

Please read and answer these important questions:

1. Do you have end stage renal disease (ESRD)? (ESRD refers to kidney disease requiring dialysis.) Yes No
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

Answering questions 2 - 7 will not affect your ability or eligibility to join our plan.

2. Other than Medicare, will you continue to have other **medical** coverage in addition to UCare? Yes No
If yes: Policy holder name: _____

Plan name: _____
(as appears on ID card)
Policy or ID#: _____ Group#: _____
Effective date: _____ Phone#: _____

3. Will you have other **prescription** drug coverage in addition to UCare (such as private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance program)? If yes: Policy holder name: _____

Plan name: _____
(as appears on ID card)
Policy or ID#: _____ Group#: _____
Effective date: _____ Phone#: _____

4. Are you a resident in a long-term care facility, such as a skilled nursing facility or nursing home? Yes No
If yes, please provide the name, address, and phone number of the facility:

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

6. Do you receive Extra Help for Medicare Part D? Yes No

7. Are you losing eligibility for the Extra Help for Medicare Part D? Yes No
If so, when? (mm/dd/yyyy): _____ / _____ / _____

Office use only

Group Name:

Group Number:

Effective Date (mm/dd/yyyy):

____ / ____ / _____

ICEP/IEP SEP/LEC _____

Your Group UCare for Seniors plan premium options:

You can choose to pay your Group UCare for Seniors premium in the following ways (please select one):

- My UCare medical premiums are paid through my former employer.
- I choose monthly billing.
- I choose monthly electronic funds transfer (EFT) from a checking or savings account. Please provide:

Bank name:

Bank routing #: Account type: Checking Savings

Your bank account #:

If you do not select a payment option, you will get a bill each month.

Please note: People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% of drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subjected to the coverage gap or a late enrollment penalty. Many people are eligible 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 Part D costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Please read and sign the following page:

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 Part A and Part 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 don't 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: October 15-December 7 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 Evidence of Coverage document from UCare for Seniors when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually 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 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 getting assistance from a sales agent, broker, or other individual employed by or contracted with *UCare for Seniors*, 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 *UCare for Seniors* will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that *UCare for Seniors* 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 my behalf under the laws of the State where I live) 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 Medicare.

Signature: _____ **Today's date:** _____

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

Name:

Relationship to enrollee:

Address:

Phone number:

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Are you the enrollee's Power of Attorney (POA)?

Yes No

If yes, is the POA paperwork attached?

Yes No

If no, please send in a copy of the POA agreement or other legal document to:

UCare Enrollment, P.O. Box 52, Minneapolis, MN 55440.

We must have the POA agreement on file in order to respond to future requests made by the POA.

**If you have questions when completing the form,
please contact us at 1-877-598-6574 (TTY 1-800-688-2534).**

Please keep the bottom yellow copy for your records.
Send the white copy in the postage-paid envelope or fax to 612-884-2011.

Please contact UCare if you need information in another language or format (Braille).