



UCare for Seniors Enrollment Request Form

Office use only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID#: _____

Effective date of coverage: _____

 ICEP/IEP OEP AEP SEP (type)_____ Not eligible_____**To enroll, please provide the following information:**

First name:	Middle initial:	Last name:
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Permanent residence street address:

City:	State:	Zip:
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Home phone number (include area code):	Alternate phone number/cell (include area code):
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County:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Mailing address (if different from permanent):
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Birth date (month/day/year):	Social Security number (optional):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Please choose the name of the primary care clinic you want to use:	Clinic Number:
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Please check which plan you want to enroll in:


- | | |
|--|--|
| <input type="checkbox"/> Value – Metro \$34 per month | <input type="checkbox"/> Value – Greater Minnesota \$41 per month |
| <input type="checkbox"/> Value Plus – Metro \$64 per month | <input type="checkbox"/> Value Plus – Greater Minnesota \$74 per month |
| <input type="checkbox"/> Classic – Metro \$102 per month | <input type="checkbox"/> Classic – Greater Minnesota \$120 per month |

Desired effective date: _____ *(Please note: In order for UCare to accept an enrollment request, a valid request must be made during an election period. Coverage always begins on the first of the month.)*

Please provide your Medicare insurance information.

Please take out your Medicare card to complete this section. Fill in these blanks so they match your red, white, and blue Medicare card OR attach a copy of your Medicare card or letter from the Social Security Administration or Railroad Retirement Board. You must have Medicare Part A and Part B to join a Medicare Advantage plan.

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MEDICARE  HEALTH INSURANCE	
SAMPLE ONLY	
Name: _____	
Medical Claim Number	Sex: _____
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Is Entitled To	Effective Date
Hospital (Part A)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Medical (Part B)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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 answered yes to this question and you do not need regular dialysis anymore or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant. Yes No

Answering questions 2-8 will not affect your ability or eligibility to join our plan.

2. Will you have other **prescription** drug coverage (such as private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance program) in addition to *UCare for Seniors*? Yes No
If yes, please list your other coverage and identification number(s) for this coverage:
Name of coverage: _____ ID#: _____ Group#: _____

3. Have you recently moved?
If yes, when: _____ Yes No

4. Are you a resident in a long-term care facility, such as a skilled nursing facility or nursing home? If yes, please provide the name, address, and phone number of the facility:

_____ Yes No

5. Are you enrolled in your State Medicaid Program?
If yes, please provide your Medicaid number: _____ Yes No

6. Do you receive extra help paying for Medicare Part D?
Are you losing eligibility for the extra help paying for Medicare Part D? Yes No Yes No

7. Do you or your spouse work? Yes No
8. Are you either losing coverage you had from an employer or union, or leaving employer or union coverage? If yes, when _____ Yes No
Please read this important information: If you have health coverage from an employer or union, joining UCare for Seniors may change how your current coverage works. If you have questions, read the communications your employer sent you, visit their web site, or contact your employer's group benefits administrator.

Your plan premium options:

You can choose to pay your *UCare for Seniors* premium in the following ways (please select one):
 Monthly billing.
 Monthly electronic funds transfer (EFT) from a checking or savings account. Please enclose a VOIDED check or provide the following:
Account holder name: _____ Account type: Checking Savings
Bank routing #: _____ Bank account #: _____
 Automatic deduction from your monthly Social Security Administration (SSA) benefit check. (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Generally, you must stay with the option you choose for the rest of the year.
Please note: If you qualify for extra help with your Medicare Part D costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you the amount that Medicare does not cover. If you don't select a payment option, you will receive a bill each month.

Please check the box below if you would prefer us to send you information in another format:
 Large print
Please contact *UCare for Seniors* at 1-877-523-1518, TTY users should call 1-800-688-2534 for more information regarding alternative formats. Our office hours are 8 a.m. to 8 p.m., seven days a week.

Please read and sign below:

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 Parts A and 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. Please note, I understand that if I do not 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: November 15-December 31 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 *UCare for Seniors* Evidence of Coverage document (known as a member contract or subscriber agreement) when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date *UCare for Seniors* coverage begins, I must get all of my health care from *UCare for Seniors*, with the exception of emergency or urgently needed services or out-of-area dialysis services. 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. Without authorization, **NEITHER MEDICARE NOR UCARE WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with *UCare for Seniors*, he/she may be compensated based on my enrollment in *UCare for Seniors*.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or prescription drug plan options and concerning medical assistance through the state Medicaid Program and the Medicare Savings Program.

Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that UCare 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 behalf of the individual under the laws of the State where the individual resides) 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 UCare or by Medicare.

Your signature: _____ **Today's date:** _____

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

Name: _____ **Address:** _____

Phone number: (____) _____ **Relationship to enrollee:** _____

Note: *Please include a copy of the Power of Attorney agreement or other legal document.*

***If you have questions when completing the form,
please contact us at 1-877-523-1518 (TTY 1-800-688-2534).
Keep the bottom (yellow) copy for your records. Send the white copy in the postage-paid envelope.***