Enrollment Request Form

UnitedHealthcare® Group Medicare Advantage (HMO), (HMO-POS), (Regional PPO) is a Medicare Advantage plan.
Please complete this Enrollment Request Form using the instructions provided below:

1. Plan Information

- Your Plan Sponsor, Group Number and GPS # have been completed for you on the sticker above Section 1. Please check that your information is correct on the next page. If they are incorrect or missing, please provide the correct information. You can find your Group Number and Plan Sponsor Name on your Benefit Highlights.
- 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.

2. 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.

3. 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.

4. 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.

5. Return the Enrollment Request Form

- Return the completed Enrollment Request Form in the enclosed self-addressed, postage paid envelope or send to:

SDCCD – ATTN: BENEFITS
3375 Camino Del Rio S. Suite #385
San Diego, CA 92108

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

6. Temporary Plan member ID card

- After we receive and process your enrollment you will receive an Acknowledgement Notice from us.
- **Your Acknowledgement Notice will act as your temporary Plan 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 on the sticker above Section 1, ready when you call.

Turn the page to enroll ——→

UnitedHealthcare®

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Please fill in all information requested.
Please print in black or blue ink.

I prefer to receive materials in the following language:
☐ Spanish
☐ Chinese (Spoken: ☐ Cantonese ☐ Mandarin)
☐ Other _____

Last Name First Name Medicare Claim Number

Plan Sponsor: CS VEBA	
Group Number: 144104	
GPS Employer ID: 1930	GPS Branch #: 001

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.

1. Plan Information

Effective Date

___ / ___ / ___

On what date should your coverage begin (your proposed effective date)?

Plan Sponsor Use Only:
Please date stamp this document to indicate when you received the completed and signed form.

Contracting Medical Group/Primary Care Physician (PCP) Name:

Contracting Medical Group/Doctor #

Are you currently a patient of this doctor? ☐ Yes ☐ No

2. Applicant Information – As it appears on your Medicare card

	Last Name	First Name	M.I.	Sex	Birth Date	Home Telephone
☐ Mr. ☐ Mrs. ☐ Ms.				☐ M ☐ F	___ / ___ / ___	( )

Permanent Residence Street Address (Not a P.O. Box)	City	
County	State	Zip Code
Mailing Address (only if different from your Permanent Residence Address)	City	
	State	Zip Code
E-mail Address		
Emergency Contact Name	Emergency Contact Telephone ( )	
Emergency Contact's Relationship to you		

Last Name First Name Medicare Claim Number

Medicare Information (as it appears on your red, white and blue Medicare card)	What is your Medicare Claim Number? _____ Part A Effective Date? ___ / ___ / ___ Part B Effective Date? ___ / ___ / ___

Are you a resident in an institution (for example, skilled nursing facility, rehabilitation hospital)? ☐ Yes ☐ No

If "yes", name of institution _____

Address of institution (number and street) _____

City _____

State _____

Zip Code _____

Phone number of institution ( ) _____ Your date of admission in institution ___ / ___ / ___

3. 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#?	
Are you currently employed?	☐ Yes ☐ No
If "no", retirement date (month/date/year)	

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, Worker's Compensation, 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 other coverage and identification number(s) for this coverage:

Name of other coverage: _____

Your member ID# for this coverage: _____ Group Number for this 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# _____

Last Name First Name Medicare Claim Number

4. 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** / /

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 UnitedHealthcare or by Medicare.

Name (Print) **Signature**

Address

Telephone Number **Relationship to Applicant**

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 **Date** **Relationship to Applicant**

☐ Plan representative, check here if you signed above and assisted in completing this form.

Sales Representative/Broker, please provide your signature above and complete the line below.

Sales Representative/Broker Name (Please Print) Agent/Broker ID# Referring Broker ID# Today's Date / /

For Office Use Only

Agent Name: _____ Agent Number: _____ NIPR# _____

Effective Date: ____ /____ / 20____

PBP: _____ Group Number: _____ ☐ SEP ☐ Employer Group SEP ☐ ICEP ☐ AEP (type): _____