



# UCare Comprehensive Dental Enrollment Form

Please type or print in ink.

**UCare Comprehensive Dental Coverage is only available to UCare for Seniors Classic (HMO-POS) and select UCare for Seniors Group (HMO-POS) members.**

Please indicate:

- I am enrolling in *UCare for Seniors Classic*.
- I am enrolling in *UCare for Seniors* through an employer group.
- I am currently a *UCare for Seniors Classic* member.

My member ID number is:

## Enrollee Information

Medical claim number (located on your Medicare card):

-  -  -

First name:

Middle initial:

Last name:

Street:

City:

State:

Zip:

-

Phone:

-  -

**Mailing address (if different from permanent address):**

Street:

City:

State:

Zip:

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**Payment options:**

- I currently have, or I am currently making arrangements to have, my UCare medical premiums withheld from my Social Security or Railroad Retirement Board check.
- I currently have, or I am currently making arrangements to have, my UCare medical premiums billed monthly or automatically deducted from my savings or checking account.
- My UCare medical premiums are paid through my former employer. (Applies to Group members only.)

**Release of information:** By joining *UCare Comprehensive Dental*, 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. 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 *UCare for Seniors* or by Medicare.

**Your signature:** \_\_\_\_\_ **Today's date:** \_\_\_\_\_

If you are the authorized representative, you must 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.**

*Retain the bottom (yellow) copy for your records.  
Send the top (white) copy to UCare or fax your form to 612-676-6562.*

A health plan with a Medicare contract.

**Office use only**

**Group Number:**

**Group Name:**

**Effective Date:**  -  -