UnitedHealthcare® Group Medicare Advantage (HMO), (HMO-POS) and (Regional PPO) are Medicare Advantage plans.

Please complete the Enrollment Request Form on the next page using the instructions provided below:

**Plan Information**

Your Plan Sponsor, Group Number, GPS Employer ID and GPS Branch Number have been completed for you in section one of the Enrollment Request Form.

Please check that your information is correct on the next page. If it is incorrect or missing, please provide the correct information. You can find your Group Number and Plan Sponsor Name on the front cover of your Pre Kit Booklet.

Include the date you expect your coverage to begin.

Write in the name of the Primary Care Physician (PCP) you have selected. You will find the Provider number underneath your doctor’s name in the Provider Directory. If you did not receive a Provider Directory, please call the number at the bottom of this page or visit our website at www.UHCRetiree.com to find your Provider number.

**Applicant Information**

The enrollee using this form must be enrolling in a Medicare Advantage plan. Please complete a separate Enrollment Request Form for eligible spouse and/or dependents.

Please write your name (last name, first name and middle initial) exactly as it appears on your red, white and blue Medicare card. Your plan member ID card will reflect your name as it appears on your Medicare card.

Attach a copy of your Medicare card or your Letter of Verification from Social Security or the Railroad Retirement Board, if possible.

**Medical Information**

Please complete the questions about End-Stage Renal Disease (ESRD). ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to maintain life.

**Sign and Date Enrollment Request Form**

(Use a ballpoint pen and press hard.)

In order to process this Enrollment Request Form, **you must sign the form where indicated.**

If someone has assisted you in completing this form, that person must also sign this form and indicate his/her relationship to you. If you are receiving assistance from a sales agent, broker, or other individual employed by or contracted with our plan, he/she may be paid commission based on your enrollment in the plan.

If your authorized representative helped you complete this form, he/she must sign and submit a copy of the applicable court order or Durable Power of Attorney that establishes authority to act on your behalf, if requested by the plan.
Return the completed Enrollment Request Form in the enclosed self-addressed, postage paid envelope or send to:
UnitedHealthcare
P.O. Box 29650
Hot Springs, AR 71903-9973

Incomplete information on this form may delay the processing of your enrollment.

After we receive and process your enrollment you will receive a Confirmation of Enrollment from us, which will include your member ID card.

Questions? Call Customer Service toll-free about your plan:

1-877-714-0178, TTY 711
8 a.m. – 8 p.m. local time, 7 days a week

You can also call us if you would like to enroll over the phone. Please have your Plan Sponsor name and Group Number, found in Section 1 of the Enrollment Request Form, ready when you call.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract.
# UnitedHealthcare

## ENROLLMENT REQUEST FORM

To enroll in the UnitedHealthcare Group Medicare Advantage (HMO), (HMO-POS) or (Regional PPO) for Groups plan, please provide the following:

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

- [ ] Spanish
- [ ] Chinese (Spoken [ ] Cantonese [ ] Mandarin)
- [ ] Other ________

Please contact us 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.

### 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 print in black or blue ink.)

<table>
<thead>
<tr>
<th>Mr.</th>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
</table>

| Birth Date | Sex | Home Telephone Number |
| _____ / _____ / _____ | [ ] Male [ ] Female |

| Permanent Residence Street Address (P.O. box not allowed) |
| City | State | ZIP |
| County |

| Mailing Address (only if different from your Permanent Street Address) (P.O. box allowed for mailing only) |
| City | State | ZIP |

Email Address

Emergency Contact

| Contact Telephone Number | Contact Relationship to You |
| ( ) – |

In the future, would you be willing to receive materials through electronic means? [ ] Yes [ ] No

### 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 or Part B (or both) to join a Medicare Advantage plan. An incorrect or incomplete Medicare Claim Number may cause a delay or denial of coverage.

<table>
<thead>
<tr>
<th>Medicare Claim Number</th>
</tr>
</thead>
</table>

| Part A (Hospital) Effective Date | Part B (Medical) Effective Date |
| _____ / _____ / _____ | _____ / _____ / _____ |
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 ______
Telephone Number of Institution (________) _______________________________ Date of Admission ______ / ______ / ______

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 ______ / ______ / ______
End Date ______ / ______ / ______
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 United-Healthcare? □ Yes □ No
If "yes," what is your UnitedHealthcare member ID number?

Do you or your spouse work? □ Yes □ No
If "no," retirement date ______ / ______ / ______

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
What is the name of the health insurance? ______________________________________
Group Number __________________________ ID 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.

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 Centers for Medicare & Medicaid Services (CMS) guidelines.

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

Today’s Date ______ / ______ / ______
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
Address
City | State | ZIP
Telephone Number | Relationship to Applicant
( ) | -
Signature

Today’s Date __/__/____

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 __/__/____

☐ 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:

Sales Representative/Broker Signature | Today’s Date __/__/____

Sales Representative/Broker Name (Please Print)

Agent/Broker ID Number | Referring Broker ID Number

7. For office use only:

Agent Name

Agent Number | NIPR Number

Effective Date __/__/____ | Group Number | PBP Number

☐ SEP  ☐ Employer Group SEP  ☐ ICEP/IEP  ☐ AEP (type) ______________
By electing enrollment in this plan, you agree to the following:

You must keep your Medicare Parts A and B by continuing to pay the Part B premiums and, if applicable, Part A premiums, if not otherwise paid for under Medicaid or by another third party. You can only be in one Medicare Advantage plan or Medicare Prescription Drug plan at a time. By enrolling in this plan, you will automatically be disenrolled from any other Medicare Advantage Health plan or prescription drug plan of which you may be a member. It is your responsibility to inform the plan of any prescription drug coverage that you have or may get in the future. Enrollment in this plan is generally for the entire year, unless special election periods apply. If you want to keep your membership in this plan for the following plan year, you do not need to notify us or fill out any paperwork. You will automatically remain enrolled as a member of this plan if you do not sign up for a different plan or request disenrollment from this plan. You may leave this plan only at certain times of the year or under special circumstances, by sending a request to the plan or by calling 1-800-MEDICARE (1-800-633-4227) (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.

You must live in the service area and if you move out of the service area defined for the plan (see the Summary of Benefits for a description of the plan’s service area), you must notify the plan of the move and find a new plan in your area. If you permanently move out of the service area, you will be disenrolled from the plan and can enroll in a plan in your new service area. People with Medicare aren’t usually covered under Medicare while out of the country except for limited coverage near the U.S. border. However, under this plan, when you are outside of the United States you are covered only for Emergency or Urgently Needed Care.

As a member of this plan, you have the right to appeal plan decisions about payments or services if you disagree. You will be bound by the benefits, copays, exclusions, limitations and other terms of the plan. It is your responsibility to read the Evidence of Coverage when you get it to know which rules you must follow to get coverage with this Medicare Advantage plan and the amounts for which you will be responsible for payment under the plan.

By joining this Medicare Advantage Health plan, you acknowledge that UnitedHealthcare will release your information to Medicare and other plans as is necessary for treatment, payment and health care operations. You also acknowledge the plan will release your information, including your prescription drug event data, if applicable, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. If you intentionally provide false information, you may be disenrolled from the plan.

If you previously had prescription drug coverage or any insurance that included drugs, you may be asked for proof that your previous prescription drug coverage was at least as good as Medicare’s standard prescription drug coverage (creditable prescription drug coverage). You may wait until you are asked to send us proof or you may provide it now. If you would like to provide copies of your proof of creditable prescription drug coverage now and you are required to complete an Enrollment Request Form you can include your proof in the same envelope as the Enrollment Request Form. If you are not required to complete an Enrollment Request Form and would like to send the copies of your proof now, please use the address below:

UnitedHealthcare
P.O. Box 29650
Hot Springs, AR 71903-9973
You don’t have to send proof to enroll. However, if you are asked for proof and don’t provide it, your premium may be increased because of a late enrollment penalty. For more information about the late enrollment penalty, you may visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227) (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.

Your enrollment in this plan will be effective the first day of the month following the month in which you submit your completed and signed request form, unless your employer’s health plan coverage or your Medicare entitlement goes into effect at a later date.

If your eligibility in the UnitedHealthcare Group Medicare Advantage plan is not approved by Medicare, you will be financially responsible for all medical services rendered as of the date of your enrollment confirmation. Upon confirmation from Medicare, the plan will send you written notice of your effective date. Until you have received this written notification, you should not drop any supplemental insurance you have in effect now.

If you disenroll from this employer-sponsored plan, you will be automatically transferred to Original Medicare. Also, if you choose to enroll in a non-employer-sponsored Medicare Advantage plan, or another employer-sponsored Medicare Advantage plan, you will be automatically disenrolled from this employer-sponsored plan.

Counseling services may be available in your state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Additional Statements of Understanding for each specific plan:

**UnitedHealthcare Group Medicare Advantage (HMO)**

By enrolling in this plan, you must receive all covered benefits from plan contracted providers and pharmacies, with the exception of emergency or urgently needed services or out-of-area renal dialysis. Authorized services and other services contained in your Evidence of Coverage document will be covered as disclosed. If you do not receive prior authorization as required for covered services, neither Medicare nor the plan will pay for services.

**UnitedHealthcare Group Medicare Advantage (HMO-POS)**

By enrolling in this plan, benefits are available both in and out-of-network, and you must use in-network providers to enjoy the lowest share of your cost. Some non-emergency care from out-of-network providers may not be covered at all under the Point of Service plan. Additionally, some out-of-network services may be limited by county or state and require prior authorization.

**UnitedHealthcare Group Medicare Advantage (Regional PPO)(PPO)**

By enrolling in this plan, if you use out-of-network providers for health care, benefits will generally be paid at the out-of-network benefit level. Check your Evidence of Coverage to determine your share of the cost differential for using out-of-network providers.

All Medicare Advantage plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

Members of our Medicare Advantage health plans have the right to request an organization determination including the right to file an appeal and the right to file a grievance. Medicare Advantage health plan organizations must identify, track, resolve and report all activity related to an appeal or grievance.

Plans are insured through UnitedHealthcare Insurance Company and its affiliated companies, a Medicare Advantage organization with a Medicare contract.
Enrollment Request Form

Outpatient Prescription Drug Plan
# Outpatient Prescription Drug Plan Enrollment Form

(Please Print)

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.)

<table>
<thead>
<tr>
<th>Date of Retiree's Retirement</th>
<th>Source of Enrollment</th>
<th>Marital Status of Applicant:</th>
</tr>
</thead>
<tbody>
<tr>
<td>mm/dd/yyyy</td>
<td>Open Enrollment</td>
<td>Single</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## 1. Personal Information

<table>
<thead>
<tr>
<th>Applicant Last Name</th>
<th>Applicant First Name</th>
<th>MI</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Date of Birth</th>
<th>Marital Status of Applicant:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>mm/dd/yyyy</td>
<td>Single</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Retiree</th>
<th>Relation to Retiree:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Claim #</th>
<th>Part A Effective Date</th>
<th>Part B Effective Date</th>
<th>Part D Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>mm/dd/yyyy</td>
<td>mm/dd/yyyy</td>
<td>mm/dd/yyyy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Permanent Residence Street Address (P.O. Box is not allowed)</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Telephone #</th>
<th>Alternate Telephone #</th>
<th>E-mail Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>()</td>
<td>()</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the future, would you be willing to receive materials through electronic means?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Institution Name</th>
<th>Date of Admission</th>
<th>Telephone #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mm/dd/yyyy</td>
<td>()</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doctor's Name</th>
<th>Doctor's Telephone #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>()</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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: \( \frac{\text{mm}}{\text{dd}}/\frac{\text{yyyy}}{\text{yyyy}} \)

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 1-888-556-6648, 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

<table>
<thead>
<tr>
<th>1a. Name</th>
<th>1b. Insurance Company Name</th>
<th>1c. Policy #</th>
<th>1d. Effective Date</th>
<th>1e. Other Employer Name and Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>( \frac{\text{mm}}{\text{dd}}/\frac{\text{yyyy}}{\text{yyyy}} )</td>
<td></td>
</tr>
</tbody>
</table>

FOR OFFICE USE ONLY

RETIREE □ YES □ NO GROUP # ___________________________

PLAN CODE ___________________________

SPouse, DOMESTIC PARTNER, OR CHILD □ YES □ NO VERIFICATION: _____ DATE _____/_____/_____

Initial

FOR EMPLOYER USE ONLY

□ Enrollee is eligible for retiree coverage

Effective Date: _____/_____/_____
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. I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns of member) and UnitedHealthcare Insurance Company or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. All parties to this agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Print Name of Applicant:

Signature of Applicant or Authorized Representative:  

Today’s Date:

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: ____________________________