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

Name of the plan you are enrolling in:		
Name:	**Member or Medicare number:**	
Home phone number:		
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 check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

❑ Available languages: None

❑ Large print

Please contact UCare at 1-877-523-1515 if you need information in another format or language than what is listed above. Our office hours are 8 a.m. 8 p.m., seven days a week. TTY users should call 1-800-688-2534.

Your plan premium

You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

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:

Account holder name:____

Bank routing #:________________________ Bank account #:________________________

Account type: ❏ Checking ❏ Savings

❏ Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

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.

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 by UCare or by 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):

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