

UCare for Seniors (HMO-POS) Short Enrollment Request Form

Name of plan you are enrolling in:		
Name:	Member or Medicare number:	
Home phone number (P.O. Box not allowed):		
Permanent street address:		
City:	State:	Zip code:
Mailing address (only if different from your permanent street address) Street address:		
City:	State:	Zip code:
Please fill out the following: I am currently a member of the _____ plan in UCare with a monthly premium of \$_____. I would like to change to the _____ plan in UCare. I understand that this plan has different health benefits and a monthly premium of \$_____.		
Name of chosen Primary Care Physician (PCP), clinic or health center:		
Please contact UCare at 1-877-523-1515 if you need information in another format or language other than English. Our office hours are 8 a.m. 8 p.m., daily. TTY users should call 1-800-688-2534.		

Your plan premium

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay UCare the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. 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.

If you qualify for extra help with your Medicare prescription drug coverage 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 for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

Get a bill.

Monthly electronic funds transfer (EFT) from a checking or savings account. Please provide the following:

Bank name: _____

Bank routing #: _____ Member bank account #: _____

Account type: Checking Savings

Automatic deduction from your monthly Social Security or RRB benefit check. (The Social Security deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and sign below:

UCare for Seniors is a plan that has a contract with the Federal government.

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

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 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 people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border, however this plan provides world-wide emergency care.

I understand that beginning on the date *UCare for Seniors*' coverage begins, I must get all of my health care from *UCare for Seniors*, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by UCare 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 my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. 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 from Medicare.

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: _____

Office Use Only:

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

If broker, add broker number: _____

