Low Option

UnitedHealthcare®

ENROLLMENT REQUEST FORM

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

1. Plan information:	
Plan Sponsor: County of Santa Barbara	
Group Number: 523345	GPS Employer ID: 2108
GPS Branch Number: 001	

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.	Plan Sponsor use ONLY: Please date stamp this document to indicate when you received the completed and signed form. **Effective Date Requested:** ____ /____ /____ (i.e., your proposed effective date, or on what day your coverage should begin)
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.)

☐ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial
Birth Date ____ /____ /____	Sex ☐ Male ☐ Female	Home Telephone Number ( ) –	
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.	Medicare Claim Number Part A (Hospital) Effective Date ____ /____ /____ Part B (Medical) Effective Date ____ /____ /____

Last Name First Name Medicare Claim Number

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 UnitedHealthcare? ☐ 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** ____ /____ /____

Last Name First Name Medicare Claim Number

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:	
Licensed Sales Representative/Broker Signature	Today's Date ____ /____ /____
Licensed 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) _____		

Statements of Understanding

By electing enrollment 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 I must continue to pay my Medicare Part B premium and, if applicable, Part A premiums, if not otherwise paid for by Medicaid or another third party. I understand I can be in only one Medicare Advantage or Prescription Drug plan at a time. My enrollment in this plan will automatically end my enrollment in another Medicare health plan. If I have prescription drug coverage, or if I get prescription drug coverage from somewhere other than this plan, I will inform you.

Enrollment in this plan is generally for the entire plan year. I may leave this plan only at certain times of the year or under special conditions.

If I choose to disenroll from this plan, which is sponsored by my former employer, union or trust group plan sponsor, I will be automatically transferred to Original Medicare. Also, if I choose to enroll in a different Medicare Advantage plan not offered by my plan sponsor, I will be automatically disenrolled from this plan provided through my plan sponsor.

This plan covers a specific service area. If I plan to move out of the area, I will call my plan sponsor or this plan to disenroll and get help finding a new plan in my area. I may not be covered under Medicare while out of the country, with the exception of limited coverage near the U.S. border. However, under this plan, when I am outside of the United States I am covered for emergency or urgently needed care. I have the right to appeal plan decisions about payment or services if I do not agree.

Upon enrollment, I will receive a Plan Details book that includes an Evidence of Coverage document. The Evidence of Coverage will have more information about services covered by this plan, as well as the terms and conditions. If a service is not listed in the Evidence of Coverage, it will not be paid for by Medicare or this plan without authorization.

My information, including my prescription drug event data, will be released to Medicare and other plans, only as necessary, for treatment, payment and healthcare operations. Medicare may also release my information for research and other purposes which follow all applicable Federal statutes and regulations.

If I do not have prescription drug coverage, I may have to pay a late enrollment penalty for Medicare's prescription drug coverage. 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 have a late enrollment penalty from Medicare, I will receive a letter making me aware of the penalty and what the next steps are.

For members of the UnitedHealthcare® Group Medicare Advantage (HMO) plan only

I understand that beginning on the date my UnitedHealthcare Group Medicare Advantage (HMO) coverage begins; I must get all of my health care from UnitedHealthcare Group Medicare Advantage (HMO), except for emergency or urgently needed services or out-of-area dialysis services.

UnitedHealthcare®

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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Underwritten by
UnitedHealthcare Insurance Company

Required Information

Employer/Former Employer Name: County of Santa Barbara	
Employer ID #: 523345	Employer Subsidy Group #: 2108
Employer Billing #: 001	

Outpatient Prescription Drug Plan Enrollment Form

(Please Print)

TEAR HERE

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 ___ / ___ / ___ (mm / dd / yyyy)	Source of Enrollment ☐ Open Enrollment ☐ Newly Eligible ☐ Special Enrollment

1. Personal Information

Applicant Last Name	Applicant First Name	MI	Suffix
☐ Male ☐ Female	Date of Birth ___ / ___ / ___ (mm / dd / yyyy)	Marital Status of Applicant: ☐ Single ☐ Married ☐ Divorced ☐ Widow	
Name of Retiree		Relation to Retiree: ☐ Self ☐ Spouse ☐ Child	
Medicare Claim #	Part A Effective Date ___ / ___ / ___ (mm / dd / yyyy)	Part B Effective Date ___ / ___ / ___ (mm / dd / yyyy)	Part D Effective Date ___ / ___ / ___ (mm / dd / yyyy)
Permanent Residence Street Address (P.O. Box is not allowed)	City	State	Zip
Home Telephone # ( )	Alternate Telephone # ( )	E-mail Address	

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 ___ / ___ / ___ (mm / dd / yyyy)	Telephone # ( )	
Address	City	State	Zip
Doctor's Name	Doctor's Telephone # ( )		

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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
			____ / ____ / ____ mm / dd / yyyy	
			____ / ____ / ____ mm / dd / yyyy	

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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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:	Signature

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: _____

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