UCare for Seniors Enrollment Request Form

To enroll, please provide the following information: Wisconsin

First name: Middle initial: Birth date (mm/dd/yyyy): / /

Last name: Sex: ❑ M ❑ F

Permanent residence street address (cannot be a P.O. box):

City: State:

Zip: - County:

Mailing address (if different from permanent):

Primary phone number (include area code): - -

Alternate phone number (include area code): - -

Please choose the name of the primary care clinic you want to use:

Clinic ID number (listed in the Provider Directory):

Desired effective date (mm/dd/yyyy): / /

(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 check which plan you want to enroll in*:**

❑ **Value – $61 per month**

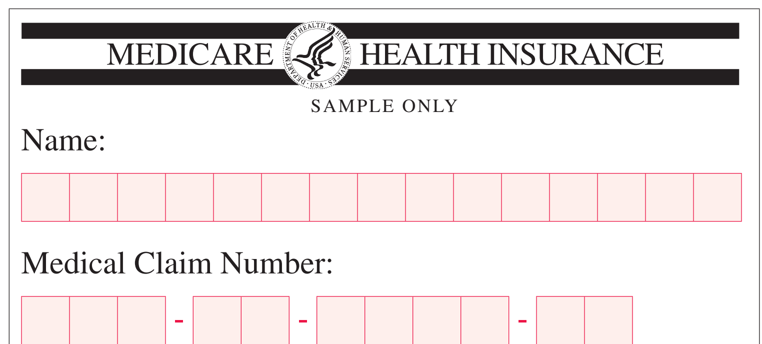
❑ **Value Plus – $89 per month**

❑ **Standard D – $67 per month**

❑ **Classic – $159 per 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 include a copy of your letter from Social Security or the Railroad Retirement Board. You must have Medicare Part A and Part B to join a Medicare Advantage plan.


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name:

Medical Claim Number: - - -

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 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. ❑ Yes ❑ No

Answering questions 2 - 10 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: ❑ Yes ❑ No
   Plan name: (as appears on ID card)
   Policy or ID#: Group#:
   Effective date: Phone#:

4. Have you recently moved and therefore *UCare for Seniors* is a new health plan option for you? ❑ Yes ❑ No
   If yes, when did you move? (mm/dd/yyyy): / /

5. 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:

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

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

   Have you had Extra Help for Medicare Part D but are losing or recently lost eligibility? ❑ Yes ❑ No
   If so, when? (mm/dd/yyyy): / /

8. Are you either losing coverage you had from an employer or union, or leaving employer or union coverage? If yes, what is the last date of coverage? (mm/dd/yyyy): / / ❑ Yes ❑ No
   Please read this important information: If you currently have health coverage from an employer or union, joining UCare for Seniors *could affect your employer or union health benefits. You could lose your employer or union coverage if you join* UCare for Seniors. *If you have questions, read the communications your employer sent you, visit their web site, or contact your employer's group benefits administrator.*

9. Did you recently involuntarily lose your creditable prescription drug coverage (coverage as good as Medicare's)? ❑ Yes ❑ No
   If yes, when did you lose your coverage? (mm/dd/yyyy): / /

10. Do you belong to the pharmacy assistance program provided by your state (e.g., WI SeniorCare)? ☐ Yes ☐ No

Your plan premium options:

You can choose to pay your *UCare for Seniors* premium (including any late enrollment penalty that you currently have or may owe) in the following ways **(please select one):**

☐ 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 #: | | | | | | | | | | | | | | |

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

Generally, you must stay with the option you choose for the rest of the year. If you do not select a payment option, you will get a bill each month. If you are assessed a Part D-Income related Monthly Adjustment Amount (IRMAA), 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 SS benefit check or be billed directly by Medicare or the RRB. DO NOT pay UCare the Part D-IRMAA.

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% or more of your 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 from Medicare.

Signature:____ **Today's date:**_______________

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

Name: **Relationship to enrollee:**

Address: **Phone number:** ___-___-____

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 1-877-523-1518 (TTY 1-800-688-2534).

Retain the bottom (yellow) copy for your records.
Send the top (white) copy in the postage-paid envelope or fax to 612-676-6562.

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

Office use only

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

______________________________________ If broker, add broker number: