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).

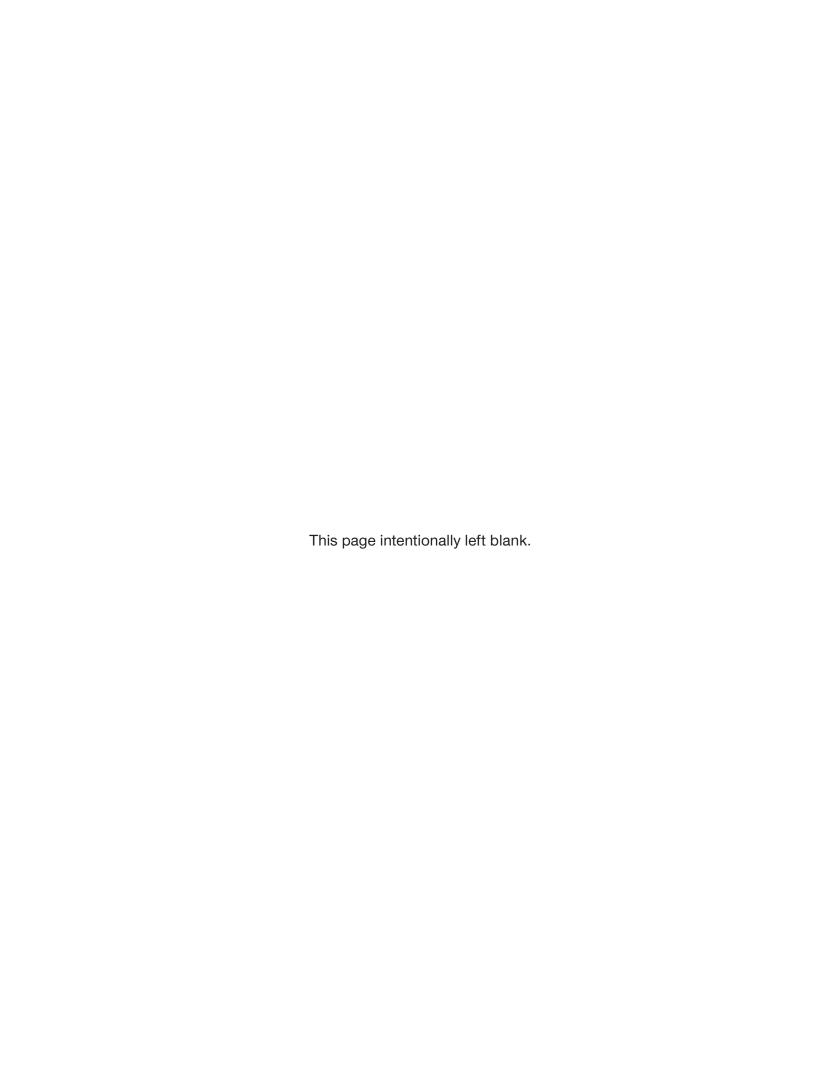
- Complete the questions about End-Stage Renal Disease (ESRD).
- Confirm the Plan Sponsor and Group Numbers are correct.
- Include the date you expect your proposed coverage to begin.



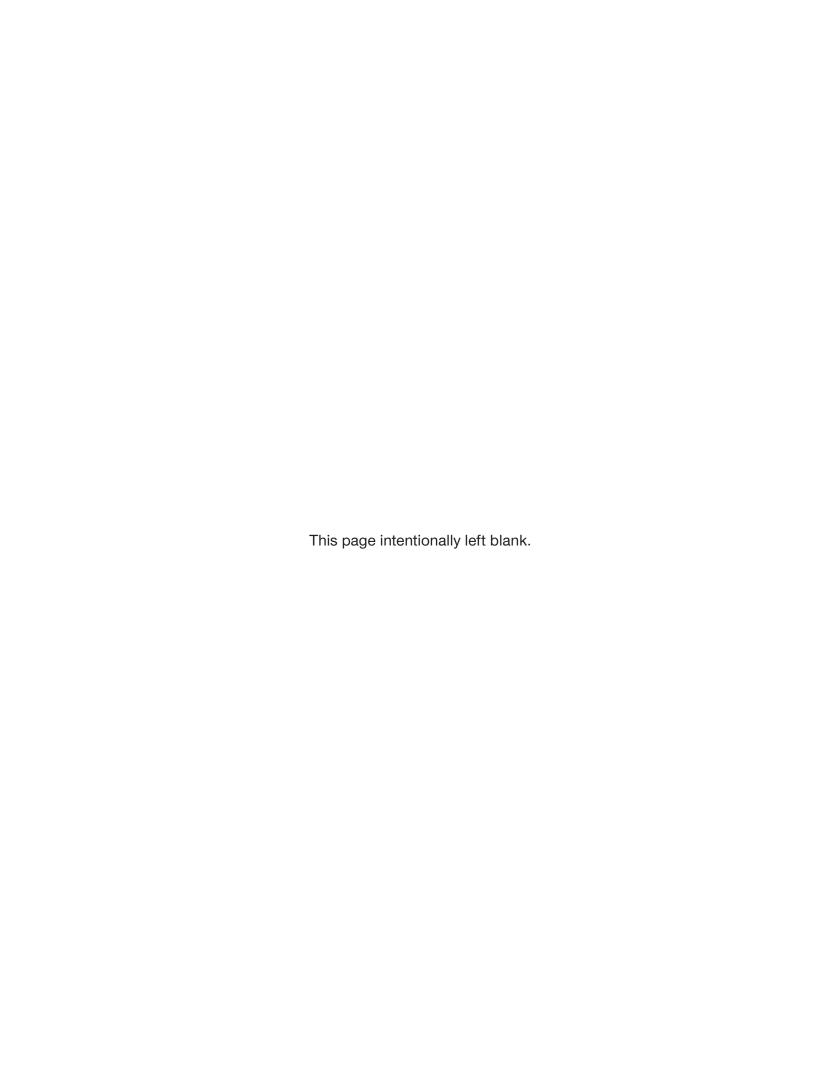
2020 Enrollment Request Form

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

	n information					
Plan Spo	onsor					
	rs Benefit Trust					
Group Number			GPS Employ	er ID		
148150			1989			
GPS Bra	nch Number					
001						
Effective	e Date Requested: MM - DD	-YYYY				
(i.e., your	proposed effective date, or or	n what day	your coverag	ge shoul	d begin)	
	onsor use ONLY: Please date s ed and signed form.	tamp this d	ocument to i	indicate	when you red	ceived the
	in the UnitedHealthcare® Grorovide the following:	up Medicar	re Advantage	e (HMO)	or (Regional	PPO) plan,
2. Info	rmation about you. (Plea	se type o	r print in bl	ack or	blue ink.)	
□ Mr. □ Mrs. □ Ms.	Mrs.		First Name		Middle Initial	
Birth Date MM-DD-YYYY			Sex: ☐ Ma	ıle 🗆 Fe	emale	
Daytime Phone Number			Mobile Pho	ne Num	nber	
() —			() —			
Permane	ent Residence Street Address (P.O. Box is	not allowed	d)		
City		State	ZIP Code		County	
Mailing A	Address (Only if it's different f	rom above	. You can gi	ve a P.O	. Box)	
City				State	ZIP Code	
Email Ad	ldress				1	

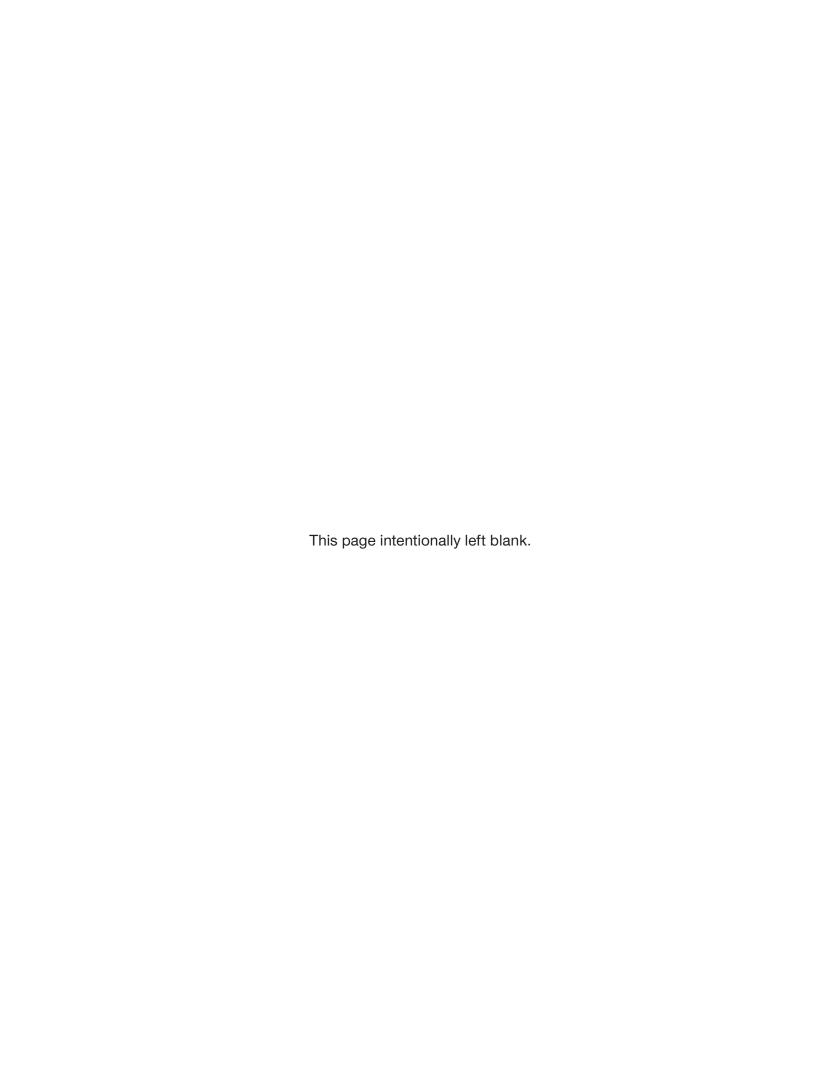


					_	
Last Name	First Name	Medicare Number				
Emergency Contact						
Contact Phone Number () -		Contact Relation	onship to	You		
3. Information abou	ıt your Medicare					
Please take out your red,	_	e card to comple	ete this s	ection.		
•		Name (as it ap	Name (as it appears on your Medicare card):			
-OF	⊰ -					
 Attach a copy of your N 	Medicare card or your	Medicare Nun				
letter from Social Secu	•	Sex: ☐ Male ☐ Female				
Retirement Board.		Is Entitled to		Effective	e Date	
		Hospital (Part	t A)	MM-DD	-YYY	
		Medical (Part	B)	MM-DD	-YYY	
		You must have join a Medicar			d Part E	3 to
4. A few questions t	o help us manage v	our plan				
I prefer to receive mater	rials in the following lar	•				
☐ Spanish ☐ Other If you don't see the langu		nlease call us to	all-free at	1-877-714-	017 8	
(TTY 711) during 8 a.m.	-	-	m-nee at	1-011-114-	0170,	
Do you have End-Stage	Renal Disease (ESRD)?				□ Yes	
If "ves", how long have you been on Medicare for ESRD?		ESRD?	art Date nd Date	MM-DD MM-DD		
If you answered "yes" to to successful kidney transplaneed dialysis or have had	ant, please attach a note	e or records from	-	•		
If "yes", are you currently	a member of UnitedHea	althcare?			□ Yes	□ No
If "yes", what is your Unit	edHealthcare member n	umber?				
Do you or your spouse we	ork?				□ Yes	□ No
If "no", what was your ret	irement date? MM-D	D-YYYY				



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Last Name First Name	Medicare Num	ber
Please read and answer these important of Are you a resident in a long-term care facility	•	? □ Yes □ No
If "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 r	not keep you from being e	nrolled in this plan:
Some individuals may have other drug coverements employee health benefits coverage, VA benefits coverage.	•	
Will you have other prescription drug cove	rage in addition to our pla	n? □ Yes □ No
If "yes", please list your other coverage and	your identification (ID) nu	mber for this coverage
Name of the Coverage		
Member Number for Coverage	Group Number for	Coverage
Do you have any health insurance other that Worker's Compensation, VA benefits or other	•	ate insurance, ☐ Yes ☐ No
Name of the Health Insurance		
Member Number for Coverage	Group Number for	Coverage
Contracting Medical Group/Primary Care P	hysician (PCP) Name Ph	none number) —
Contracting Medical Group/Doctor Number	on the website or in	umber exactly as it appears the Provider Directory. It will Don't include dashes.)
Are you now seeing or have you recently se	en this doctor?	□ Yes □ No

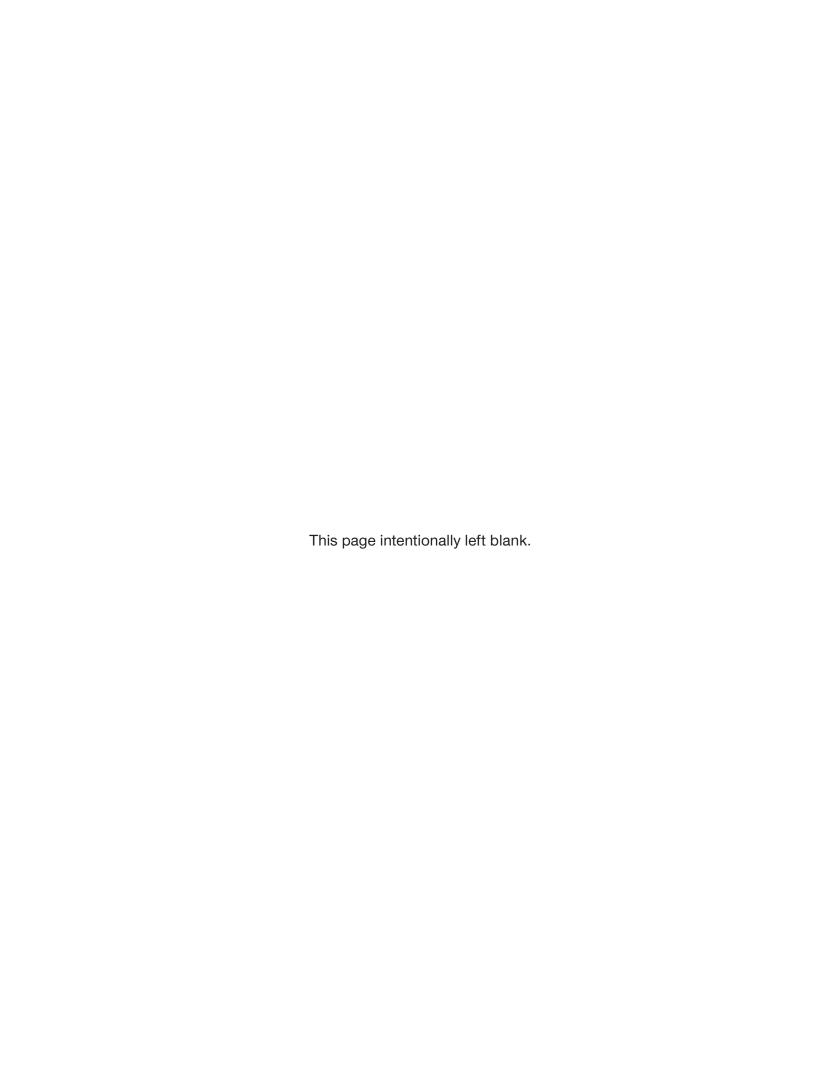


Last Name First Name Medicare Number

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.

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, effective date. Upon receipt, the plan will process		_			
Signature of applicant/member/authorized rep	resentative	Today's Date			
		MM-DD-YYYY			
6. Authorized representative information	n				
If I sign as an authorized representative, it means I I can show written proof (Power of attorney, guardian understand that I will need to submit written proof to behalf of the member beyond this application. After received your UnitedHealthcare member ID card, p back of your UnitedHealthcare member ID card to the state of the s	nship, etc.) of this right if M of this right, to the plan, if I r this application has been lease call Customer Servio	edicare asks for it. I wish to take action on approved and you have be at the number on the			
Signature		Today's Date			
		MM-DD-YYYY			
7. If someone assisted you in completing complete the information below	g this form, please ha	ave that person			
Signature (of individual who assisted in completing	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 you	r signature and complete	the information below:			
Licensed Sales Representative/Broker Signatu	Today's Date				
		MM-DD-YYYY			
Licensed Sales Representative/Broker Name (Ple	ase Print)				
Agent/Broker Number	Referring Broker Numbe	r			



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Last Name	First Name	Medicare Number			
8. For office use only					
Agent Name					
Agent Number			NIPR Number		
Effective Date MM - D D - YYYYY	Group Number		PBP Number		
□ 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:如果您説中文,您可以免費獲得語言援助服務。請致電 1-800-555-5757 (TTY: 711).

