



UCare for Seniors Group (HMO-POS) Enrollment Form

To enroll, please provide the following information:

First name:

Middle initial:

Birth date (month/day/year):

Last name:

Sex: M F

Permanent residence street address:

City:

State:

Zip:

County:

Mailing address (if different from permanent):

Home phone number (include area code):

Alternate phone number/cell (include area code):

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

Clinic ID number (listed in the Provider Directory):

Group name (company/former employer):

Are you a retiree? Yes No

If yes, date of retirement:

or dependent? Yes No

Desired effective date:

Coverage always begins on the first of the 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 attach a copy of your Medicare card or 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



Name:

SAMPLE ONLY

Medical Claim Number

Is Entitled to

Effective Date

Hospital (Part A)

Medical (Part B)

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 answered yes to this question and you don't need regular dialysis anymore, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.

Answering questions 2 - 8 will not affect your ability or eligibility to join our plan.

2. Will you have other **prescription** drug coverage in addition to *UCare for Seniors*? (such as private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or pharmaceutical assistance program) Yes No

If yes, please list your other coverage and identification (ID) number(s) for this coverage:

Name of coverage:

ID#:

Group#:

<input type="text"/>	<input type="text"/>	<input type="text"/>
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3. Will you have other medical coverage in addition to *UCare for Seniors*? Yes No

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:

<input type="text"/>

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/yyyy): -

8. Are you covered by an employer group plan? Yes No

Office use only

Group Name:

<input type="text"/>

Group Number:

<input type="text"/>

ICEP/IEP SEP/LEC _____

Your Group plan premium options:

UCare will either bill your former employer or you will be billed at home for premium payment. If you will be billed at home, you can choose to pay your UCare for Seniors premium in the following ways (please select one) *If you don't select a payment option, you will receive a bill each month:*

Monthly billing.

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

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 below:

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 Parts A and 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: November 15-December 31 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.

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 *UCare for Seniors* or 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: ____ - ____ - _____
Are you the enrollee's Power of Attorney (POA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, is the POA paperwork attached?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	

**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.