



2024 Enrollment Request Form

1. Plan information

Plan sponsor

Schools Insurance Group

Group number

15453

GPS employer ID

25201

GPS branch number

001

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 _____

If you don't see the language or format you want, please call us toll-free at **1-877-714-0178**, (TTY **711**) during 8 a.m.-8 p.m. local time, Monday-Friday.

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

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> Yes, Mexican, Mexican American or Chicano/a | <input type="checkbox"/> Yes, Cuban | <input type="checkbox"/> I choose not to answer. |
| | <input type="checkbox"/> Yes, Puerto Rican | <input type="checkbox"/> Yes, another Hispanic, Latino, or Spanish origin | |
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3. What's your race? Select all that apply.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> White | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Other Asian | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Member/Citizen of a federal or state recognized Tribe (name of Tribe) | <input type="checkbox"/> Chinese | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> I choose not to answer. |
| | <input type="checkbox"/> Filipino | <input type="checkbox"/> Samoan | |
| | <input type="checkbox"/> Japanese | | |
| | <input type="checkbox"/> Korean | | |
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4. Do you or your spouse work?

Yes No

If “**no**”, what was your retirement date?

 Last name

First name

Medicare number

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

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

 Provider or PCP full name

 Provider/PCP number

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(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

Last name

First name

Medicare number

4. ATTENTION – please sign and date

Providing your email address above enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone.

If you would rather have hard copies of required materials mailed to you, please check here:

- Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

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

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

Last name	First name	Medicare number
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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
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<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
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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	Group number	PBP number
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SEP Employer Group SEP ICEP/IEP AEP (type) _____

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).