

How to Enroll

You can enroll by phone, mail or fax. Simply choose the way that is easiest for you and follow the Enrollment Request Form Checkpoints below.



By phone

Contact us at toll-free **1-877-714-0178**, TTY **711**, 8 a.m. - 8 p.m. local time, 7 days a week to enroll over the phone.



By mail

UnitedHealthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770



By fax

Fill out the Enrollment Request Form and fax it to:
888-950-1170

Incomplete information may delay your enrollment.

Enrollment Request Form Checkpoints

- ✓ Print your name exactly as it appears on your red, white and blue Medicare card.
- ✓ Make sure your permanent address is complete and accurate.
- ✓ Sign and date your name where indicated.
- ✓ Provide the name of your Primary Care Provider (PCP).
- ✓ Complete the questions about End-Stage Renal Disease (ESRD).
- ✓ Confirm the Plan Sponsor and Group Numbers are correct.
- ✓ Include the date you expect your proposed coverage to begin.



2020 Enrollment Request Form

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

1. Plan information

Plan Sponsor

City of Hialeah

Group Number

13977

GPS Employer ID

24970

GPS Branch Number

001

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.

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

2. Information about you. (Please type or print in black or blue ink.)

<input type="checkbox"/> Mr.	Last Name	First Name	Middle Initial
<input type="checkbox"/> Mrs.			
<input type="checkbox"/> Ms.			

Birth Date MM – DD – YYYY

Sex: Male Female

Daytime Phone Number

() –

Mobile Phone Number

() –

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

City	State	ZIP Code	County
------	-------	----------	--------

Mailing Address (**Only if it's different from above. You can give a P.O. Box**)

City	State	ZIP Code
------	-------	----------

Email Address

This page intentionally left blank.

Last Name	First Name	Medicare Number
-----------	------------	-----------------

Emergency Contact _____

Contact Phone Number () -	Contact Relationship to You
---------------------------------------	-----------------------------

3. Information about your Medicare

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

Name (as it appears on your Medicare card): _____

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Medicare Number: _____

Sex: Male Female

Is Entitled to _____ Effective Date

Hospital (Part A) **MM - DD - YYYY**

Medical (Part B) **MM - DD - YYYY**

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

4. A few questions to help us manage your plan

I prefer to receive materials in the following language:

Spanish Other _____

If you don't see the language or format you want, please call us toll-free at **1-877-714-0178**, (TTY **711**) during 8 a.m. - 8 p.m. local time, 7 days a week.

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 number?

Do you or your spouse work? Yes No

If **"no"**, what was your retirement date? **MM - DD - YYYY**

This page intentionally left blank.

Last Name	First Name	Medicare Number
-----------	------------	-----------------

Please read and answer these important questions.

Are you a resident in a long-term care facility, such as a nursing home?

 Yes NoIf **“yes,”** Name of Institution

Address of Institution

City	State	ZIP Code
Phone Number of Institution () -	Date of Admission 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 NoIf **“yes,”** please list your other coverage and your identification (ID) number for this coverage

Name of Other Coverage

Member 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 the Health Insurance

Member Number for Coverage

Group Number for Coverage

Contracting Medical Group/Primary Care Physician (PCP) Name

Phone number

() -

Contracting Medical Group/Doctor 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 doctor?

 Yes No

This page intentionally left blank.

Last Name

First Name

Medicare Number

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.

Signature of applicant/member/authorized representative

Today's Date

MM – DD – YYYY

6. Authorized representative information

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (Power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and you have received your UnitedHealthcare member ID card, please call Customer Service at the number on the back of your UnitedHealthcare member ID card to update your authorization information on file.

Signature

Today's Date

MM – DD – YYYY

7. 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

Plan Representative, check here if you signed above and assisted in completing this form.

Relationship to Applicant

Sales Representative/Broker, please provide your signature and complete the information below:

Licensed Sales Representative/Broker Signature

Today's Date

MM – DD – YYYY

Licensed Sales Representative/Broker Name (Please Print)

Agent/Broker Number

Referring Broker Number

This page intentionally left blank.

Last Name	First Name	Medicare Number
-----------	------------	-----------------

8. For office use only

Agent Name

Agent Number	NIPR Number
--------------	-------------

Effective Date	Group Number	PBP Number
----------------	--------------	------------

MM-DD-YYYY

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).

This page intentionally left blank.