____ /_____

_____

Initial

TEAR HERE

TEAR HERE

What's next

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: MM / DD / YYYY	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 _____

TEAR HERE

TEAR HERE

What's next

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.

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