UnitedHealthcare®

# ENROLLMENT REQUEST FORM

To enroll in the UnitedHealthcare® Group Medicare Advantage (PPO) for Groups plan, please provide the following:

**1. Plan information:**

Plan Sponsor: SCHOOLS INSURANCE GROUP

Group Number: 15453

GPS Employer ID: N/A

GPS Branch Number: 001

**I prefer to receive materials in the following language:**

☐ Spanish
☐ Chinese (Spoken ☐ Cantonese ☐ Mandarin)
☐ Other _____

Please contact us 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.

Plan Sponsor use ONLY:
Please date stamp this document to indicate when you received the completed and signed form.

**Effective Date Requested:** ____ /____ /____
(i.e., your proposed effective date, or on what day your coverage should begin)

| Contracting Medical Group/Primary Care Physician (PCP) Name | Contracting Medical Group/Doctor Number |
|---|---|

Are you currently a patient of this doctor? ☐ Yes ☐ No

**2. Applicant information – as it appears on your Medicare card:** (Please print in black or blue ink.)

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

| Birth Date ____ /____ /____ | Sex ☐ Male ☐ Female | Home Telephone Number ( ) – |
|---|---|---|

Permanent Residence Street Address (P.O. box not allowed)

| City | State | ZIP | County |
|---|---|---|---|

Mailing Address (only if different from your Permanent Street Address) (P.O. box allowed for mailing only)

| City | State | ZIP |
|---|---|---|

Email Address

Emergency Contact

| Contact Telephone Number ( ) – | Contact Relationship to You |
|---|---|

In the future, would you be willing to receive materials through electronic means? ☐ Yes ☐ No

**3. Please provide your Medicare insurance information:**

Use your red, white and blue Medicare card to complete this section – 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. An incorrect or incomplete Medicare Claim Number may cause a delay or denial of coverage.

Medicare Claim Number

Part A (Hospital) Effective Date
____ /____ /____

Part B (Medical) Effective Date
____ /____ /____

Last Name First Name Medicare Claim Number

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 _____

Telephone Number of Institution ( ) – Date of Admission ____ /____ /____

**4. Medical information:**

| | |
|---|---|
| **Do you have End-Stage Renal Disease (ESRD)?** | ☐ Yes ☐ No |
| If **"yes"** how long have you been on Medicare for ESRD? | Start Date ____ /____ /____<br>End Date ____ /____ /____ |

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 ID number?

Do you or your spouse work? ☐ Yes ☐ No

If **"no,"** retirement date ____ /____ /____

**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 _____

ID 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

What is the name of the health insurance? _____

Group Number _____ ID 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.

**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 Centers for Medicare & Medicaid Services (CMS) guidelines.**

| **Applicant Signature** (or signature of authorized representative) | **Today's Date** |
|---|---|
| | ____ /____ /____ |