Preferred Care Partners
A UnitedHealthcare Company

# 2024 Enrollment Request Form

☐ **UHC Preferred Complete Care FL-0003 (HMO C-SNP) H1045-018-000 - B5L**

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

| Last name | First name | Middle initial |
|---|---|---|
| | | |

| Birth date | Sex ☐ Male ☐ Female |
|---|---|
| Home phone number ( ) - | Mobile phone number ( ) - |

Medicare number

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

| City | County | State | ZIP code |
|---|---|---|---|
| | | | |

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

| City | State | ZIP code |
|---|---|---|
| | | |

Email address (optional)

**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

| Member number | Group number | RxBin | RxPCN (optional) |
|---|---|---|---|
| | | | |

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

## How do you want to pay?

Enrollee name _____

Agent name/ID number _____

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 **1-855-548-1564**, TTY **711,** 8 a.m.-8 p.m. local time, 7 days a week. Or visit **myPreferredCare.com** for online help.

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**2. 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

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Enrollee name _____

Agent name/ID number _____

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

____ White
____ Black or African American
____ American Indian or Alaska Native
____ Asian Indian
____ Chinese
____ Filipino
____ Japanese
____ Korean
____ Vietnamese
____ Other Asian
____ Native Hawaiian
____ Samoan
____ Guamanian or Chamorro
____ Other Pacific Islander
____ I choose not to answer
____ Member/Citizen of a federal or state recognized Tribe (name of Tribe)_____

**4. 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

**5. 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

## 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

Enrollee name _____

Agent name/ID number _____

(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.

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

Enrollee name _____

Agent name/ID number _____

**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 | Branch ID |
|---|---|

**Agent must complete**

| | | | |
|---|---|---|---|
| ☐ IEP (MA-PD enrollees) | ☐ ICEP (MA enrollees) | ☐ IEP (MA-PD enrollees eligible for 2nd IEP) | ☐ OEP (Jan 1 – Mar 31) |
| ☐ OEP (Newly eligible) | ☐ SEP (Dual LIS change of status) | ☐ SEP (Change in residence) | ☐ SEP (Loss of EGHP coverage) |
| ☐ SEP (Chronic) | ☐ SEP (Dual LIS maintaining) | ☐ AEP (October 15-December 7) | ☐ OEPI |

☐ SEP (SEP reason) _____

**Licensed Sales Representative signature (optional)** **Date**

**Please mail or fax this completed form to:**

UnitedHealthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770

Fax: 1-888-950-1170

Fax the front and back of each page

Enrollee name _____
Agent name/ID number _____

**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 Complete Care FL-0003 (HMO C-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. 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. Enrollment in the plan depends on the plan's contract renewal with Medicare. This plan is available to anyone having a qualifying chronic care condition.

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

# 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. 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 Chronic Condition Special Needs Plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.