



# 2024 Enrollment Request Form

UHC Preferred Dual Complete FL-D001 (HMO D-SNP) H1045-012-000 - B6H

**Information about you** (Please type or print in black or blue ink)

Last name	First name	Middle initial
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Birth date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Home phone number ( ) -	Mobile phone number ( ) -
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Social Security number  
(Required for people who are enrolling in D-SNP plans):

■ ■ ■ ■ - ■ ■ ■ - ■ ■ ■ ■ ■ ■
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Medicare number

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Permanent residence street address (**P.O. box is not allowed**)

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City	County	State	ZIP code
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Mailing address (**Only if it's different from above. You can give a P.O. box.**)

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City	State	ZIP code
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Email address (optional)

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**Do you have other insurance that will cover your prescription drugs?**  Yes  No  
(Examples: Other private insurance, TRICARE, federal employee coverage, VA benefits or state programs.)

If yes, what is it?  
Name of other insurance

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Member number	Group number	RxBin	RxPCN (optional)
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Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Enrollee name \_\_\_\_\_  
Agent name/ID number \_\_\_\_\_

**How do you want to pay?**

If you have a monthly plan premium (including any late enrollment penalty you may owe) you can pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT).

If you don't choose an option below, we'll send a bill each month to your mailing address.

If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), Social Security (SS) will send you a letter and ask you how you want to pay it:

- You can pay it from your SS check
- Medicare can bill you
- The Railroad Retirement Board (RRB) can bill you

- I want to pay from my Social Security check
- I want to pay from my Railroad Retirement Board (RRB) check
- I want to pay directly from a bank account

Account type  Checking  Savings  
 Account holder name: \_\_\_\_\_  
 Bank routing number \_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_  
 Bank account number \_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_/\_\_

**A few questions to help us manage your plan**

**1. Would you prefer plan information in another language or an accessible format?**  Yes  No

Please check what you'd like:  Spanish  Braille  Other \_\_\_\_\_

If you don't see the language or format you want, please call us toll-free at **1-855-874-6282**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **myPreferredCare.com** for online help.

**2. Are you enrolled in your state Medicaid program?**  Yes  No

If yes, please give us your Medicaid number: \_\_\_\_\_

Enrollee name \_\_\_\_\_

Agent name/ID number \_\_\_\_\_

**3. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.**

- No, not of Hispanic, Latino/a, or Spanish origin
- Yes, Mexican, Mexican American, or Chicano/a
- Yes, Puerto Rican
- Yes, Cuban
- Yes, another Hispanic, Latino, or Spanish origin
- I choose not to answer

**4. What's your race? Select all that apply.**

- |   |  |                                     |
|---|--|-------------------------------------|
| <input type="checkbox"/> White  | <input type="checkbox"/> Black or African American |                                     |
| <input type="checkbox"/> American Indian or Alaska Native   |  |                                     |
| <input type="checkbox"/> Asian Indian   | <input type="checkbox"/> Chinese                   | <input type="checkbox"/> Filipino   |
| <input type="checkbox"/> Japanese   | <input type="checkbox"/> Korean                    | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Other Asian  | <input type="checkbox"/> Native Hawaiian           | <input type="checkbox"/> Samoan     |
| <input type="checkbox"/> Guamanian or Chamorro  | <input type="checkbox"/> Other Pacific Islander    |                                     |
| <input type="checkbox"/> I choose not to answer   |  |                                     |
| <input type="checkbox"/> Member/Citizen of a federal or state recognized Tribe (name of Tribe)_____ |  |                                     |

**5. Do you or your spouse work?**  Yes  No

Do you or your spouse have other health insurance that will cover medical services?  
 (Examples: Other employer group coverage, LTD coverage, Workers' Compensation,  
 auto liability, or Veterans benefits)  Yes  No

If yes, please complete the following:

\_\_\_\_\_  
 Name of health insurance company

\_\_\_\_\_  
 Member number

**6. Please give us the name of your primary care provider (PCP), clinic or health center.**

You can find a list on the plan website or in the Provider Directory.

\_\_\_\_\_  
Provider or PCP full name

Provider/PCP number: \_\_\_\_\_ (Please enter the number exactly as it appears  
 on the website or in the Provider Directory. It will  
 be 10 to 12 digits. Don't include dashes.)

Are you now seeing or have you recently seen this provider?  Yes  No

Enrollee name \_\_\_\_\_

Agent name/ID number \_\_\_\_\_

**Please read and sign**

**By completing this form, I agree to the following:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information.
- I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.
- I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private-Fee-For-Service (PFFS), MA Medicare Medical Savings Account (MSA) plans).
- Release of information:** By joining this Medicare Advantage Plan, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- I give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health plan.
- I give consent for all entities under UnitedHealthcare and its affiliates and any outside vendor used by UnitedHealthcare to call the phone number(s) I have provided using an autodialer and/or prerecorded voice.
- The information on this 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.
- My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

**When I sign below, it means that I have read and understand the information on this form**

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file.

Enrollee name \_\_\_\_\_

Agent name/ID number \_\_\_\_\_

Signature of applicant/member/authorized representative    Today's date

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**If you are the authorized representative, please sign above and complete the information below**

**\* Not a Sales Agent**

Last name

First name

Address

City

State

ZIP code

Phone number (       )       -

Relationship to applicant

Enrollee name \_\_\_\_\_

Agent name/ID number \_\_\_\_\_

**For Licensed Sales Representative/agency use only**

Licensed Sales Representative/writing ID	Initial receipt date
Licensed Sales Representative/agent name	Proposed effective date
Employer group name	
Employer group ID <input type="text"/>	Branch ID <input type="text"/>

**Agent must complete**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> IEP (MA-PD enrollees) | <input type="checkbox"/> ICEP (MA enrollees)             | <input type="checkbox"/> IEP (MA-PD enrollees eligible for 2nd IEP) | <input type="checkbox"/> OEP (Jan 1 – Mar 31)        |
| <input type="checkbox"/> OEP (Newly eligible)  | <input type="checkbox"/> SEP (Dual LIS change of status) | <input type="checkbox"/> SEP (Change in residence)                  | <input type="checkbox"/> SEP (Loss of EGHP coverage) |
| <input type="checkbox"/> SEP (Chronic)         | <input type="checkbox"/> SEP (Dual LIS maintaining)      | <input type="checkbox"/> AEP (October 15-December 7)                | <input type="checkbox"/> OEPI                        |
- SEP (SEP reason) \_\_\_\_\_

<b>Licensed Sales Representative signature (optional)</b>	<b>Date</b>
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**Please mail or fax this completed form to:**

UnitedHealthcare  
P.O. Box 30769  
Salt Lake City, UT 84130-0769

Fax: 1-888-950-1169

Fax the front and back of each page

Enrollee name \_\_\_\_\_  
Agent name/ID number \_\_\_\_\_  
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**PRIVACY ACT STATEMENT:** The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

UHC Preferred Dual Complete FL-D001 (HMO D-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare.

Preferred Care Partners is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare. This plan is available to anyone who has both Medical Assistance from the State and Medicare.

This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

OMB No. 0938-1378

Expires: 7/31/2024

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## Enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

### Understanding the benefits

- ✓ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit our plan website or call to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.
- ✓ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ✓ Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ✓ Review the Formulary to make sure your drugs are covered.

### Understanding important rules

- ✓ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medicaid or another third party. This premium is normally taken out of your Social Security check each month.
- ✓ Benefits may change on January 1 of each year.
- ✓ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ✓ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ✓ This plan is a Dual Eligible Special Needs Plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.