UnitedHealthcare®
Community Plan

2014
INDIVIDUAL ENROLLMENT FORM

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Please contact UnitedHealthcare Dual Complete™ if you need information in another language or format (Braille).

1. To enroll in a UnitedHealthcare Dual Complete™ plan, please provide the following information:

UnitedHealthcare® Dual Complete™ (HMO SNP) UDC

2. Applicant Information (please type or print in black or blue ink).

☐ Mr.
☐ Mrs.
☐ Ms.

Last Name

First Name

Middle Initial

Birth Date
M M / D D / Y Y Y Y

Sex
☐Male ☐Female

Home Phone Number
( ) -

Alternative Phone Number
( ) -

Social Security Number
- -

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

Apt

City

State

ZIP Code -

County

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

City

State

ZIP Code -

Email Address (optional). Please email me plan information and updates.

Enrollee Name:_____

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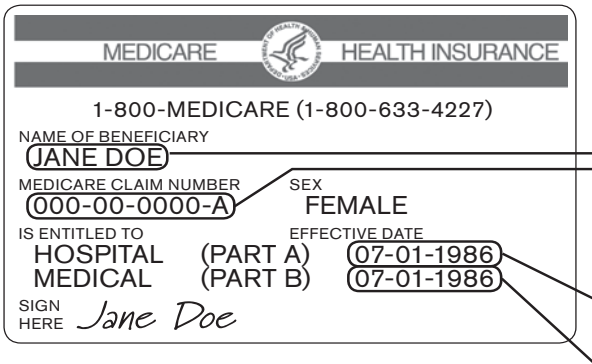
3. Please provide your Medicare insurance information.

Please take out 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.



Name (exactly as it appears on Medicare card)

Medicare Claim Number Letter (s)

Sex: ☐ Male ☐ Female

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

You must have Medicare Part A and Part B to join a Medicare Advantage Plan.

4. Your payment options (if applicable).

If you have a monthly plan premium (or if you currently have a late-enrollment penalty) we need to know how you prefer to pay it. You can pay by mail or we will provide you a monthly statement. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. **DO NOT pay UnitedHealthcare Dual Complete™ the Part D-IRMAA.**

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount Medicare doesn't cover.

If you do not select a payment option, you will receive a monthly statement for the amount that Medicare doesn't cover.

Enrollee Name:_____

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Please select a premium payment option (choose only one):

☐ **Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check.** *(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a payment coupon book for your monthly premiums).*

☐ **Monthly statement**

5. Please read and answer these important questions:

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

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need Dialysis, otherwise we may need to contact you to obtain additional information.

If "**yes,**" are you currently a member of a health care company? ☐ **Yes** ☐ **No**

Name of Company

Member ID

Do you have any other prescription drug coverage such as private insurance, TRICARE, VA benefits, State Pharmaceutical Assistance Program or Federal Employee Health Benefits coverage?

☐ **Yes** ☐ **No** If **"yes,"**

Name of other coverage

Member ID for this coverage

Group ID

Effective Date

M M / D D / Y Y Y Y

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 -

Phone Number of institution

( ) -

Date of admission to the institution

M M / D D / Y Y Y Y

Are you enrolled in your state Medicaid program? ☐ Yes ☐ No

If "**yes,**" please provide your Medicaid ID

Do you or your spouse work? ☐ Yes ☐ No

Enrollee Name:_____

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6. Primary Care Physician (PCP), clinic or health center selection.

Refer to the plan website or Provider Directory for selection.

PCP Full Name

Provider/PCP ID: Enter the 10 or 11 digit PCP ID exactly as it appears in the website or directory. Include zeros, but not dashes. (For a 10 digit ID, leave the last box blank.)

Provider/PCP ID

Are you now seeing or have you recently seen this doctor? ☐ Yes ☐ No

Do you or your spouse have any health insurance other than Medicare, such as state insurance, Workers' Compensation or Veterans Administration (VA) benefits?
☐ Yes ☐ No

If you answered **"YES"** please provide the following information:

What kind do you have?

Group number

ID Number

7. Alternative formats (check only one):

Please check one of the boxes below if you would prefer to be sent information in a language other than English, or in another format:

☐Spanish ☐ Chinese ☐ Other

Please contact UnitedHealthcare Dual Complete™ at **1-888-834-3721** (TTY 711) if you need information in another format or language than those listed above. Our office hours are 8 a.m. to 8 p.m. local time, 7 days a week.

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STOP **Please read this important information.**

If you currently have health coverage from an employer or union, joining UnitedHealthcare Dual Complete™ could affect your employer or union health benefits. You could lose your employer or union health coverage if you join UnitedHealthcare Dual Complete™. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

To be enrolled in a Dual Special Needs Plan you must be eligible for your state's Medicaid program. In order to enroll in a Chronic Conditions Special Needs Plan, Medicare requires that your chronic condition be verified. We'll contact your physician's office to verify your chronic condition.

Enrollee Name:_____

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8. Please read and sign below.

By completing this enrollment application, I agree to the following:

This is a Medicare Advantage plan that has a contract with the Federal Government. This is not a Medicare Supplement plan. You'll need to keep your Medicare Parts A and B. You can only be enrolled in one Medicare Advantage Plan at a time. Enrollment in this plan will automatically end your enrollment in another Medicare Advantage or prescription drug plan.

If you have prescription drug coverage, or receive any in the future from somewhere other than this plan, it is your responsibility to let us know. Enrollment in this plan is generally for the entire year. You can only leave or change this plan during Medicare's open enrollment period of October 15th - December 7th, or under special circumstances.

I will read the Evidence of Coverage document from UnitedHealthcare Dual Complete™ when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. This plan only covers the area that you live in. If you're planning to move out of the area, please call us and we will help you find a plan in your new area. Medicare may not cover you while out of the country with the exception of limited coverage near the U.S. border. You have the right to appeal plan decisions about payment or services if you disagree.

I understand that beginning on the date UnitedHealthcare Dual Complete™ coverage begins, I must get all of my health care from UnitedHealthcare Dual Complete™, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by my plan and other services contained in my plan's Evidence of Coverage document will be covered. Without authorization, **neither Medicare nor UnitedHealthcare Dual Complete™ will pay for the services.**

If a sales agent helped you choose a plan, the sales agent may receive compensation based on you enrolling in the plan.

Release of Information:
We will release your information including your prescription drug event data to Medicare, only as necessary, for treatment, payment and health care operations. Medicare may also release your information for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of your knowledge. If you intentionally provide false information on this form, you will be disenrolled from the plan.

Your signature (or the signature of the person authorized to act on your behalf under the laws of the state where you live) on this application means that you have read and understand the contents of this application. If signed by an authorized individual (as described above), 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 from Medicare.

Signature of Applicant/Member/Authorized Representative	Today's Date M M / D D / Y Y Y Y

Enrollee Name:_____

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9. If you are the authorized representative, you must sign above and provide the following information.

Last Name | First Name

Address

City | State | ZIP Code

Phone Number ( ) -

Relationship to Applicant

10. For licensed sales representative/agency use only.

☐ New Member
☐ Plan Change

Employer Group Name

Employer Group ID | Branch ID

Where did this application originate? ☐ Retail/Mall Program ☐ Community Meeting ☐ Member Meeting ☐ Local B2B Outreach ☐ Local Event Outreach ☐ Other

How was this application submitted? ☐ Appointment ☐ Mail in ☐ Other

Licensed Sales Representative/Agent ID | Initial Receipt Date (M M / D D / Y Y Y Y)

Licensed Sales Representative/Agent Name | Proposed Effective Date (M M / D D / Y Y Y Y)

Licensed Sales Agent Phone Number ( ) -

Agent must complete

☐ AEP
☐ ICEP (MA enrollees)
☐ IEP (MA-PD enrollees)
☐ IEP (MA-PD enrollees eligible for 2nd IEP)
☐ OEPI
☐ SEP (Chronic)
☐ SEP (Full Dual Eligible & Partial Dual Eligible)
☐ SEP (SEP Reason)

SEP Eligibility Date (M M / D D / Y Y Y Y)

Licensed Sales Agent Signature (required)

Enrollee Name:_____

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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 the plan depends on the plan's contract renewal with Medicare.

This information is available for free in other languages. Please call our customer service number at 1-888-834-3721, TTY 711, 8 a.m. - 8 p.m. local time, 7 days a week.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente al número 1-888-834-3721, TTY 711, de 8 a.m. – 8 p.m. hora local, los 7 días de la semana.

本資訊也有其他語言的免費版本。請撥打 1-888-834-3721 聯絡我們的客戶服務部, 聽語障專線711, 每週 7 天, 當地時間上午 8 時至晚上 8 時.

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