Underwritten by
UnitedHealthcare Insurance Company

Enrollment Request Form

Outpatient Prescription Drug Plan

Underwritten by
UnitedHealthcare Insurance Company

Required Information

Employer/Former Employer Name:	
Employer ID #:	Employer Subsidy Group #:
Employer Billing #:	

Outpatient Prescription Drug Plan Enrollment Form

(Please Print)

Please complete the entire form ▪ Incomplete information can delay the enrollment process
(Please Print – If you need more room for your answers to any questions, please use a separate sheet of paper.)

Date of Retiree's Retirement ___ / ___ / ___ (mm / dd / yyyy)	Source of Enrollment ☐ Open Enrollment ☐ Newly Eligible ☐ Special Enrollment

1. Personal Information

Applicant Last Name	Applicant First Name	MI	Suffix

☐ Male ☐ Female	Date of Birth ___ / ___ / ___ (mm / dd / yyyy)	Marital Status of Applicant: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Name of Retiree	Relation to Retiree: ☐ Self ☐ Spouse ☐ Child

Medicare Claim #	Part A Effective Date ___ / ___ / ___ (mm / dd / yyyy)	Part B Effective Date ___ / ___ / ___ (mm / dd / yyyy)	Part D Effective Date ___ / ___ / ___ (mm / dd / yyyy)

Permanent Residence Street Address (P.O. Box is not allowed)	City	State	Zip

Home Telephone # ( )	Alternate Telephone # ( )	E-mail Address

In the future, would you be willing to receive materials through electronic means? ☐ Yes ☐ No

If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next three lines. Providing this information will not affect your eligibility to enroll.

Institution Name	Date of Admission ___ / ___ / ___ (mm / dd / yyyy)	Telephone # ( )

Address	City	State	Zip

Doctor's Name	Doctor's Telephone # ( )

Applicant Last Name | Applicant First Name | MI | Medicare Claim #

2. Benefit Coordination / Other Insurance Carrier Information

1. Do you have other health insurance? ☐ Yes ☐ No If Yes, complete Section 1a. – 1e. below.

2. Are you permanently disabled? ☐ Yes ☐ No If Yes, complete the following:

2a. Date disability began: ____ / ____ / ____
mm / dd / yyyy

3. Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No

If you have special needs, this document may be available in other formats or languages upon request. Please contact us at **1-888-556-6648,** TTY users should call **711**. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week.

Do you work or plan to work? ☐ Yes ☐ No

1a. Name	1b. Insurance Company Name	1c. Policy #	1d. Effective Date	1e. Other Employer Name and Address
			____ / ____ / ____ mm / dd / yyyy	
			____ / ____ / ____ mm / dd / yyyy	

FOR OFFICE USE ONLY

RETIREE ☐ YES ☐ NO GROUP # _____

PLAN CODE _____

SPOUSE OR CHILD
☐ YES ☐ NO

VERIFICATION: _____ DATE _____/_____/_____
Initial

FOR EMPLOYER USE ONLY

☐ Enrollee is eligible for retiree coverage

Effective Date: _____/_____/_____

_____
Initial

Applicant Last Name	Applicant First Name	MI	Medicare Claim #

3. Terms and Conditions

I am requesting enrollment under the UnitedHealthcare Insurance Company ("UnitedHealthcare") Group Retiree Policy. By signing this Enrollment Form, I agree to and understand the following:

1. All coverage is subject to the terms and conditions of the UnitedHealthcare Group Policy.
2. UnitedHealthcare or its designee shall have access and use of my medical records for purposes of utilization review surveys, processing of claims, financial audit or other purposes reasonably related to the performance of this Enrollment Form.
3. Any material omission or intentional misrepresentation in answering the questions on this Enrollment Form may result in the denial of benefits and the termination of my coverage.
4. Coverage shall not begin until acceptance of this Enrollment Form by UnitedHealthcare. Acceptance will not occur until after UnitedHealthcare validates Medicare coverage and eligibility for coverage under the group retiree plan. Upon acceptance of this Enrollment Form, UnitedHealthcare shall be bound by the terms of my UnitedHealthcare Group Policy and the Amendments thereto (if applicable).
5. My current prescription drug coverage under Part D is provided by a UnitedHealthcare plan. I understand that if my coverage under the Part D plan ends, this coverage will also end.
6. All statements and descriptions in this enrollment form are deemed to be representations and not warranties.
7. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I certify that I have read the Terms and Conditions printed on this Enrollment Form and that I accept them and will abide by them. I further certify that the information provided in the Enrollment Form is true and complete to the best of my knowledge and belief.

Print Name of Applicant:		
Signature of Applicant or Authorized Representative:	Today's Date:	**Signature**

Authorized Representative Information

If you are the authorized representative (Responsible Party, Power of Attorney, Family Member, etc.), you must sign above and provide the following information:

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip code: _____

Relationship to Enrollee: _____


Please Open To Continue Completing Form

Duplicate of Form

WHITE COPY – UNITEDHEALTHCARE PINK COPY – RETIREE

Duplicate of Form

WHITE COPY – UNITEDHEALTHCARE PINK COPY – RETIREE

Duplicate of Form

WHITE COPY – UNITEDHEALTHCARE PINK COPY – RETIREE