Once Completed, Fax Application to: 888-950-1170

Agency Name: HR Rep Name: Email/Phone:

UnitedHealthcare®

2020 Enrollment Request Form

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

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1. Plan information

Plan Sponsor

Government of the District of Columbia

Group Number	GPS Employer ID
13708	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.)

☐ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial

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

Emergency Contact

Contact Phone Number
( ) –

Contact Relationship to You

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3. Information about your Medicare

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

Sex ☐ Male ☐ Female

Is Entitled to Effective Date

Hospital (Part A) MM/DD/YYYY

Medical (Part B) MM/DD/YYYY

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

4. A few questions to help us manage your plan

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

Please contact us toll-free 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.

Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If **"yes"**, how long have you been on Medicare for ESRD? Start Date MM/DD/YYYY
End Date MM/DD/YYYY

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 number?

Do you or your spouse work? ☐ Yes ☐ No

If **"no"**, what was your retirement date? MM/DD/YYYY

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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

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

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

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

Contracting Medical Group/Primary Care Physician (PCP) Name	Phone number ( ) –

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.)

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 / YYYY

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

☐ 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**

MM / DD / YYYY

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Last Name | First Name | Medicare Number

Licensed Sales Representative/Broker Name (Please Print)

Agent/Broker Number	Referring Broker Number

7. For office use only

Agent Name

Agent Number		NIPR Number
Effective Date MM/DD/YYYY	**Group Number**	**PBP Number**

☐ 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：如果您説中文，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 #:	

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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
Date of Birth MM / DD / YYYY	Marital Status of Applicant: ☐ Single ☐ Married ☐ Divorced ☐ Widow		☐ Male ☐ Female
Name of Retiree		Relation to Retiree: ☐ Self ☐ Spouse ☐ 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? ☐ 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 #

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

Spouse or child

☐ Yes ☐ No

Group # _____

Plan Code _____

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	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 _____