Enrollment INSTRUCTIONS

UnitedHealthcare® Group Medicare Advantage (HMO) and (Regional PPO) are Medicare Advantage Plans. UnitedHealthcare® RxSupplement™ is an Outpatient Prescription Drug Plan that works together with your Medicare Advantage plan.

Please complete BOTH of the Enrollment Request Forms on the next page using the instructions provided below. You can also enroll right over the phone by giving us a call at the number listed below.

Plan Information	Please confirm the Plan Sponsor and Group Number match what is listed on the front cover of this booklet. If the information is incorrect or missing, please provide the correct information. Include the date you expect your coverage to begin. Write in the name of the Primary Care Physician (PCP) you have selected. The provider number can be found underneath your doctor's name in the Provider Directory or by calling the number at the bottom of this page or visiting our website at **www.UHCRetiree.com**.
Applicant Information	You must complete a separate form for each person enrolling in this plan. Please write your name exactly as it appears on your red, white and blue Medicare card. This is how it will appear on your member ID card. Attach a copy of your Original 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)
Sign and Date the Enrollment Request Form	In order to process this form, **you must sign the form where indicated.** If someone helped you complete 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 a commission based on your enrollment in the plan. If your authorized representative helped you complete this form, he/she must sign the form and submit a copy of the court order or Durable Power of Attorney that allows them to act on your behalf, if requested by the plan.
Return the Enrollment Request Form	Return the completed forms in the enclosed envelope and send to: UnitedHealthcare P.O. Box 29650 Hot Springs, AR 71903-9973 **Incomplete information may delay your enrollment.**

Questions? Call Customer Service:

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

Learn more online at **www.UHCRetiree.com**

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 RxSupplement is not a Medicare Part D prescription drug plan. This is an employer group retiree prescription drug plan. UnitedHealthcare RxSupplement group retiree prescription drug plans are underwritten by UnitedHealthcare Insurance Company or, in New York, UnitedHealthcare Insurance Company of New York. These are private insurance companies not connected with or endorsed by the U.S. Government or the federal Medicare program. RxSupplement plans may not be available in all states. UnitedHealthcare is part of the UnitedHealth Group family of companies.

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: IBEW LOCAL 332

Group Number: 100111 | GPS Employer ID: 1812

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: IBEW LOCAL 332	
Employer ID #: 100111	Employer Subsidy Group #: 1812
Employer Billing #: 001	

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.)

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 # ( )		

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

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: _____