United Healthcare®

2021 Enrollment Request Form

1. Plan information

Plan Sponsor

Santa Barbara County Firefighters Local 2046

Group Number	GPS Employer ID
15883	024994

GPS Branch Number

001

Effective Date Requested: MM – DD – YYYY

(i.e., your proposed effective date, or on what day your coverage should begin)

Plan Sponsor use ONLY: Please date stamp this document to indicate when you received the completed and signed form.

To enroll in the UnitedHealthcare® Group Medicare Advantage (PPO) plan, please provide the following:

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

☐ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial

Birth Date MM – DD – YYYY	Sex: ☐ Male ☐ Female
Daytime Phone Number ( ) –	Mobile Phone Number ( ) –

Permanent Residence Street Address **(P.O. Box is not allowed)**

City	State	ZIP Code	County

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

City	State	ZIP Code

Email Address

Last Name First Name Medicare Number

Emergency Contact

Contact Phone Number
( ) –

Contact Relationship to You

3. 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):

Medicare Number:

Sex: ☐ Male ☐ Female

Is Entitled to	Effective Date
Hospital (Part A)	MM – DD – YYYY
Medical (Part B)	MM – DD – YYYY

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

4. A few questions to help us manage your plan

Would you prefer plan information in another language or an accessible format? ☐ Yes ☐ No
If **"yes"**, please select from the following:
☐ Spanish ☐ Other
If you don't see the language or format you want, please call us toll-free at , (TTY) during .

Do you or your spouse work? ☐ Yes ☐ No
If **"no"**, what was your retirement date? MM – DD – YYYY

Last Name First Name Medicare Number

Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If **"yes"**, please provide the following:

Name of Institution

Address of Institution

City	State	ZIP Code
Phone Number of Institution ( ) –	Date of Admission MM – DD – YYYY	

Your answer to the following questions will not keep you from being enrolled in this plan:

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State Pharmaceutical Assistance Programs.

Will you have other **prescription drug coverage** in addition to our plan? ☐ Yes ☐ No

If **"yes"**, please provide the following:

Name of Other Coverage

Member Number for Coverage	Group Number for Coverage

Do you have any **health insurance** other than Medicare, such as private insurance, Worker's Compensation, VA benefits or other employer coverage? ☐ Yes ☐ No

If **"yes"**, please provide the following:

Name of the Health Insurance

Member Number for Coverage	Group Number for Coverage

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

Contracting Medical Group/Primary Care Provider (PCP) Name	Phone number ( ) –

Contracting Medical Group/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 doctor? ☐ Yes ☐ No

Last Name | First Name | Medicare Number

5. ATTENTION – please sign and date

I understand that my signature on this Enrollment Request Form means that I have read and understood the contents of this Enrollment Request Form, including the Statements of Understanding, and that the information provided by me is accurate and complete. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

This Enrollment Request Form must be signed, dated and received prior to your desired effective date. Upon receipt, the plan will process the form according to Medicare guidelines.

Signature of applicant/member/authorized representative | **Today's Date** MM – DD – YYYY

6. Authorized representative information

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 UnitedHealthcare member ID card, please call Customer Service at the number on the back of your UnitedHealthcare member ID card to update your authorization information on file.

Signature | **Today's Date** MM – DD – YYYY

7. If someone assisted you in completing this form, please have that person complete the information below

Signature (of individual who assisted in completing this form) | **Today's Date** MM – DD – YYYY

☐ Plan Representative, check here if you signed above and assisted in completing this form.

Relationship to Applicant

Sales Representative/Broker, please provide your signature and complete the information below:

Licensed Sales Representative/Broker Signature | **Today's Date** MM – DD – YYYY

Licensed Sales Representative/Broker Name (Please Print)

Agent/Broker Number

Referring Broker Number

Last Name | First Name | Medicare Number

8. For office use only

Agent Name

Agent Number		NIPR Number
Effective Date MM–DD–YYYY	Group Number	PBP Number

☐ SEP ☐ Employer Group SEP ☐ ICEP/IEP ☐ AEP (type) _____

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 primera página de este libro.