United Healthcare® Dual Complete

2021 Enrollment Request Form

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Please contact the plan if you need this information in another language or an accessible format (Braille).

☒ **UnitedHealthcare Dual Complete® LP1 (HMO-POS D-SNP) H0169-004-000 - UD7**

This plan is designed for people with both Medicare and Medicaid. We may need to contact you to ask for proof of eligibility.

This is a Health Maintenance Organization - Point of Service (HMO-POS) plan. It has a network of doctors, specialists, hospitals and other providers you can use. In some cases, you may get covered services from out-of-network providers. However, if you go to a provider within the network, the costs may be lower.

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

☐ Mr. ☐ Mrs. ☒ Ms.

Last Name: Walker

First Name: Shermaine

Middle Initial:

Birth Date: 1 - 14 - 1973

Sex ☐ Male ☒ Female

Daytime Phone Number: (316) 794-9782

Mobile Phone Number: ( ) -

Social Security Number (Required for people who are enrolling in D-SNP plans): ___ - ___ - ____

Permanent Residence Street Address **(P.O. Box is not allowed)**: 2247 N. Piatt

City: Wichita County: Sedgwick State: KS ZIP Code: 67219

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

City County State ZIP Code

Email Address

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Ready to Enroll

Enrollee Name: Shermaine Walker

Agent Name / ID No.: Lindsay Mills 2220680

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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

Member Number | Group Number | Date Plan Started MM - DD - YYYY

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Information about your Medicare.

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card): Shermaine Walker

Medicare Number: 2QH2L186DM94

Sex: F

Is Entitled to	Effective Date
Hospital (Part A)	08-01-2021
Medical (Part B)	08-01-2021

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

If your plan has a premium how do you want to pay?

Response to these questions is optional.

If you have a monthly plan premium (including any late enrollment penalty you may owe), you can choose to 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) or by mail.

If you need to pay a late enrollment penalty (LEP), please choose how you want to pay it. If you don't choose an option below, we'll send a bill each month to your mailing address.

☒ **I want to pay from my Social Security or Railroad Retirement Board (RRB) check.**

I get monthly benefits from: ☒ Social Security ☐ RRB

We will bill you directly until the Social Security Administration or Railroad Retirement Board approves the deduction. It could take up to 90 days after the approval for the first deduction to occur, so please continue to make payments. If the Social Security Administration or Railroad Retirement Board does not approve your request for automatic deduction, we will notify you and continue to send a paper bill for your monthly premiums.

☐ **I want to pay directly from a bank account.**

Enrollee Name Shermaine Walker

- Please attach a blank check from the account you'd like to use. Write "VOID" across the front. Please DO NOT send a deposit slip or money order.
- Please read the statement below.

The bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). The bank will pay the funds from a checking or savings account on or about the fifth of each month. The charges may include up to $200 of current retroactive charges plus the monthly premium amount. If I choose to stop paying directly from the account, I will tell both UHIC and the bank. I will give them a reasonable amount of time to change the method of payment.

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Account Type ☐ Checking ☐ Savings

Account Holder Name: _____

Bank Routing Number

Bank Account Number

Signature _____ **Date** MM - DD - YYYY

☐ **I want to pay by mail.**
We'll send a bill to your mailing address each month.

If you want to pay by credit card.
After you become a member, you can call us to have your monthly payment automatically charged to a Visa, Mastercard or Discover credit card. Until then, we'll send you a bill each month.

A few notes about your costs.

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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

Please DO NOT pay the plan the Part D-IRMAA at this time.

Need help with your prescription drug costs?
If you have a limited income, you may be able to get Extra Help with your prescription drug costs. If you qualify, Medicare could pay for 75% or more of your costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, you won't have a coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only part of your premium, we will bill you for the amount that Medicare doesn't cover.

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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.

A few questions to help us manage your plan.

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

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

Please check what you'd like: ☐ Spanish ☐ Other_____

If you don't see the language or format you want, please call us toll-free at 1-844-560-4944, TTY 711 during 8 a.m. - 8 p.m. local time, 7 days a week. Or visit www.UHCCommunityPlan.com for online help.

2. Are you enrolled in your State Medicaid program? ☒ Yes ☐ No

If yes, please give us your Medicaid number: DD00152042

3. Do you live in a nursing home or a long-term care facility? ☐ Yes ☒ No

If yes, please give us information on the long-term care facility:

Name

Address | City | State | ZIP Code

Phone Number ( ) – | Date You Moved There MM - DD - YYYY

4. Do you have health insurance with an employer or union right now? ☐ Yes ☒ No

If yes, you could lose that plan if you join this plan. Please talk to your employer or union. Ask how joining this plan could affect your current plan. You may also want to check your employer or union's website, or read any information sent to you. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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5. Do you or your spouse work?

Do you or your spouse have other health insurance that will cover medical services? ☐ Yes ☒ No
(Examples: Other employer group coverage, LTD coverage, Workman's Compensation, Auto Liability, or Veterans benefits)
If yes, please complete the following: ☐ Yes ☒ No

Name of Health Insurance Company

Subscriber Name

Group Number

Member Number

Effective Dates (if applicable)
- - - -

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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
Nichole Riddel

Phone Number (316) 274-9850

Provider/PCP Number:
00372127300 3

(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 doctor? ☒ Yes ☐ No

To select paperless delivery complete and sign the application and provide your email address.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

If you would rather have hard copies of required materials mailed to you, please check here

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

TEAR HERE

Please read and sign. Shermaine Walker

By completing this form, I agree to the following:

- This is a Medicare Advantage plan. It has a contract with the federal government. This is not a Medicare Supplement plan.
- I must keep both Part A and 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.

Enrollee Name Shermaine Walker

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, Workman's Compensation, Auto Liability, or Veterans benefits) ☐ Yes ☒ No

If yes, please complete the following:

Name of Health Insurance Company

Subscriber Name

Group Number

Member Number

Effective Dates (if applicable)
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Enrollee Name Shermane Walker

- I can only be in one Medicare health plan or Prescription Drug plan at a time. If I'm a member of another Medicare health plan or Prescription Drug plan and I join this plan, I will lose the other plan.
- If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan.
- I may have to pay a late enrollment penalty (LEP). This would only happen if I didn't sign up for and keep creditable prescription drug coverage when I first qualified for Medicare. "Creditable" means the coverage is as good as a Medicare prescription drug plan. If I need to pay an LEP, the plan will tell me.
- I understand that I am joining the plan for the entire calendar year. If I want to change plans, I'll need to do so during the Annual Enrollment Period for Medicare Advantage AND Medicare prescription drug coverage between October 15 and December 7. There may be special situations that would allow me to leave the plan at other times.
- This plan serves a specific service area. If I move out of the area that this plan 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 this plan I have the right to appeal plan decisions about payment or services if I disagree.
- 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.
- 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. **Without authorization, neither Medicare nor UnitedHealthcare will pay for benefits or services**.
- I understand that beginning on the date the plan coverage begins, using network services can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If I happen to pay full price for any network or out-of-network services received, this plan provides refunds for all medically necessary covered benefits.
- If I currently have Medicare Supplement Insurance (Medigap), I will cancel it in writing. I, not my agent, must cancel. I will cancel after my new plan tells me I've been accepted into the plan.
- **Release of Information:** By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that UnitedHealthcare will release my information, including my prescription drug event data, to Medicare, who may release it for research and 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 any outside vendor used by UnitedHealthcare to call the phone number(s) I have provided.

Enrollee Name Shermaine Walker

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Ready to Enroll

- If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help.
- 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.
- Your 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 you have received your member ID card, please call Customer Service at the number on the back of your member ID card to update your authorization information on file.

Signature of Applicant/Member/Authorized Representative Today's Date 09-02-2021

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

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For licensed sales representative/agency use only.

☒ New Member Employer Group Name
☐ Plan Change

Employer Group ID Branch ID

Licensed Sales Representative/Writing ID
2220680

Initial Receipt Date
09-02-2021

Licensed Sales Representative/Agent Name
Lindsay Mills

Proposed Effective Date
10-01-2021

Licensed Sales Representative Phone Number 3163212387

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Where did this application originate?

☐ National Retail/Mall Program ☐ Community Meeting ☒ Appointment ☐ Other
☐ Member Meeting ☐ Local Event Outreach ☐ Walmart Program

How was this application submitted? ☐ Mail ☒ Fax ☐ Online

Agent must complete

☐ IEP (MA-PD enrollees) ☐ ICEP (MA enrollees) ☐ IEP (MA-PD enrollees eligible for 2nd IEP) ☐ OEP (Jan1 – 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)
☐ SEP Eligibility Date 09-01-2021

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Licensed Sales Representative Signature (required) **Date:** 09-02-2021

Lindsay Mills

Please mail or fax this completed form to:

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

Fax: 1-888-950-1170

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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.

Plans are 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 information is available for free in other languages. Please call our customer service number located on the first page of this book.

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

OMB No. 0938-1378
Expires: 7/31/2023

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