



2020 Enrollment Request Form

Please contact the plan if you need this information in another language or an accessible format (Braille).

UnitedHealthcare Dual Complete[®] (HMO-POS D-SNP) H5253-041-000 - UD5

This plan is designed for people with both Medicare and Medicaid. We may need to contact you to ask for proof of eligibility.

This is a Health Maintenance Organization - Point of Service (HMO-POS) plan. It has a network of doctors, specialists, hospitals and other providers you can use. In some cases, you may get covered services from out-of-network providers. However, if you go to a provider within the network, the costs may be lower.

Information about you. (Please type or 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 MM-DD-YYYY | | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Daytime Phone Number () - | | Mobile Phone Number () - | |
| Social Security Number (Required for people who are enrolling in D-SNP plans): | | <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid gray; width: 20px; height: 20px;"></div> <div style="border: 1px solid gray; width: 20px; height: 20px;"></div> <div style="border: 1px solid gray; width: 20px; height: 20px;"></div> - <div style="border: 1px solid gray; width: 20px; height: 20px;"></div> <div style="border: 1px solid gray; width: 20px; height: 20px;"></div> - <div style="border: 1px solid gray; width: 20px; height: 20px;"></div> <div style="border: 1px solid gray; width: 20px; height: 20px;"></div> <div style="border: 1px solid gray; width: 20px; height: 20px;"></div> <div style="border: 1px solid gray; width: 20px; height: 20px;"></div> </div> | |
| Permanent Residence Street Address (P.O. Box is not allowed) | | | |
| City | | County | State ZIP Code |
| Mailing Address (Only if it's different from above. You can give a P.O. Box.) | | | |
| City | | County | State ZIP Code |
| Email Address | | | |

Enrollee Name _____
 Agent Name / ID No. _____
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To select paperless delivery complete and sign the application and provide your email address.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

If you would rather have hard copies of required materials mailed to you, please check here

- Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Information about your Medicare.

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card. Name (as it appears on your Medicare card): _____

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. Medicare Number: _____ Sex: _____

Is Entitled to _____ Effective Date _____

Hospital (Part A) MM-DD-YYYY

Medical (Part B) MM-DD-YYYY

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

If your plan has a premium how do you want to pay?

If you have a monthly plan premium (including any late enrollment penalty you may owe), you can choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT) or by mail.

If you need to pay a late enrollment penalty (LEP), please choose how you want to pay it.

If you don't choose an option, we'll send a bill each month to your mailing address.

- I want to pay from my Social Security or Railroad Retirement Board (RRB) check.**

I get monthly benefits from: Social Security RRB

We'll set it up. It may take a few months before payment starts, so the first payment may include more than one premium. In most cases, if Social Security or RRB accepts your request

Enrollee Name _____

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for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction or there is a delay in setup, we will send you a paper bill for your monthly premiums.

I want to pay directly from a bank account.

- Please attach a blank check from the account you'd like to use. Write "VOID" across the front. Please DO NOT send a deposit slip or money order.
- Please read the statement below.

The bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). The bank will pay the funds from a checking or savings account on or about the fifth of each month. The charges may include up to \$200 of current retroactive charges plus the monthly premium amount. If I choose to stop paying directly from the account, I will tell both UHIC and the bank. I will give them a reasonable amount of time to change the method of payment.

Account Type **Checking** **Savings**

Account Holder Name: _____

Bank Routing Number

Bank Account Number

Signature _____

Date **MM-DD-YYYY**

I want to pay by mail.

We'll send a bill to your mailing address each month.

If you want to pay by credit card.

After you become a member, you can call us to have your monthly payment automatically charged to a Visa, Mastercard or Discover credit card. Until then, we'll send you a bill each month.

Enrollee Name _____

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A few notes about your costs.

If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)

Social Security (SS) will send you a letter and ask you how you want to pay it:

- You can pay it from your SS check
- Medicare can bill you
- The Railroad Retirement Board (RRB) can bill you

Please DO NOT pay the plan the Part D-IRMAA at this time.

Need help with your prescription drug costs?

If you have a limited income, you may be able to get Extra Help with your prescription drug costs. If you qualify, Medicare could pay for 75% or more of your costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, you won't have a coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. 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 part of your premium, we will bill you for the amount that Medicare doesn't cover.

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.

A few questions to help us manage your plan.

1. Would you prefer plan information in another language or an accessible format? Yes No

Please check what you'd like: Spanish Other _____

If you don't see the language or format you want, please call us toll-free at 1-855-545-9340, TTY 711 during 8 a.m. - 8 p.m. local time, 7 days a week. Or visit www.UHCCCommunityPlan.com for online help.

2. Do you have end stage renal disease? Yes No

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, 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 Number _____

3. Are you enrolled in your State Medicaid program? Yes No

If yes, please give us your Medicaid number: _____

Enrollee Name _____

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4. Do you live in a nursing home or a long-term care facility?

Yes No

If yes, please give us information on the long-term care facility:

| | | | |
|------------------------------|--|-------|----------|
| Name | | | |
| Address | City | State | ZIP Code |
| Phone Number () - | Date You Moved There MM-DD-YYYY | | |

5. Do you have health insurance with an employer or union right now?

Yes No

If yes, you could lose that plan if you join this plan. Please talk to your employer or union. Ask how joining this plan could affect your current plan. You may also want to check your employer or union’s website, or read any information sent to you. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

6. Do you or your spouse work?

Yes No

Do you or your spouse have other health insurance that will cover medical services?

(Examples: Other employer group coverage, LTD coverage, Workman’s Compensation, Auto Liability, or Veterans benefits)

Yes No

If yes, please complete the following:

| | |
|----------------------------------|---|
| Name of Health Insurance Company | |
| Subscriber Name | Group Number |
| Member Number | Effective Dates (if applicable) MM-DD-YYYY - MM-DD-YYYY |

7. Do you have other insurance that will cover your prescription drugs?

Yes No

(Examples: Other private insurance, TRICARE, Federal employee coverage, VA benefits, or state programs.)

If yes, what is it?

| | | |
|-------------------------|--------------|--|
| Name of Other Insurance | | |
| Member Number | Group Number | Date Plan Started MM-DD-YYYY |

Enrollee Name _____

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8. Please give us the name of your primary care provider (PCP), clinic or health center.

You can find a list on the plan website or in the Provider Directory.

| | |
|---|--|
| Provider or PCP Full Name | Phone Number () - |
| Provider/PCP Number: ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ | (Please enter the number exactly as it appears on the website or in the Provider Directory. It will be 10 to 12 digits. Don't include dashes.) |
| Are you now seeing or have you recently seen this doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Please read and sign.

By completing this form, I agree to the following:

- This is a Medicare Advantage plan. It has a contract with the federal government. This is not a Medicare Supplement plan.
- I need to keep my Medicare Parts A and B. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- I can only be in one Medicare health plan or Prescription Drug plan at a time. If I'm a member of another Medicare health plan or Prescription Drug plan and I join this plan, I will lose the other plan.
- If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan.
- I may have to pay a late enrollment penalty (LEP). This would only happen if I didn't sign up for and keep creditable prescription drug coverage when I first qualified for Medicare. "Creditable" means the coverage is as good as a Medicare prescription drug plan. If I need to pay a LEP, the plan will tell me.
- I understand that I am joining the plan for the entire calendar year. If I want to change plans, I'll need to do so during the Annual Enrollment Period for Medicare Advantage AND Medicare prescription drug coverage between October 15 and December 7. There may be special situations that would allow me to leave the plan at other times.
- This plan covers a specific area. If I plan to move out of the area, I will call my plan to switch to a plan in the new area. Medicare may not cover me when I'm out of the country. However, I have some limited coverage near the U.S. border.
- I will receive information on how to get an Evidence of Coverage. (The EOC is also known as a member contract or subscriber agreement.) The EOC will list services the plan covers, as well as the plan's terms and conditions. The plan will cover services it approves, as well as services listed in the EOC. If a service isn't listed in the EOC or approved by the plan, Medicare and the plan won't pay for it. If I disagree with how the plan covers my care, I have the right to make an appeal.
- I understand that beginning on the date the plan coverage begins, using network services can cost less than using services out-of-network, except for emergency or urgently needed services

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or out-of-area dialysis services. If I happen to pay full price for any network or out-of-network services received, this plan provides refunds for all medically necessary covered benefits.

- If I currently have Medicare Supplement Insurance (Medigap), I will cancel it in writing. I, not my agent, must cancel. I will cancel after my new plan tells me I've been accepted into the plan.
- My plan will give my information to Medicare and other plans when needed for treatment, payment and health care operations. This may include my prescription drug information. Medicare uses the information to understand how my care was handled or billed. Other plans may need my information when they help pay for my care. Medicare may also give my information for research and other purposes. All federal laws and rules protecting my privacy will be followed.
- If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help.
- The information on this form is correct, to the best of my knowledge. I understand that if I put information on this form that I know is not true, I will lose the plan.

When I sign below, it means that I have read and understand the information on this form.

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (Power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and you have received your member ID card, please call Customer Service at the number on the back of your member ID card to update your authorization information on file.

Signature of Applicant/Member/Authorized Representative Today's Date **MM-DD-YYYY**

If you are the authorized representative, please sign above and complete the information below.

*** NOT A SALES AGENT**

| | | |
|----------------------------------|---------------------------|----------|
| Last Name | First Name | |
| Address | | |
| City | State | ZIP Code |
| Phone Number () - | Relationship to Applicant | |

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For licensed sales representative/agency use only.

New Member Employer Group Name
 Plan Change

Employer Group ID

Branch ID

Licensed Sales Representative/Writing ID
 @AGENTID@

Initial Receipt Date
 MM-DD-YYYY

Licensed Sales Representative/Agent Name
 @AGENTFULLNAME@

Proposed Effective Date
 MM-DD-YYYY

Licensed Sales Representative Phone Number @AGENTPHONE@

Where did this application originate?

- National Retail/Mall Program Community Meeting Appointment Other
 Member Meeting Local Event Outreach Walmart Program

How was this application submitted? Mail Fax Online

Agent must complete

- IEP (MA-PD enrollees) ICEP (MA enrollees) IEP (MA-PD enrollees eligible for 2nd IEP) OEP (Jan1 - Mar 31)
 OEP (newly eligible) SEP (Dual LIS change of status) SEP (change in residence) SEP (loss of EGHP coverage)
 SEP (Chronic) SEP (Dual LIS maintaining) AEP (October 15-December 7) OEPI

SEP (SEP Reason) _____
 SEP Eligibility Date MM-DD-YYYY

Licensed Sales Representative Signature (required)

Date: MM-DD-YYYY

Please mail or fax this completed form to:

UnitedHealthcare
 P.O. Box 30770
 Salt Lake City, UT 84130-0770

Fax: 1-888-950-1170

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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 contract with the State Medicaid Program. 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 1-855-814-6894 (TTY: 711). 注意：如果您說中文，您可以免費獲得語言援助服務。請致電 1-855-814-6894 (聽力語言殘障服務專線 TTY : 711).

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