



## 2018 Enrollment Request Form

To enroll in the UnitedHealthcare® Group Medicare Advantage (PPO) plan, please provide the following:

### I prefer to receive materials in the following language:

- Spanish  
 Chinese (Spoken  Cantonese  Mandarin)  
 Other \_\_\_\_\_

Please contact us Toll-Free at **1-877-714-0178**, 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.

### 1. Plan information

Plan Sponsor: City of Hialeah

Group Number:

GPS Employer ID:

GPS Branch Number:

**Effective Date Requested:** MM/DD/YYYY  
(i.e., your proposed effective date, or on what day your coverage should begin)

Plan Sponsor use ONLY: Please date stamp this document to indicate when you received the completed and signed form.

Contracting Medical Group/Primary Care Physician (PCP) Name

Contracting Medical Group/Doctor Number

Are you currently a patient of this doctor?  Yes  No

### 2. Applicant information – as it appears on your Medicare card

(Please use black or blue ink.)

Mr.      Last Name      First Name      Middle Initial  
 Mrs.  
 Ms.

Birth Date

MM/DD/YYYY

Sex

- Male  
 Female

Home Telephone Number

(      )      -

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

City

State

ZIP Code

County

Mailing Address (only if different from your Permanent Street Address) (P.O. Box allowed for mailing only)

City

State

ZIP Code

Email Address

Emergency Contact

Contact Telephone Number  
(      )      -

Contact Relationship to You

### 3. Please provide your Medicare insurance information

Use 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.

You must have Medicare Part A and Part B to join a Medicare Advantage plan. An incorrect or incomplete Medicare Claim number may cause a delay or denial of coverage.

Medicare Claim Number

Part A (Hospital) Effective Date MM/DD/YYYY

Part B (Medical) Effective Date MM/DD/YYYY

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\_\_\_\_\_  
Last Name      First Name      Medicare Claim Number

**Please read and answer these important questions.**

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 \_\_\_\_\_

Telephone Number of Institution (      )      -      Date of Admission **MM/DD/YYYY**

**4. Medical information**

**Do you have End-Stage Renal Disease (ESRD)?**  Yes  No

If “yes”, how long have you been on Medicare for ESRD? Start Date **MM/DD/YYYY**

End Date **MM/DD/YYYY**

If you answered “yes” to this question and you don’t need regular dialysis anymore or have had a successful kidney transplant, please attach a note or records from your doctor showing you don’t need dialysis or have had a successful kidney transplant.

If “yes”, are you currently a member of UnitedHealthcare?  Yes  No

If “yes”, what is your UnitedHealthcare member ID number?

Do you or your spouse work?  Yes  No

If “no”, what was your retirement date? **MM/DD/YYYY**

**Your answer to the following questions will not keep you from being enrolled in this plan:**

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 our plan?  Yes  No

If “yes”, please list your other coverage and your identification (ID) number for this coverage

Name of Other Coverage \_\_\_\_\_

ID Number for Coverage: \_\_\_\_\_ Group Number for Coverage \_\_\_\_\_

Do you have any **health insurance** other than Medicare, such as private insurance, Worker’s Compensation, VA benefits or other employer coverage?  Yes  No

Name of health insurance \_\_\_\_\_

Group Number \_\_\_\_\_ Group Number for Coverage \_\_\_\_\_

**5. ATTENTION – please sign and date**

I understand that my signature on this Enrollment Request Form means that I have read and understood the contents of this Enrollment Request Form, including the Statements of Understanding, and that the information provided by me is accurate and complete. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

**This Enrollment Request Form must be signed, dated and received prior to your desired effective date. Upon receipt, the plan will process the form according to Medicare guidelines.**

**Applicant Signature** (or signature of authorized representative, please complete box below)

**Today’s Date**

**MM/DD/YYYY**

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Last Name	First Name	Medicare Claim Number
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**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.

Last Name	First Name
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Address

City	State	ZIP Code
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Telephone Number ( ) -	Relationship to Applicant
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Signature	Today's Date MM/DD/YYYY
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**6. 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 MM/DD/YYYY
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<input type="checkbox"/> Plan Representative, check here if you signed above and assisted in completing this form.	Relationship to Applicant
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**Sales Representative/Broker, please provide your signature and complete the information below:**

Licensed Sales Representative/Broker Signature	Today's Date MM/DD/YYYY
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Licensed Sales Representative/Broker Name (Please Print)

Agent/Broker ID Number	Referring Broker ID Number
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**7. For office use only**

Agent Name

Agent Number	NIPR Number
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Effective Date MM/DD/YYYY	Group Number	PBP Number
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SEP    Employer Group SEP    ICEP/IEP    AEP (type) \_\_\_\_\_

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare. UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-555-5757 (TTY: 711). 注意：如果您說中文，您可以免費獲得語言援助服務。請致電 1-800-555-5757 (TTY: 711).

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# Outpatient Prescription Drug Plan Enrollment Form

(Please Print)

Underwritten by  
UnitedHealthcare Insurance Company

## Required Information

Employer/Former Employer Name: City of Hialeah	
Employer ID #:	Employer Subsidy Group #:
Employer Billing #:	

**Please complete the entire form. Incomplete information can delay the enrollment process. (Please Print – If you need more room for your answers to any questions, please use a separate sheet of paper.)**

Date of Retiree's Retirement <b>MM / DD / YYYY</b>	Source of Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Newly Eligible <input type="checkbox"/> Special Enrollment
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### 1. Personal Information

Applicant Last Name	Applicant First Name	MI	Suffix
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Date of Birth <b>MM / DD / YYYY</b>	Marital Status of Applicant: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Name of Retiree	Relation to Retiree: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
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Medicare Claim #	Part A Effective Date <b>MM / DD / YYYY</b>	Part B Effective Date <b>MM / DD / YYYY</b>	Part D Effective Date <b>MM / DD / YYYY</b>
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Permanent Residence Street Address (P.O. Box is not allowed)

City	State	Zip
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E-mail Address

Home Telephone # ( )	Alternate Telephone # ( )
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In the future, would you be willing to receive materials through electronic means?  Yes  No

If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next three lines. Providing this information will not affect your eligibility to enroll.

Institution Name	Date of Admission <b>MM / DD / YYYY</b>	Telephone # ( )
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Address

City	State	Zip
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Doctor's Name	Doctor's Telephone # ( )
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GRPRETRX-APP-NA-FL

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Applicant Last Name

Applicant First Name

MI

Medicare Claim #

**2. Benefit Coordination / Other Insurance Carrier Information**

1. Do you have other health insurance?  Yes  No If Yes, complete Section 1a. – 1e. below.

2. Are you permanently disabled?  Yes  No If Yes, complete the following:

2a. Date disability began: **MM / DD / YYYY**

3. Do you have a disability affecting your ability to communicate or read?  Yes  No

If you have special needs, this document may be available in other formats or languages upon request. Please contact us at **1-877-714-0178**, TTY users should call **711**. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week.

Do you work or plan to work?  Yes  No

1a. Name	1b. Insurance Company Name	1c. Policy #	1d. Effective Date	1e. Other Employer Name and Address
			<b>MM / DD / YYYY</b>	
			<b>MM / DD / YYYY</b>	

**FOR OFFICE USE ONLY**

Retiree

Yes  No

Group # \_\_\_\_\_

Plan Code \_\_\_\_\_

Spouse or child

Yes  No

Verification \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Initial \_\_\_\_\_

**FOR EMPLOYER USE ONLY**

Enrollee is eligible for retiree coverage

Effective Date

\_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Initial

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What's next

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TEAR HERE

Applicant Last Name

Applicant First Name

MI

Medicare Claim #

**3. Terms and Conditions**

I am requesting enrollment under the UnitedHealthcare Insurance Company (“UnitedHealthcare”) Group Retiree Policy. By signing this Enrollment Form, I agree to and understand the following:

1. All coverage is subject to the terms and conditions of the UnitedHealthcare Group Policy.
2. UnitedHealthcare or its designee shall have access and use of my medical records for purposes of utilization review surveys, processing of claims, financial audit or other purposes reasonably related to the performance of this Enrollment Form.
3. Any material omission or intentional misrepresentation in answering the questions on this Enrollment Form may result in the denial of benefits and the termination of my coverage.
4. Coverage shall not begin until acceptance of this Enrollment Form by UnitedHealthcare. Acceptance will not occur until after UnitedHealthcare validates Medicare coverage and eligibility for coverage under the group retiree plan. Upon acceptance of this Enrollment Form, UnitedHealthcare shall be bound by the terms of my UnitedHealthcare Group Policy and the Amendments thereto (if applicable).
5. My current prescription drug coverage under Part D is provided by a UnitedHealthcare plan. I understand that if my coverage under the Part D plan ends, this coverage will also end.
6. All statements and descriptions in this enrollment form are deemed to be representations and not warranties.

I certify that I have read the Terms and Conditions printed on this Enrollment Form and that I accept them and will abide by them. I further certify that the information provided in the Enrollment Form is true and complete to the best of my knowledge and belief.

Print Name of Applicant:

Signature of Applicant or Authorized Representative:

Today’s Date:

MM / DD / YYYY



**Authorized Representative Information**

If you are the authorized representative (Responsible Party, Power of Attorney, Family Member, etc.), you must sign above and provide the following information:

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Relationship to Enrollee \_\_\_\_\_

TEAR HERE

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# Statements of UNDERSTANDING

**By enrolling in this plan, 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 Part A and Part B, and continue to pay my Medicare Part B and, if applicable, Part A premiums, if they are not paid for by Medicaid or a third party.



**I can only have one Medicare Advantage or Prescription Drug plan at a time.**

- Enrolling in this plan will automatically disenroll me from any other Medicare health plan. If I disenroll from this plan, I will be automatically transferred to Original Medicare. If I enroll in a different Medicare Advantage plan or Medicare Part D Prescription Drug Plan, I will be automatically disenrolled from this plan.
- If I have prescription drug coverage or if I get prescription drug coverage from somewhere other than this plan, I will inform UnitedHealthcare.
- Enrollment in this plan is for the entire plan year. I may leave this plan only at certain times of the year or under special conditions.



**If I do not have prescription drug coverage, I may have to pay a late enrollment penalty.**

This would apply if I did not sign up for and maintain creditable prescription drug coverage when I first became eligible for Medicare. If I get a late enrollment penalty, I will receive a letter making me aware of the penalty and what the next steps are.



**The service area includes the 50 United States, the District of Columbia and all U.S. territories.**

I may not be covered while out of the country, except for limited coverage near the U.S. border. However, under this plan, when I am outside of the U.S. I am covered for emergency or urgently needed care.



**I will get a Plan Details book that includes an Evidence of Coverage (EOC).**

- The EOC will have more information about services covered by this plan. If a service is not listed, it will not be paid for by Medicare or this plan without authorization.
- I have the right to appeal plan decisions about payment or services if I do not agree.



**My information will be released to Medicare and other plans, only as necessary, for treatment, payment and health care operations.**

Medicare may also release my information for research and other purposes that follow all applicable Federal statutes and regulations.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

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