UCare Group *UCare for Seniors* (HMO-POS) Enrollment Request Form

To enroll, please provide the following information:

First name:

Middle initial:

Birth date (mm/dd/yyyy): / /

Last name:

Sex: ❑ M ❑ F

Permanent residence street address (cannot be a P.O. box):

City:

State:

Zip: -

County:

Mailing address (if different from permanent):

Primary phone number (include area code): - -

Alternate phone number (include area code): - -

Email address (optional - we will use this to send you plan information only):

Please choose the name of the primary care clinic you want to use:

Clinic ID number (listed elsewhere in this kit):

Group name (company/former employer):

Are you a retiree from the Group named above? ❑ Yes ❑ No

If yes, date of retirement (mm/yyyy): /

Are you a dependent of a retiree from the Group named above? ❑ Yes ❑ No

Desired effective date (mm/dd/yyyy): / / *Coverage always begins on the first of the month.*

Office use only

❑ ICEP/IEP

❑ SEP/LEC

_____

Group Name:

Effective Date (mm/dd/yyyy): / /

Group Number:

Please provide your Medicare insurance information.

Please take out your Medicare card to complete this section. Fill in these blanks with the information from your red, white, and blue Medicare card 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 and Part B to join a Medicare Advantage plan.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name:

Medicare Claim Number

Is Entitled to / Effective Date

Hospital (Part A)

Medical (Part B)

Please read and answer these important questions:

1. Do you have end-stage renal disease (ESRD)? (ESRD refers to kidney disease requiring dialysis.) If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor confirming this development, otherwise we may need to contact you to obtain additional information. ❑ Yes ❑ No

Answering questions 2 - 7 will not affect your ability or eligibility to join our plan.

2. Other than Medicare, will you continue to have other **medical** coverage in addition to UCare? ❑ Yes ❑ No

If yes: Policy holder name:

Plan name: (as appears on ID card)

Policy or ID#: Group#:

Effective date: Phone#:

3. Will you have other **prescription** drug coverage in addition to UCare (such as private insurance, TRICARE, Federal employee health benefits coverage, or VA benefits)? ❑ Yes ❑ No

If yes: Policy holder name:

Plan name: (as appears on ID card)

Policy or ID#: Group#:

Effective date: Phone#:

4. Are you a resident in a long-term care facility, such as a skilled nursing facility or nursing home? ❑ Yes ❑ No

If yes, please provide the name, address, and phone number of the facility:

5. Are you enrolled in your State Medicaid Program (called Medical Assistance)? ❑ Yes ❑ No

If yes, please provide your Medicaid number:

6. Are you enrolled in the program through Social Security called Extra Help for Medicare Part D? ❑ Yes ❑ No

7. Are you losing eligibility for the Extra Help for Medicare Part D? ❑ Yes ❑ No

If so, when? (mm/dd/yyyy): / /

Your Group* UCare for Seniors *plan premium options:

Check if this applies:

❑ My UCare medical premiums are paid through my former employer.

If your UCare premium is not paid through your former employer, you can choose to pay your Group *UCare for Seniors* premium in the following ways (please select one):

❑ I choose monthly billing.

❑ I choose monthly electronic funds transfer (EFT) from a checking or savings account. Please provide:

Bank name:

Bank routing #: Account type: ❑ Checking ❑ Savings

Your bank account #:

If you do not select a payment option, you will get a bill each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security (SS) Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your SS benefit check or be billed directly by Medicare or the RRB. DO NOT pay UCare the Part D-IRMAA.

Please note: People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Please read and sign the following page:

By completing this enrollment form, I agree to the following: *UCare for Seniors* is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part A and Part B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15-December 7 of every year), or under certain special circumstances.

UCare for Seniors serves a specific service area. If I move out of the area that *UCare for Seniors* serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of *UCare for Seniors*, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from *UCare for Seniors* when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. However, this plan provides worldwide emergency care.

I understand that beginning on the date *UCare for Seniors* coverage begins, I should get my health care from *UCare for Seniors*. In some cases, I may get covered services from out-of-network providers. With the exception of emergency or urgently needed services, or out-of-area dialysis services, it may cost me more to get care from out-of-network providers. If medically necessary, *UCare for Seniors* provides refunds for all covered benefits, even if I get services out of network. Services authorized by *UCare for Seniors* and other services contained in my *UCare for Seniors* Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with *UCare for Seniors*, he/she may be paid based on my enrollment in *UCare for Seniors.*

Release of information: By joining this Medicare health plan, I acknowledge that *UCare for Seniors* will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that *UCare for Seniors* will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this enrollment form means that I have read and understand the contents of this enrollment form. If signed by an authorized individual (as described above), 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.

Signature:_____ **Today's date:**_____

If you are the authorized representative, you must sign above and provide the following information:

Name: Relationship to enrollee:

Address: Phone number: - -

Are you the enrollee's Power of Attorney (POA)? ❑ Yes ❑ No

If yes, is the POA paperwork attached? ❑ Yes ❑ No

If no, please send in a copy of the POA agreement or other legal document to:
UCare Enrollment, P.O. Box 52, Minneapolis, MN 55440.
We must have the POA agreement on file in order to respond to future requests made by the POA.

If you have questions when completing the form,
please contact us at 1-877-598-6574 (TTY 1-800-688-2534)
8 a.m. to 8 p.m., seven days a week.

Please keep the bottom yellow copy for your records.
Send the white copy in the postage-paid envelope or fax to 612-884-2011.

UCare for Seniors is an HMO-POS plan with a Medicare contract. Enrollment in *UCare for Seniors* depends on contract renewal.

Please contact UCare if you need information in another language or format (Braille).