Enrollment Request Form

Please Read This Important Information

If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage through your Medicare Advantage plan that will meet your needs. By joining UnitedHealthcare® MedicareRx for Groups (PDP), your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan and your Plan Sponsor send you, and if you have questions, contact your Medicare Advantage plan or your Plan Sponsor.

UnitedHealthcare MedicareRx for Groups is a Medicare Prescription Drug Plan available through your Plan Sponsor. If you enroll in an individual Prescription Drug Plan in the future, you could lose your group-sponsored coverage and you may not be able to re-enroll. Before you decide to change your coverage, ask your Plan Sponsor about your options.

UnitedHealthcare®

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UnitedHealthcare®

Required Information

Plan Sponsor Name:
GPS Employer ID:
GPS Branch #:

I prefer to receive materials in the following language: ☐ Spanish ☐ Chinese (Spoken: ☐ Cantonese ☐ Mandarin) ☐ Other _____ Please contact us at 1-888-556-6648, 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.

Complete one form per person. Must be received prior to Effective Date Requested.

To Enroll in the UnitedHealthcare MedicareRx for Groups Plan, Please Provide the Following:

Last Name:	First Name:	Middle Initial:	Effective Date Requested:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: __ __/__ __/__ __ __ __ (M M/ D D/ Y Y Y Y)	Sex: ☐ M ☐ F	Home Telephone Number: (_ _ _) _ _ _ - _ _ _ _		
Permanent Residence Street Address (P.O. Box is not allowed):				
City:	State:	Zip Code:		
Mailing Address (only if different from your Permanent Residence Address): Street Address:	City:	State:	Zip Code:	
Emergency Contact: Contact Telephone Number:	Relationship to You:			
E-mail Address:				

In the future, would you be willing to receive materials through electronic means? ☐ Yes ☐ No

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section. • Please fill in these blanks so they match your red, white and blue Medicare card **— 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 Prescription Drug Plan. An incorrect or incomplete Medicare Claim Number may cause a delay or denial of coverage.	Name: _____ Medicare Claim Number: Sex:_____ ___ ___ ___ . ___ ___ . ___ ___ ___ ___ _____ Is Entitled To: Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____

Last Name First Name Medicare Claim Number

Please Answer the Following Questions:

1. 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 UnitedHealthcare MedicareRx for Groups?
   ☐ Yes ☐ No

   If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	ID # for this coverage:	Group # for this coverage:

2. Do you, on your own or through your spouse, have any additional primary, supplemental or liability plan other than Medicare that includes prescription drug coverage? ..... ☐ Yes ☐ No

3. Are you a resident in a long-term care facility, such as a nursing home? ..... ☐ Yes ☐ No

   If "Yes," please provide the following information:

   Name of Facility: _____ Phone Number: _____

   Address of Institution (number and street): _____

Please Read Below:

By completing this enrollment application, I agree to the following: UnitedHealthcare MedicareRx for Groups is a Medicare Prescription Drug Plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform UnitedHealthcare MedicareRx for Groups of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug Plan at a time — if I am currently in a Medicare Prescription Drug Plan, my enrollment in UnitedHealthcare MedicareRx for Groups plan will end that enrollment. Enrollment in this Plan is generally for the entire year. Once I enroll, I may leave this Plan only at certain times of the year, or under certain special circumstances, by sending a request to UnitedHealthcare MedicareRx for Groups or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

UnitedHealthcare MedicareRx for Groups serves a specific service area. If I move out of the area that UnitedHealthcare MedicareRx for Groups serves, I need to notify the Plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies in order for benefits to be payable, except in an emergency when I cannot reasonably use the Plan network pharmacies. Once I am a member of UnitedHealthcare MedicareRx for Groups, I have the right to appeal Plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from UnitedHealthcare MedicareRx for Groups when I get it to know which rules I must follow to get coverage.

I understand that if I leave this Plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a Late Enrollment Penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with UnitedHealthcare MedicareRx for Groups, he/she may be paid based on my enrollment in the Plan. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a 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.

Last Name First Name Medicare Claim Number

Please Read and Sign Below:

Release of Information: The information on this enrollment 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. I understand that my signature (or the signature of the person authorized to act on my behalf under the state law where I live) on this application means that I have read and understand the contents of this application.

You must sign and date this Enrollment Request Form in order for it to be processed.

Applicant or Authorized Representative Signature (if Signature of Authorized Representative, please complete box below)	Today's Date:	Signature

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.

Name: _____ Date: _____

Signature: _____ Telephone #: _____

Address: _____ City: _____ State: ____ Zip code: _____

Relationship to Enrollee: _____

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:	Relationship to Applicant:
_____ ☐ Plan Representative, check here if you signed above and assisted in completing this form.		

UnitedHealthcare MedicareRx for Groups Use Only

Plan ID #: _____

Effective Date of Coverage: _____ IEP: _____ AEP: ____ SEP (type): _____

GPS Employer ID #: _____ GPS Branch #: _____

Plan Representative/Agent/Broker Signature: _____

Print Name: _____ Agent ID# _____ Telephone Number: _____

Employer Use Only

☐ Enrollee is eligible for retiree coverage.	Effective Date:	Initials:

Please Open To Continue Completing Form

Questions?

If reply envelope is missing mail this form to:
UnitedHealthcare
P.O. Box 29200
Hot Springs, AR 71903-9200

Duplicate of Form

For Your Records

Duplicate of Form

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