UnitedHealthcare

2023 Enrollment Request Form

1. Plan information

Plan sponsor

Group number	GPS employer ID

GPS branch number

Effective date requested:

(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)

Last name	First name	Middle initial
Birth date	Sex: ☐ Male ☐ Female	

Home phone number	Mobile phone number	Medicare number
( ) –	( ) –	

Permanent residence street address **(P.O. Box is not allowed)**

City	County	State	ZIP code

Mailing address **(Only if it's different from above. You can give a P.O. Box)**

City	State	ZIP code

Email address (Optional)

Last name First name Medicare number

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"**, what is it?

Name of other insurance

Member number	Group number
Rx Bin	Rx PCN (Optional)

Your answer to the following questions will not keep you from being enrolled in this plan:

3. A few questions to help us manage your plan

1. Would you prefer plan information in another language or an accessible format? ☐ Yes ☐ No

If **"yes"**, please select from the following:

☐ Spanish ☐ Braille ☐ Other ________________

2. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino, or Spanish origin
☐ I choose not to answer.

3. What's your race? Select all that apply.

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Samoan
☐ Guamanian or Chamorro
☐ Other Pacific Islander
☐ I choose not to answer.

4. Do you or your spouse work? ☐ Yes ☐ No

If **"no"**, what was your retirement date?

5. Do you have any health insurance other than Medicare, such as private insurance, Worker's Compensation, VA benefits or other employer coverage? ☐ Yes ☐ No

If **"yes"**, please provide the following:

Name of the health insurance

Member number

Last name First name Medicare number

6. Please give us the name of your primary care provider (PCP), clinic or health center.

Provider or PCP full name

Provider/PCP 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 provider? ☐ Yes ☐ No

7. Do you live in a nursing home, long-term care facility, or senior community? ☐ Yes ☐ No

If **"yes"**, please give us information on the nursing home, long-term care facility, or senior community:

Name

Address

City	State	ZIP code

Date you moved there

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. If my plan includes outpatient prescription drug benefits, I understand that my signature on this enrollment request form means that I will be automatically enrolled in my plan's outpatient prescription drug benefits which includes Part D and supplemental prescription drug coverage. 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**

Last name First name Medicare number

5. Authorized representative information

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare member ID card, I can call Customer Service at the number on my UnitedHealthcare member ID card to update my authorization information on file.

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 number	Referring broker 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) ____________________