

2024 Enrollment Request Form

 \square UHC Dual Complete IN-D001 (PPO D-SNP) H0271-054-000 - BNP

Information about yo	ou (Please	e type or print in	black or b	lue ink)	
Last name		First name			Middle initial
Birth date			Sex □ N	Male □ Fer	male
Home phone number () -		Mobile phone number () -			
Social Security number (Required for people who	are enrol	lling in D-SNP pla	ans):	_	-
Medicare number					
Permanent residence stre	et addres	ss (P.O. box is n	ot allowed	d)	
City	Co	ounty		State	ZIP code
Mailing address (Only if i	t's differe	ent from above.	You can g	jive a P.O. I	box.)
City				State	ZIP code
Email address (optional)					
Do you have other insura	nce that v	will cover your p	orescriptio	on drugs?	□ Yes □ No
(Examples: Other private in programs.) If yes, what is it?	nsurance,	TRICARE, feder	ral employ	ee coverage	e, VA benefits or state
Name of other insurance					-
Member number	Gr	oup number		RxBin	RxPCN (optional)
Answering these questions them out.	s is your c	choice. You can't	t be denied	d coverage l	because you don't fill
Enrollee name					
Agent name/ID number Y0066 ERFMA 2024 C					CSIN24LP0133615 00

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	
 Would you prefer plan information in another language or an accer Please check what you'd like: ☐ Spanish ☐ Braille ☐ Other 	
If you don't see the language or format you want, please call us toll-fi	
711, 8 a.m8 p.m. local time, 7 days a week. Or visit UHC.com/Med	
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	000000000000000000000000000000000000000
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3. Are you Hispanic, Latino/a, or Spanish origi	
No, not of Hispanic, Latino/a, or Spanis	
Yes, Mexican, Mexican American, or C	hicano/a
Yes, Puerto Rican	
Yes, Cuban	
Yes, another Hispanic, Latino, or Span	ish origin
I choose not to answer	
4. What's your race? Select all that apply.	
	or African American
American Indian or Alaska Native	of Afficati Afficiati
Asian Indian Chines	se Filipino
	•
·	
Guamanian or Chamorro Other I	Pacific Islander
I choose not to answer	as a visite of Table 2 (visite a)
Member/Citizen of a federal or state re	cognized Tribe (name of Tribe)
5. Do you or your spouse work?	
Do you or your spouse have other health insura	
(Examples: Other employer group coverage, L	·
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 car	re provider (PCP) clinic or health center
	ny doctor who accepts Medicare and the plan's payment
terms.	- Duraidan Dinastana
You can find a list on the plan website or in the	e 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	this provider? Li Yes Li No
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 permissible purposes under applicable law as required to administer my health plan. □ I give consent for all entities un	If you would rather have hard copies of required materials mailed to you, please check here:
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 The information on this form is correct to the b intentionally provide false information on this form is voluntary. However plan. 	orm I will be disenrolled fro	om the plan.
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 I show written proof (power of attorney, guardianship understand that I will need to submit written proof of behalf of the member beyond this application. After received my UnitedHealthcare UCard®, I can call CounitedHealthcare UCard to update my authorization	o, etc.) of this right if Medic of this right, to the plan, if I r this application has been ustomer Service at the nur n information on file.	care asks for it. I wish to take action on approved and I have mber on my
Signature of applicant/member/authorized repre	esentative 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/age	ncy use only	1		
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 (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS	☐ SEP (Chang residence) ☐ AEP (Octob		☐ SEP (Loss of EGHP coverage) ☐ OEPI	
,	maintaining)	December 7)			
SEP (SEP reason)					
Licensed Sales Repre	sentative signature (opt	ional)	Da	te	

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
Agent name/ID number _
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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 IN-D001 (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.

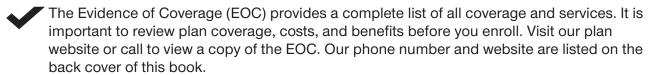
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

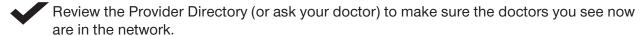
OMB No. 0938-1378 Expires: 7/31/2024 Y0066 ERFMA 2024 C

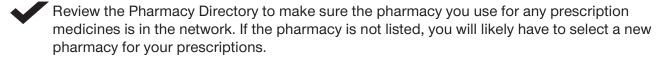
Enrollment checklist

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.