

# 2024 Enrollment Request Form

☐ UHC Dual Complete ME-S003 (PPO D-SNP) H0271-065-000 - BAR

Information about y	ou (Please	e type or print in	black or blue	e ink)	
Last name		First name			Middle initial
Birth date		Sex □ Male □ Female			
Home phone number ( ) -		Mobile phone number ( ) -			
Social Security number (Required for people wh	io are enrol	lling in D-SNP pl	ans):	-	-
Medicare number					
Permanent residence st	reet addres	ss (P.O. box is n	ot allowed)		
City	Co	County State		State	ZIP code
Mailing address (Only if	it's differe	ent from above.	You can giv	e a P.O. k	oox.)
City				State	ZIP code
Email address (optional)	)				
Do you have other insur	ance that	will cover your p	prescription	drugs?	☐ Yes ☐ No
(Examples: Other private programs.) If yes, what is it?	insurance,	TRICARE, feder	ral employee	coverage	e, VA benefits or state
Name of other insurance	<del></del>				
Member number	Gr	oup number	R	xBin	RxPCN (optional)
Answering these question them out.	ns is your c	choice. You can't	t be denied o	coverage l	pecause you don't fill
Enrollee name					
Agent name/ID number _ Y0066_ERFMA_2024_C					CSME24LP0133626_

### How do you want to pay?

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

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

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			
☐ I want to pay from my Social Security check			
☐ I want to pay from my Railroad Retirement Board (RRB) check			
☐ I want to pay directly from a bank account			
Account type □ Checking □ Savings Account holder name:			
Bank routing number/////			
Bank account number//////			
A few questions to help us manage your plan			
1. Would you prefer plan information in another language or an accessi	<b>ble format?</b> □ Yes □ No		
Please check what you'd like: ☐ Spanish ☐ Braille ☐ Other			
If you don't see the language or format you want, please call us toll-free a 711, 8 a.m8 p.m. local time, 7 days a week. Or visit UHC.com/Medicar	•		
2.Are you enrolled in your state Medicaid program?	☐ Yes ☐ No		
If yes, please give us your Medicaid number:			
Enrollee name			
Agent name/ID number	00145041 00400000 000		
Y0066_ERFMA_2024_C	CSME24LP0133626_000		

3. Are you Hispanic, Latino/a, or Spanish origin				
No, not of Hispanic, Latino/a, or Spanis				
Yes, Mexican, Mexican American, or Ch	nicano/a			
Yes, Puerto Rican				
Yes, Cuban				
Yes, another Hispanic, Latino, or Spanish origin				
I choose not to answer				
4. What's your race? Select all that apply.				
White Black o	or African American			
American Indian or Alaska Native				
Asian Indian Chinese	e Filipino			
Japanese Korean	Vietnamese			
Other Asian Native	Hawaiian Samoan			
Guamanian or Chamorro Other F	Pacific Islander			
I choose not to answer				
Member/Citizen of a federal or state red	cognized Tribe (name of Tribe)			
5. Do you or your spouse work?	☐ Yes ☐ No			
Do you or your spouse have other health insura	ince that will cover medical services?			
(Examples: Other employer group coverage, LT				
auto liability, or Veterans benefits)	☐ Yes ☐ No			
If yes, please complete the following:				
Name of health insurance company				
Member number				
6. Please give us the name of your primary care	e provider (PCP), clinic or health center.			
	y doctor who accepts Medicare and the plan's payment			
terms.	, acctor with accepte meanage and the plane payment			
You can find a list on the plan website or in the	Provider Directory.			
Provider or PCP full name				
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 to	his provider?			
Enrollee name				
Agent name/ID number				
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# Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

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.

□ 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.  Please read and sign  By completing this form, I agree to the following:  □ I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.  □ I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information.  □ I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.  □ I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private-Fee-For-Service (PFFS), MA Medicare Medical Savings Account (MSA) plans).  □ Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).  □ I give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permission to share my protected health information with organizations or person(s) for permission to share my protected	If you would rather have hard copies of required materials mailed to you, please check here:
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Y0066 ERFMA 2024 C

<ul> <li>The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan.</li> <li>My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.</li> </ul>			
When I sign below, it means that I have read and	understand the informat	ion 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 I have received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file.			
Signature of applicant/member/authorized repre	semanive Today's date	•	
If you are the authorized representative, information below	please sign above an	d complete the	
*Not a Sales Agent			
Last name	First name		
Address			
City	State	ZIP code	
Phone number ( ) –	Relationship to applicant		
Enrollee name			

For Licensed Sales Representative/agency use only					
Licensed Sales Representative/writing ID				Initial receipt date	
Licensed Sales Representative/agent name			Proposed effective date		
Employer group name					
Employer group ID		Branch II			
Agent must complete					
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PD enrollees eligi 2nd IEP)		☐ OEP (Jan 1 – Mar 31)	
☐ OEP (Newly eligible)	☐ SEP (Dual LIS change of status)	☐ SEP (Chang		☐ SEP (Loss of EGHP coverage)	
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)	☐ AEP (Octob December 7)	er 15-	□ OEPI	
☐ SEP (SEP reason)					
Licensed Sales Representative signature (optional)  Date					

## Please mail or fax this completed form to:

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

Fax: 1-888-950-1170

Fax the front and back of each page

Enrollee name	
Agent name/ID number	

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

UHC Dual Complete ME-S003 (PPO D-SNP) is 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.

This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

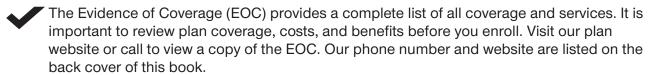
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

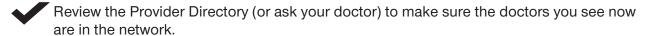
OMB No. 0938-1378 Expires: 7/31/2024 Y0066 ERFMA 2024 C

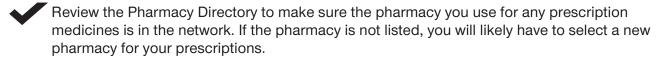
# **Enrollment checklist**

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

#### **Understanding the benefits**







Review the Formulary to make sure your drugs are covered.

#### **Understanding important rules**

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medicaid or another third party. This premium is normally taken out of your Social Security check each month.
- Benefits may change on January 1 of each year.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care.
- Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- This plan is a Dual Eligible Special Needs Plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.