UnitedHealthcare®
Community Plan

2015
Individual Enrollment Request Form

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Please contact the Plan if you need information in another language or format (Braille).

UnitedHealthcare Dual Complete™

1. To Enroll in UHC Community Plan, Please Provide the Following Information:

UnitedHealthcare Dual Complete (HMO SNP) H0251-002 - 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
Primary Phone Number ( ) -	Alternate Phone Number ( ) -

Social Security Number
- -

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

City	County	State	Zip Code

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

City	State	Zip Code

E-mail Address. Please email me plan information and updates.

Enrollee Name:_____

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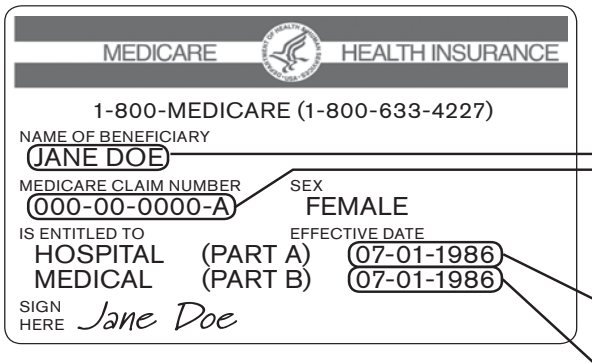
3. Please Provide Your Medicare Insurance Information

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. Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail (we will provide you a monthly statement) or Electronic Funds Transfer (EFT) each month. 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, 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 the Plan 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, it is recommended you choose the EFT option or receive a monthly statement 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. If you would like to set up EFT, please enclose a blank check with **VOID** written on the front.

Enrollee Name:_____

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Please Select a Premium Payment Option:

☐ **Monthly Statement**

☐ **Electronic Funds Transfer (EFT)** from your bank account each month. Please enclose a blank check with **VOID** written on the front or provide the following:

Account holder name: _____

Bank routing number: _ _ _ _ _ _ _ _ _

Bank account number: _ _ _ _ _ _ _ _ _ _

Account type: ☐ Checking ☐ Saving

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) 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 or RRB accepts your request 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, we will send you a monthly statement for your monthly premiums.)

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 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 ID _____

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 the plan?
☐ **Yes** ☐ **No**
Name of other coverage _____

If **"yes,"** 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 _____ - _____

Enrollee Name: _____

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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 number: _____

Do you or your spouse work? ☐ Yes ☐ No

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 on the website or directory. Include zeros, but not dashes. (For a 10- digit ID, leave the last box blank.)
Provider/PCP ID __ __ __ __ __ __ __ __ __ __ __

Provider/PCP Phone Number (_____) _____ - _____
Are you now seeing or have you recently seen this doctor? □ **Yes** □ **No**

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 the Plan 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, or visit us online at www.UHCCommunityPlan.com.

Please Read This Important Information.

If I have health coverage from an employer or union right now, I could lose my employer or union health coverage if I join this plan. I will read the communications my employer or union sends me and if I have questions, I will visit their website or I will call my benefits administrator or the office who answers questions about my employer or union coverage.

I chose a plan designed for people with both Medicare and Medicaid. If my Medicaid status cannot be verified, the Plan may contact me to obtain proof. If the Plan can't get proof within the allotted time, I will not be enrolled in this plan.

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Enrollee Name:_____

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8. Please Read and Sign Below.

By completing this enrollment request form, 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 Parts A and B, and I must continue to pay my Medicare Part B premium if I have one, if not otherwise paid for by Medicaid or another third party. One thing I need to know is that I can only be in one Medicare Advantage or Prescription Drug plan at a time. My enrollment in this plan will automatically end my enrollment in another Medicare Advantage or Prescription Drug plan. If I have prescription drug coverage, or if I get prescription drug coverage, from somewhere other than this plan, I will inform you. I may have to pay a late enrollment penalty for Medicare's prescription drug coverage. This would only apply if I did not sign up for and maintain creditable prescription drug coverage when I first became eligible for Medicare. If I have a late enrollment penalty from Medicare, I will receive a letter making me aware of the penalty and what the next steps are.

Enrollment in this plan is generally for the entire calendar year. I can leave or change this plan only during the Annual Election Period (Example: October 15th through December 7th of each year), or under special circumstances.

This plan covers a specific service area. If I plan to move out of the area, I will call my Plan to Disenroll and find a new plan in my new area. I may not be covered under Medicare while out of the country, with the exception of limited coverage near the U.S. border.

Upon enrollment, I will receive a Welcome Guide that includes an Evidence of Coverage document. The Evidence of Coverage will have more information about services covered by the plan, as well as the terms and conditions. If a service is not listed in the Evidence of Coverage, or it is not authorized, it will not be paid for by Medicare or the Plan. I have the right to appeal plan decisions about payment or services if I do not agree.

I understand that beginning on the date my plan coverage begins, I must get all of my health care from the Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by the plan and other services contained in my plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE PLAN WILL PAY FOR THE SERVICES.**

If I currently have a Medicare Supplement Insurance (Medigap) policy, I need to cancel my policy in writing. I understand that I (not my agent) need to send my cancellation request to my Medicare Supplement Insurance plan after I receive enrollment confirmation from my new plan.

My information including my prescription drug event data will be released to Medicare and other plans, only as necessary, for treatment, payment and healthcare operations. Medicare may also release my information for research and other purposes which follow all applicable Federal statutes and regulations.

I understand that if I receive assistance from a sales agent or broker, or other individual employed by or contracted with the plan, they may receive compensation based on my enrollment in this plan. My signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the information on 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.

Enrollee Name:_____

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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.

Medicare evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change from one year to the next. Star ratings for all plans can be found on Medicare.gov.

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

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		

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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 ☐ Member Meeting ☐ Local Event Outreach	☐ Community Meeting ☐ Local B2B Outreach ☐ Other
How was this application submitted?	☐ Appointment ☐ Other	☐ Mail in

Licensed Sales Representative/Writing 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 ( ) -	

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Enrollee Name:_____

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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) ☐ SEP (Partial Dual Eligible)

☐ SEP (SEP Reason) _____

☐ SEP Eligibility Date _____ / _____ / _____
M M / D D / Y Y Y Y

Licensed Sales Agent Signature (required)

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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.

Please contact the Plan 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, or visit us online at www.UHCCommunityPlan.com.

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. a 8 p.m. hora local, los 7 días de la semana.

本資訊免費提供其他語言版本。請聯絡我們的客戶服務部，電話 1-888-834-3721，聽力語言殘障服務專線711。10 月1 日至2 月14 日間，每週7 天，當地時間上午8 時至下午8 時間提供服務。2 月15 日至9 月30 日間，週一至週五，當地時間上午8 時至下午8 時間提供服務。

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