2012 Individual Enrollment Form

When you are ready to enroll

Contact your local sales agent to help you choose the best plan for you and complete this individual enrollment form, **or**

Call a UnitedHealthcare® sales agent who can help you enroll over the phone. Toll-free: **1-888-565-8202,** TTY **711,** 8 a.m. – 8 p.m. local time, 7 days a week.

Note: If you do not have an agent helping you enroll, please complete the enrollment form, sign and date it, and send the enrollment copy to: UnitedHealthcare, Enrollment Department, 1001 Brinton Road Pittsburgh, PA 15221.

I understand the person who is discussing plan options with me is a sales agent, broker or other person employed by or contracted with UnitedHealthcare Services, Inc. The person may be paid based on my enrollment in a plan.

If you currently have health coverage through an employer or union, joining one of our plans could affect your employer or union health benefits. You could lose your employer or union health coverage if you join our plan. Read the communications your employer or union sends you. If you have questions, visit their website or contact their office. If you can't find any contact information, your benefits administrator or the office that answers questions about your coverage can help.

Turn the page to enroll.

UnitedHealthcare®

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2012 Individual Enrollment Form

Please contact UnitedHealthcare® if you need information in another language or format (audio tape).

For sales representative/agency use only

☐ New Member ☐ Plan Change	Employer Group ID Number	Branch ID

Where did this application originate from? ☐ 1. Retail/Mall Program ☐ 2. Community Meeting ☐ 3. Member Meeting ☐ 4. Local B2B Outreach ☐ 5. Local Event Outreach ☐ 6. Other

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

1. Applicant information (please type or print in black or blue ink)

Last Name	First Name	Middle Initial
Birth Date ____ / ____ / ____	Gender ☐ Male ☐ Female	☐ Mr. ☐ Mrs. ☐ Ms.

Home Telephone Number ( )	Alternate Phone Number (optional) ( )

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

City	State	ZIP Code	County

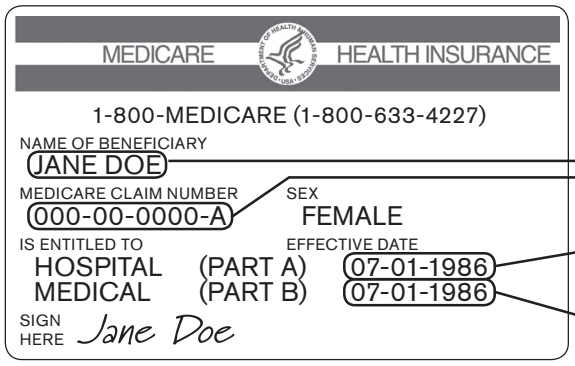
Mailing Address (only if different from your Permanent Residence Street Address)

City	State	ZIP Code

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

2. 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 appears on Medicare Card)

___ ___ ___ – ___ ___ – ___ ___ ___ ___ – ___

Medicare Claim Number Letter(s)

Part A (Hospital) effective date ____ / ____ / ____

Part B (Medical) effective date ____ / ____ / ____

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

Enrollee's name _____

Proposed effective date ____ / ____ / ____

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3. Your payment options (if applicable)

If we determine that you owe a late-enrollment penalty (or if you currently have a late-enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT), pay with a credit card each month or we will provide you a coupon book. 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 the RRB. DO NOT pay UnitedHealthcare® 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 coupon book or EFT option.

(If you do not select a payment option, you will receive a coupon book 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.)

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

☐ **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 paper bill for your monthly premiums).*

☐ **Electronic Funds Transfer (EFT)** from your bank account each month.
Enclose a **voided** check or provide the following:
Account Holder Name _____ Bank Routing Number_____
Bank Account Number _____ Account Type ☐ Checking ☐ Savings

☐ **Coupon Book**

☐ **Credit Card** Please provide the following information:
Type of Card: _____
Account Holder Name (as it appears on card): _____
Account number: _____
Expiration Date: ____/_____ (MM/YYYY) _____/_____

4. Benefit plan selections (choose only one)

Health Maintenance Organization (HMO) plans with a medical and Part D drug benefit
☐ UnitedHealthcare® MedicareComplete® (HMO)

Enrollee's name _____
Proposed effective date ____ / ____ / ____

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4a. Complete the following if the plan chosen includes routine dental coverage

Name of dental provider _____ Provider ID# (please refer to Provider Directory) _____
Are you currently a patient of this dentist? ☐ Yes ☐ No

4b. Optional supplemental benefit plans

These plans are not available in all service areas.
Please review the Summary of Benefits to confirm availability and to learn about any applicable premiums.
If available, you can choose the dental plan below.
☐ Dental Platinum Rider **You do not need to select a Dental Facility for these plans.**

5. Primary Care Physician (PCP), Clinic or Health Center Selection (This section required for most plans.)

Refer to the plan website or Provider Directory for selection.
PCP Full Name _____
Enter the 10 or 11 numeric 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

6. 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
If "yes," 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 Plan name of other coverage _____
Member ID# for this coverage _____
Group ID# _____ Effective Date (optional) _____

Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)? ☐ Yes ☐ No
If "yes," name of institution _____
Address of institution _____
City, State, ZIP Code _____
Phone number of institution (_____) _____ Date of admission to the institution ____ /____ /____

Are you enrolled in your state Medicaid program? ☐ Yes ☐ No
If "yes," please provide your Medicaid ID number _____

Do you or your spouse work? ☐ 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 have other health insurance, what kind do you have? _____
What is the name of the health insurance? _____
Group # _____ ID# _____

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7. Alternative formats (check only one)

Please check one of the boxes if you would prefer us to send you information in a language other than English or in another format:

☐ Spanish ☐ Chinese
☐ Large Print (English Only)
☐ Other _____

Please contact UnitedHealthcare® at 1-888-565-8202 if you need information in another format or language than those listed above. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week. TTY users should call 711.

Statements of understanding

1. UnitedHealthcare® MedicareComplete® (HMO) is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. For MA Only Plans, I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late-enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.
2. UnitedHealthcare® MedicareComplete® (HMO) serves a specific service area. If I move out of the area that UnitedHealthcare® MedicareComplete® (HMO) serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of UnitedHealthcare® MedicareComplete® (HMO), 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® MedicareComplete® (HMO) when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.
3. By joining this Medicare health plan, I acknowledge that UnitedHealthcare® MedicareComplete® (HMO) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that UnitedHealthcare® MedicareComplete® (HMO) will release my information including my prescription drug event data to Medicare, who may release it 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 my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Enrollee's name _____
Proposed effective date ____ / ____ / ____

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Statements of understanding (cont.)

4. I understand that if I previously had prescription drug coverage or any insurance that included drugs, I may be asked for proof that my previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). I can send copies of my proof with this form or I can wait until I am asked for it. I don't have to send proof to enroll. However, if I am asked for my proof and I don't provide it, my premium may be increased because of a late-enrollment penalty. For more information about the late-enrollment penalty, I may visit www.medicare.gov or 1-800-MEDICARE (1-800-633-4227); (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.
5. Counseling services may be available in my state to provide advice concerning Medicare Supplement Insurance or other Medicare Advantage or Prescription Drug Plan options as well as medical assistance through the state Medicaid Program and the Medicare Savings Program.

Additional statements of understanding for each specific plan

UnitedHealthcare® MedicareComplete® (HMO)
I understand that beginning on the date UnitedHealthcare® MedicareComplete® plan coverage begins, I must receive all covered benefits from plan contracted providers and pharmacies, except for emergency or urgently needed services or out-of-area renal dialysis. I understand that authorized services and other services contained in my Evidence of Coverage document will be covered as disclosed. If I do not receive prior authorization as required for covered services, I understand that **neither Medicare nor UnitedHealthcare® will pay for services.**

Fraud warning: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Enrollment Form or files a claim containing a false or a deceptive statement, has committed insurance fraud. Commission of insurance fraud may result in disenrollment or denial of benefits and may subject the individual to civil or criminal liability.

Enrollee's name _____
Proposed effective date ____ / ____ / ____

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8. Please read this important information

I understand that 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 Enrollment Form means that I have read, understand and agree to the contents of this Enrollment Form, Statements of Understanding and the Additional Statement of Understanding (for the plan I have chosen) on this form.

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

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 from Medicare.

Signature of applicant/member/authorized representative	Today's Date _____/_____/_____

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

Name			Relationship to applicant
Address			Telephone Number ( )
City	State	ZIP Code	Alternate Phone Number (optional) ( )

9. For sales representative/agency use only

Selling Staff Member/Agent ID	Initial Receipt Date
Selling Staff Member/Agent Name	Proposed Effective Date
Agent Telephone Number	Did the agent assist in completing the application? ☐ Yes ☐ No
Agent Signature (required)	

10. Election period

☐ AEP
☐ ICEP
☐ IEP (MA or MA-PD enrollees)
☐ IEP (MA-PD enrollees eligible for 2nd IEP)
☐ OEPI
☐ SEP (SEP Reason Code_____)

Enrollee's name _____
Proposed effective date ____ / ____ / ____

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UnitedHealthcare®

Receipt

Important Enrollment Information

Application Date _____

Proposed Effective Date _____

Medicare ID _____

Plan Name _____

Health Plan/PBP Number _____

Sales Agent ID _____

Sales Agent Name _____

Sales Agent Phone Number _____

This copy verifies you met with an agent who sells UnitedHealthcare® Products. Once UnitedHealthcare® receives the Enrollment Form, you will receive a copy of your original Enrollment Form in the mail within two weeks. This copy is for your records only. **Please do not resubmit.**

Please contact your sales agent if you do not receive a copy of your original Enrollment Form in the mail within two weeks.

Talk to your local sales agent for answers or to enroll.

If you do not have a local sales agent, please call **1-888-565-8202,** TTY **711,** 8 a.m. – 8 p.m. local time, 7 days a week.

Visit our website at: **www.UHCCommunityPlan.com**

Visit our website at:
www.UHCCommunityPlan.com

A UnitedHealthcare® Medicare Solution

This information is available for free in other languages. Please contact our UnitedHealthcare® Customer Service number at 1-888-565-8202, TTY/TDD: 711, 8 a.m. to 8 p.m. local time, 7 days a week, for additional information.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente de UnitedHealthcare® al número 1-888-565-8202, TTY/TDD: 711, de 8 a.m. a 8 p.m. hora local, los 7 días de la semana, para obtener más información.

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2012 Individual Enrollment Form

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I understand the person who is discussing plan options with me is a sales agent, broker or other person employed by or contracted with UnitedHealthcare Services, Inc. The person may be paid based on my enrollment in a plan.

If you currently have health coverage through an employer or union, joining one of our plans could affect your employer or union health benefits. You could lose your employer or union health coverage if you join our plan. Read the communications your employer or union sends you. If you have questions, visit their website or contact their office. If you can't find any contact information, your benefits administrator or the office that answers questions about your coverage can help.

Turn the page to enroll.

UnitedHealthcare®

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2012 Individual Enrollment Form

Please contact UnitedHealthcare® if you need information in another language or format (audio tape).

For sales representative/agency use only

☐ New Member ☐ Plan Change	Employer Group ID Number	Branch ID

Where did this application originate from? ☐ 1. Retail/Mall Program ☐ 2. Community Meeting ☐ 3. Member Meeting ☐ 4. Local B2B Outreach ☐ 5. Local Event Outreach ☐ 6. Other

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

1. Applicant information (please type or print in black or blue ink)

Last Name	First Name	Middle Initial
Birth Date ____ / ____ / ____	Gender ☐ Male ☐ Female	☐ Mr. ☐ Mrs. ☐ Ms.

Home Telephone Number ( )	Alternate Phone Number (optional) ( )

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

City	State	ZIP Code	County

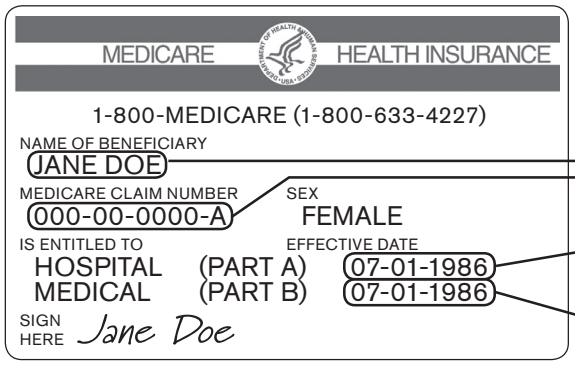
Mailing Address (only if different from your Permanent Residence Street Address)

City	State	ZIP Code

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

2. 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 appears on Medicare Card)

___ ___ ___ – ___ ___ – ___ ___ ___ ___ – ___
Medicare Claim Number Letter(s)

Part A (Hospital) effective date ____ / ____ / ____

Part B (Medical) effective date ____ / ____ / ____

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

Enrollee's name _____

Proposed effective date ____ / ____ / ____

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3. Your payment options (if applicable)

If we determine that you owe a late-enrollment penalty (or if you currently have a late-enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT), pay with a credit card each month or we will provide you a coupon book. 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 the RRB. DO NOT pay UnitedHealthcare® 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 coupon book or EFT option.

(If you do not select a payment option, you will receive a coupon book 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.)

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

☐ **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 paper bill for your monthly premiums).*

☐ **Electronic Funds Transfer (EFT)** from your bank account each month.
Enclose a **voided** check or provide the following:
Account Holder Name _____ Bank Routing Number_____
Bank Account Number _____ Account Type ☐ Checking ☐ Savings

☐ **Coupon Book**

☐ **Credit Card** Please provide the following information:
Type of Card: _____
Account Holder Name (as it appears on card): _____
Account number: _____
Expiration Date: ____/_____ (MM/YYYY) _____/_____

4. Benefit plan selections (choose only one)

Health Maintenance Organization (HMO) plans with a medical and Part D drug benefit
☐ UnitedHealthcare® MedicareComplete® (HMO)

Enrollee's name _____
Proposed effective date ____ / ____ / ____

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4a. Complete the following if the plan chosen includes routine dental coverage

Name of dental provider _____ Provider ID# (please refer to Provider Directory) _____
Are you currently a patient of this dentist? ☐ Yes ☐ No

4b. Optional supplemental benefit plans

These plans are not available in all service areas.
Please review the Summary of Benefits to confirm availability and to learn about any applicable premiums.
If available, you can choose the dental plan below.
☐ Dental Platinum Rider **You do not need to select a Dental Facility for these plans.**

5. Primary Care Physician (PCP), Clinic or Health Center Selection (This section required for most plans.)

Refer to the plan website or Provider Directory for selection.
PCP Full Name _____
Enter the 10 or 11 numeric 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

6. 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
If "yes," 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 Plan name of other coverage _____
Member ID# for this coverage _____
Group ID# _____ Effective Date (optional) _____

Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)? ☐ Yes ☐ No
If "yes," name of institution _____
Address of institution _____
City, State, ZIP Code _____
Phone number of institution (_____) _____ Date of admission to the institution ____ /____ /____

Are you enrolled in your state Medicaid program? ☐ Yes ☐ No
If "yes," please provide your Medicaid ID number _____

Do you or your spouse work? ☐ 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 have other health insurance, what kind do you have? _____
What is the name of the health insurance? _____
Group # _____ ID# _____

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7. Alternative formats (check only one)

Please check one of the boxes if you would prefer us to send you information in a language other than English or in another format:

☐ Spanish ☐ Chinese
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Enrollee's name _____
Proposed effective date ____ / ____ / ____

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Statements of understanding (cont.)

4. I understand that if I previously had prescription drug coverage or any insurance that included drugs, I may be asked for proof that my previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). I can send copies of my proof with this form or I can wait until I am asked for it. I don't have to send proof to enroll. However, if I am asked for my proof and I don't provide it, my premium may be increased because of a late-enrollment penalty. For more information about the late-enrollment penalty, I may visit www.medicare.gov or 1-800-MEDICARE (1-800-633-4227); (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.
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Enrollee's name _____
Proposed effective date ____ / ____ / ____

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8. Please read this important information

I understand that 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 Enrollment Form means that I have read, understand and agree to the contents of this Enrollment Form, Statements of Understanding and the Additional Statement of Understanding (for the plan I have chosen) on this form.

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

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 from Medicare.

Signature of applicant/member/authorized representative	Today's Date _____/_____/_____

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

Name			Relationship to applicant
Address			Telephone Number ( )
City	State	ZIP Code	Alternate Phone Number (optional) ( )

9. For sales representative/agency use only

Selling Staff Member/Agent ID	Initial Receipt Date
Selling Staff Member/Agent Name	Proposed Effective Date
Agent Telephone Number	Did the agent assist in completing the application? ☐ Yes ☐ No
Agent Signature (required)	

10. Election period

☐ AEP
☐ ICEP
☐ IEP (MA or MA-PD enrollees)
☐ IEP (MA-PD enrollees eligible for 2nd IEP)
☐ OEPI
☐ SEP (SEP Reason Code_____)

Enrollee's name _____
Proposed effective date ____ / ____ / ____

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UnitedHealthcare®

Receipt

Important Enrollment Information

Application Date _____

Proposed Effective Date _____

Medicare ID _____

Plan Name _____

Health Plan/PBP Number _____

Sales Agent ID _____

Sales Agent Name _____

Sales Agent Phone Number _____

This copy verifies you met with an agent who sells UnitedHealthcare® Products. Once UnitedHealthcare® receives the Enrollment Form, you will receive a copy of your original Enrollment Form in the mail within two weeks. This copy is for your records only. **Please do not resubmit.**

Please contact your sales agent if you do not receive a copy of your original Enrollment Form in the mail within two weeks.

Talk to your local sales agent for answers or to enroll.

If you do not have a local sales agent, please call **1-888-565-8202,** TTY **711,** 8 a.m. – 8 p.m. local time, 7 days a week.

Visit our website at: **www.UHCCommunityPlan.com**

Visit our website at:
www.UHCCommunityPlan.com

A UnitedHealthcare® Medicare Solution

This information is available for free in other languages. Please contact our UnitedHealthcare® Customer Service number at 1-888-565-8202, TTY/TDD: 711, 8 a.m. to 8 p.m. local time, 7 days a week, for additional information.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente de UnitedHealthcare® al número 1-888-565-8202, TTY/TDD: 711, de 8 a.m. a 8 p.m. hora local, los 7 días de la semana, para obtener más información.

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