MEDICA HEALTHCARE
A UnitedHealthcare Company

# 2021 Enrollment Request Form

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

☐ **Medica HealthCare Plans MedicareMax (HMO) H5420-001-000 - MMH**

This is a Health Maintenance Organization (HMO) plan. It has a network of doctors, specialists, hospitals and other providers you must use.

**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 | County | State | ZIP Code |
|---|---|---|---|

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

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

Email Address

**Do you have other insurance that will cover your prescription drugs?** ☐ Yes ☐ No

(Examples: Other private insurance, TRICARE, Federal employee coverage, VA benefits, or state programs.)

If yes, what is it?

Name of Other Insurance

| Member Number | Group Number | Date Plan Started MM - DD - YYYY |
|---|---|---|

Enrollee Name _____

Agent Name / ID No. _____

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## 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:_____

| 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.

## How do you want to pay?

Response to these questions is optional.
If you have a monthly plan premium (including any late enrollment penalty you may owe), you can choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT) or by mail.

If you need to pay a late enrollment penalty (LEP), please choose how you want to pay it. If you don't choose an option below, we'll send a bill each month to your mailing address.

☐ **I want to pay from my Social Security or Railroad Retirement Board (RRB) check.**

I get monthly benefits from: ☐ Social Security ☐ RRB

We will bill you directly until the Social Security Administration or Railroad Retirement Board approves the deduction. It could take up to 90 days after the approval for the first deduction to occur, so please continue to make payments. If the Social Security Administration or Railroad Retirement Board does not approve your request for automatic deduction, we will notify you and continue to send a paper bill for your monthly premiums.

☐ **I want to pay directly from a bank account.**

☐ Please attach a blank check from the account you'd like to use. Write "VOID" across the front. Please DO NOT send a deposit slip or money order.

☐ Please read the statement below.

The bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). The bank will pay the funds from a checking or savings account on or about the fifth of each month. The charges may include up to $200 of current retroactive charges plus the monthly premium amount. If I choose to stop paying directly from the account, I will tell both UHIC

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and the bank. I will give them a reasonable amount of time to change the method of payment.

**Account Type ☐ Checking ☐ Savings**

Account Holder Name: _____

Bank Routing Number

Bank Account Number

**Signature** _____ **Date** MM - DD - YYYY

☐ **I want to pay online.**

Visit www.Medicaplans.com to make a payment directly from a bank account or a Visa, Mastercard credit card.

☐ **I want to pay by mail.**

We'll send a bill to your mailing address each month or you will receive an email notification if you signed up for e-delivery.

**If you want to pay by credit card.**

After you become a member, you can call us to have your monthly payment automatically charged to a Visa, Mastercard credit card. Until then, we'll send you a bill each month.

## A few notes about your costs.

**If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)**

Social Security (SS) will send you a letter and ask you how you want to pay it:

- You can pay it from your SS check
- Medicare can bill you
- The Railroad Retirement Board (RRB) can bill you

Please DO NOT pay the plan the Part D-IRMAA at this time.

**Need help with your prescription drug costs?**

If you have a limited income, you may be able to get Extra Help with your prescription drug costs. If you qualify, Medicare could pay for 75% or more of your costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, you won't have a coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. 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 part of your premium, we will bill you for the amount that Medicare doesn't cover.

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.

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## A few questions to help us manage your plan.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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

Please check what you'd like: ☐ Spanish ☐ Other_____

If you don't see the language or format you want, please call us toll-free at 1-844-723-6471, TTY 711 during 8 a.m. - 8 p.m. local time, 7 days a week. Or visit www.Medicaplans.com for online help.

**2. Are you enrolled in your State Medicaid program?** ☐ Yes ☐ No

If yes, please give us your Medicaid number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

**3. Do you live in a nursing home or a long-term care facility?** ☐ Yes ☐ No

If yes, please give us information on the long-term care facility:

| Name | | | |
|---|---|---|---|
| Address | City | State | ZIP Code |
| Phone Number ( ) – | Date You Moved There MM - DD - YYYY | | |

**4. Do you have health insurance with an employer or union right now?** ☐ Yes ☐ No

If yes, you could lose that plan if you join this plan. Please talk to your employer or union. Ask how joining this plan could affect your current plan. You may also want to check your employer or union's website, or read any information sent to you. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

**5. Do you or your spouse work?** ☐ Yes ☐ No

Do you or your spouse have other health insurance that will cover medical services? (Examples: Other employer group coverage, LTD coverage, Workman's Compensation, Auto Liability, or Veterans benefits) ☐ Yes ☐ No

If yes, please complete the following:

| Name of Health Insurance Company | |
|---|---|
| Subscriber Name | Group Number |
| Member Number | Effective Dates (if applicable) MM - DD - YYYY - MM - DD - YYYY |

Enrollee Name _____

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

You can find a list on the plan website or in the Provider Directory.

| Provider or PCP Full Name | Phone Number (  )  - |
|---|---|
| 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 doctor? ☐ Yes ☐ No

## Please read and sign.

**By completing this form, I agree to the following:**

- ☐ This is a Medicare Advantage plan. It has a contract with the federal government. This is not a Medicare Supplement plan.
- ☐ I must keep both Part A and Part B to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- ☐ I can only be in one Medicare health plan or Prescription Drug plan at a time. If I'm a member of another Medicare health plan or Prescription Drug plan and I join this plan, I will lose the other plan.
- ☐ If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan.
- ☐ I may have to pay a late enrollment penalty (LEP). This would only happen if I didn't sign up for and keep creditable prescription drug coverage when I first qualified for Medicare. "Creditable" means the coverage is as good as a Medicare prescription drug plan. If I need to pay an LEP, the plan will tell me.
- ☐ I understand that I am joining the plan for the entire calendar year. If I want to change plans, I'll need to do so during the Annual Enrollment Period for Medicare Advantage AND Medicare prescription drug coverage between October 15 and December 7. There may be special situations that would allow me to leave the plan at other times.
- ☐ This plan serves a specific service area. If I move out of the area that this plan 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 this plan I have the right to appeal plan decisions about payment or services if I disagree.
- ☐ I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- ☐ I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor UnitedHealthcare will pay for benefits or services**.
- ☐ I understand that I must get my health care coverage from doctors or providers that are in my plan's network. I can go to any doctor or hospital in an emergency or for urgently needed

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services or out-of-area dialysis services. If I happen to pay full price for any network services, this plan provides refunds for all medically necessary covered benefits.

- If I currently have Medicare Supplement Insurance (Medigap), I will cancel it in writing. I, not my agent, must cancel. I will cancel after my new plan tells me I've been accepted into the plan.
- **Release of Information:** By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that UnitedHealthcare will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- I give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health plan.
- I give consent for all entities under UnitedHealthcare and any outside vendor used by UnitedHealthcare to call the phone number(s) I have provided.
- If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help.
- The information on this 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.
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

**When I sign below, it means that I have read and understand the information on this form.**

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 you have received your member ID card, please call Customer Service at the number on the back of your member ID card to update your authorization information on file.

**Signature of Applicant/Member/Authorized Representative** Today's Date MM - DD - YYYY

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**If you are the authorized representative, please sign above and complete the information below.**

***NOT A SALES AGENT**

| Last Name | First Name | |
|---|---|---|
| Address | | |
| City | State | ZIP Code |
| Phone Number ( ) – | Relationship to Applicant | |

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## For licensed sales representative/agency use only.

| ☐ New Member<br>☐ Plan Change | Employer Group Name |
|---|---|
| Employer Group ID | Branch ID |
| Licensed Sales Representative/Writing ID<br>@AGENTID@ | Initial Receipt Date<br>MM - DD - YYYY |
| Licensed Sales Representative/Agent Name<br>@AGENTFULLNAME@ | Proposed Effective Date<br>MM - DD - YYYY |
| Licensed Sales Representative Phone Number @AGENTPHONE@ | |

Where did this application originate?

☐ National Retail/Mall Program ☐ Community Meeting ☐ Appointment ☐ Other
☐ Member Meeting ☐ Local Event Outreach ☐ Walmart Program

How was this application submitted? ☐ Mail ☐ Fax ☐ Online

**Agent must complete**

| | | | |
|---|---|---|---|
| ☐ IEP (MA-PD enrollees) | ☐ ICEP (MA enrollees) | ☐ IEP (MA-PD enrollees eligible for 2nd IEP) | ☐ OEP (Jan1 – Mar 31) |
| ☐ OEP (newly eligible) | ☐ SEP (Dual LIS change of status) | ☐ SEP (change in residence) | ☐ SEP (loss of EGHP coverage) |
| ☐ SEP (Chronic) | ☐ SEP (Dual LIS maintaining) | ☐ AEP (October 15-December 7) | ☐ OEPI |

☐ SEP (SEP Reason) _____
☐ SEP Eligibility Date MM - DD - YYYY

**Licensed Sales Representative Signature (required)** **Date:** MM - DD - YYYY

**Please mail or fax this completed form to:**

UnitedHealthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770

Fax: 1-888-950-1170

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**PRIVACY ACT STATEMENT:** The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Medica HealthCare is 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.

This information is available for free in other languages. Please call our customer service number located on the first page of this book.

Esta información esta disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la cobertura de este libro.

OMB No. 0938-1378
Expires: 7/31/2023

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