# 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.

UnitedHealthcare®

# 2020 Enrollment Request Form

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

## 1. Plan information

Plan Sponsor

Teamsters Benefit Trust

| Group Number | GPS Employer ID |
|---|---|
| 148150 | 1989 |

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 (HMO) or (Regional PPO) plan, please provide the following:

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

| ☐ Mr.<br>☐ Mrs.<br>☐ Ms. | Last Name | First Name | Middle Initial |
|---|---|---|---|

| Birth Date MM – DD – YYYY | Sex: ☐ Male ☐ Female |
|---|---|
| Daytime Phone Number<br>( ) – | Mobile Phone Number<br>( ) – |

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

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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.

-OR-

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

Name (as it appears on your Medicare card):

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

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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 ☐ No

If **"yes,"** Name of Institution

Address of Institution

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

| Phone Number of Institution<br>( ) – | 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 ☐ No

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

Name of the 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<br>( ) – |
|---|---|
| | |

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

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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

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Last Name First Name Medicare Number

## 8. For office use only

Agent Name

| Agent Number | | NIPR Number |
|---|---|---|
| Effective Date<br>MM–DD–YYYY | Group Number | PBP Number |

☐ SEP ☐ Employer Group SEP ☐ ICEP/IEP ☐ AEP (type) _____

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