

Agency Name:



HR Rep Name:

Email/Phone:



2020 Enrollment Request Form

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

1. Plan information

Plan Sponsor

Government of the District of Columbia

Group Number

13708

GPS Employer

ID 24923

GPS Branch Number: 001



Bill Group: 1 EA ID: 12345678

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 (PPO) plan, please provide the following:

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

<input type="checkbox"/> Mr.	Last Name	First Name	Middle Initial
<input type="checkbox"/> Mrs.			
<input type="checkbox"/> Ms.			

Birth Date MM/DD/YYYY

Sex Male Female

Daytime Phone Number

() -

Mobile Phone Number

() -

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

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
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Phone Number of Institution () -	Date of Admission MM/DD/YYYY
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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 _____

Member Number for Coverage	Group Number for Coverage
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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
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Contracting Medical Group/Primary Care Physician (PCP) Name	Phone number () -
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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.)
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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 / 

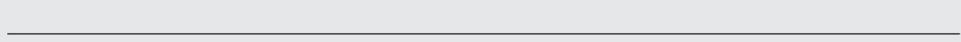
Authorized representative information:

If you are the authorized representative of the applicant, you must provide the following information and sign below.

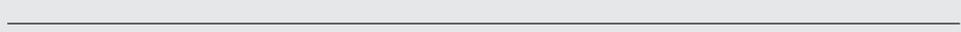
If signed by an authorized representative of the applicant, this signature certifies that:

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 Code
Phone Number () -		Relationship to Applicant	

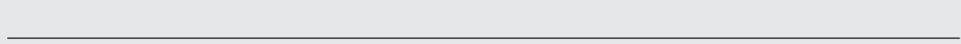
Signature	Today's Date
	MM / DD / YYYY

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
	MM / DD / YYYY

<input type="checkbox"/> Plan Representative, check here if you signed above and assisted in completing this form.	Relationship to Applicant
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Sales Representative/Broker, please provide your signature and complete the information below:

Licensed Sales Representative/Broker Signature	Today's Date
	MM / DD / YYYY

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Last Name	First Name	Medicare Number
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Licensed Sales Representative/Broker Name (Please Print)

Agent/Broker Number	Referring Broker Number
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7. For office use only

Agent Name

Agent Number	NIPR Number
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Effective Date MM/DD/YYYY	Group Number	PBP Number
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SEP Employer Group SEP ICEP/IEP AEP (type) _____

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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 Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-555-5757 (TTY: 711). 注意：如果您說中文，您可以免費獲得語言援助服務。請致電 1-800-555-5757 (TTY: 711).

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Outpatient Prescription Drug Plan Enrollment Form

(Please Print)

Underwritten by
UnitedHealthcare Insurance Company

Required Information

Employer/Former Employer Name: Government of the District of Columbia	
Employer ID #: 24923	Employer Subsidy Group #: 13708
Employer Billing #:	

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 / YY 	Source of Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Newly Eligible  <input type="checkbox"/> Special Enrollment
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1. Personal Information

Applicant Last Name	Applicant First Name	MI	Suffix
Date of Birth MM / DD / YYYY	Marital Status of Applicant: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow		<input type="checkbox"/> Male <input type="checkbox"/> Female
Name of Retiree	Relation to Retiree: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		
Medicare # 	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
E-mail Address			
Home Telephone # ()		Alternate Telephone # ()	
In the future, would you be willing to receive materials through electronic means? <input type="checkbox"/> Yes <input type="checkbox"/> 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 #

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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Applicant Last Name

Applicant First Name

MI

Medicare #

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:

MM/DD / YYYY



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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