## How to enroll

You can enroll by phone, mail or fax. Simply choose the way that is easiest for you and follow the Enrollment Request Form checkpoints below.



#### By phone

Contact us at toll-free **1-877-714-0178**, TTY **711**, 8 a.m. - 8 p.m. local time, 7 days a week to enroll over the phone.



#### By mail

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



#### By fax

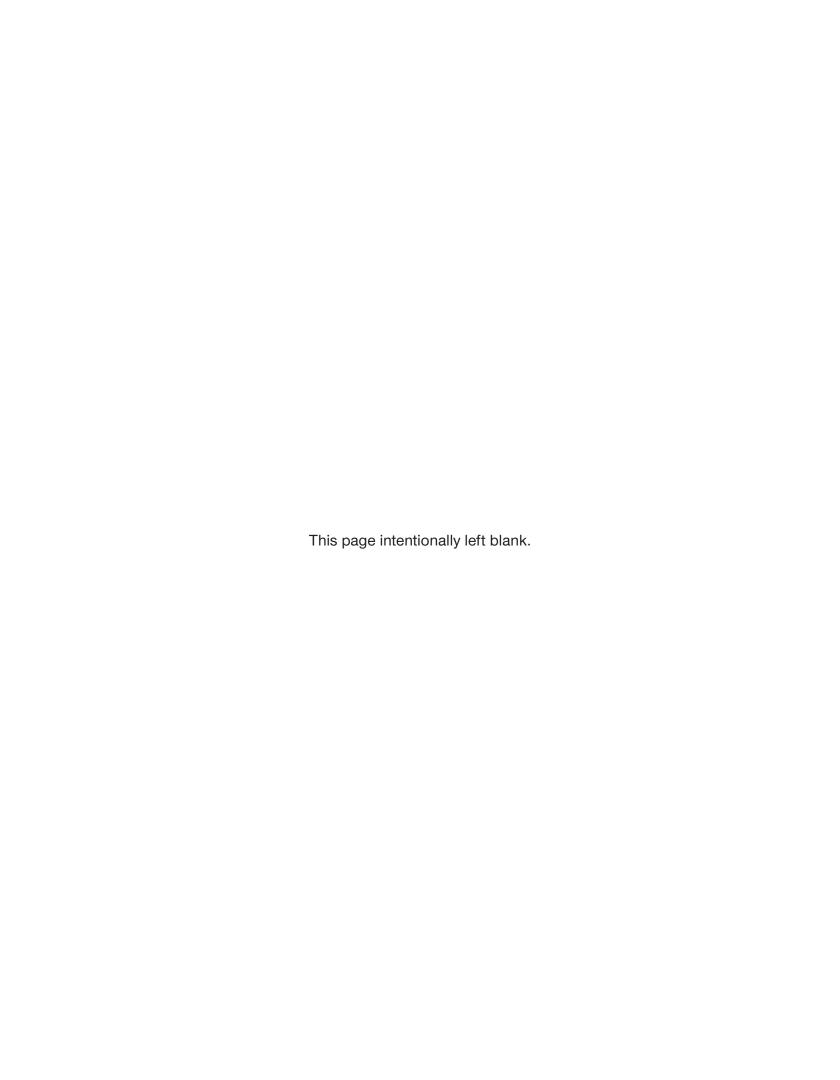
Fill out the Enrollment Request Form and fax it to:

888-950-1170

Incomplete information may delay your enrollment.

### **Enrollment Request Form checkpoints**

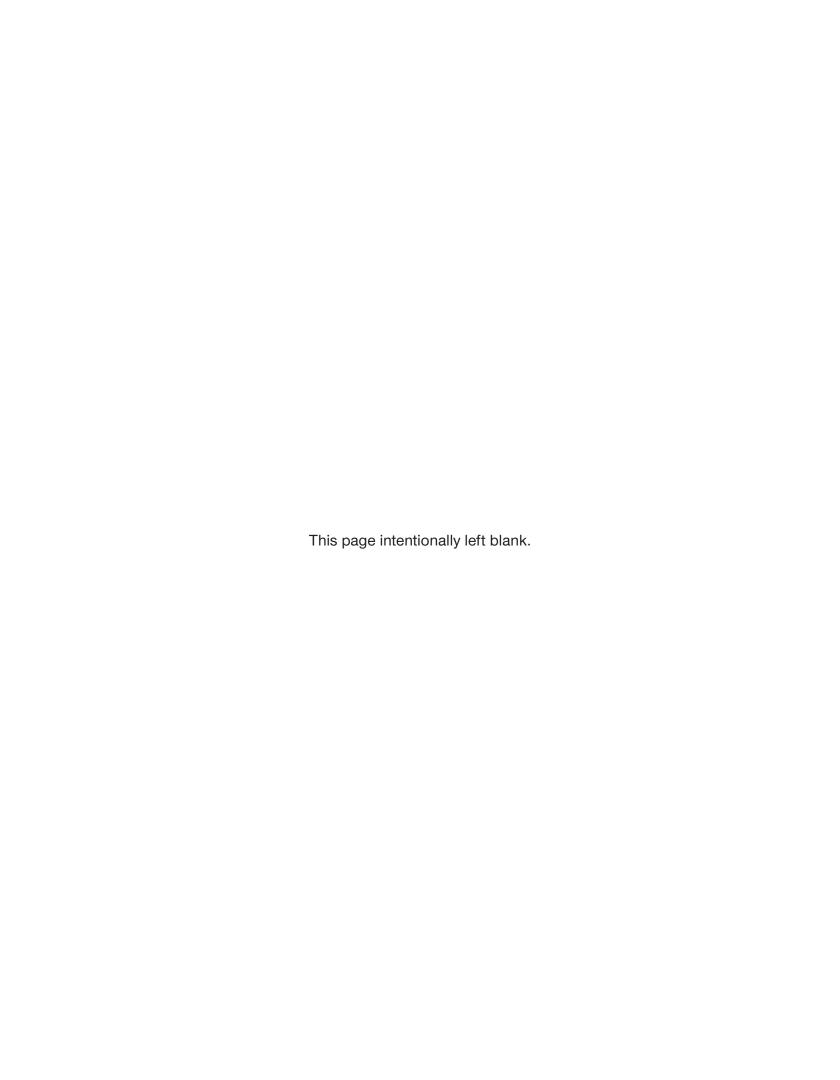
- Print your name exactly as it appears on your red, white and blue Medicare card
- Make sure your permanent address is complete and accurate
- Sign and date your name where indicated
- Provide the name of your primary care provider (PCP)
- Confirm the plan sponsor and group numbers are correct
- Include the date you expect your proposed coverage to begin



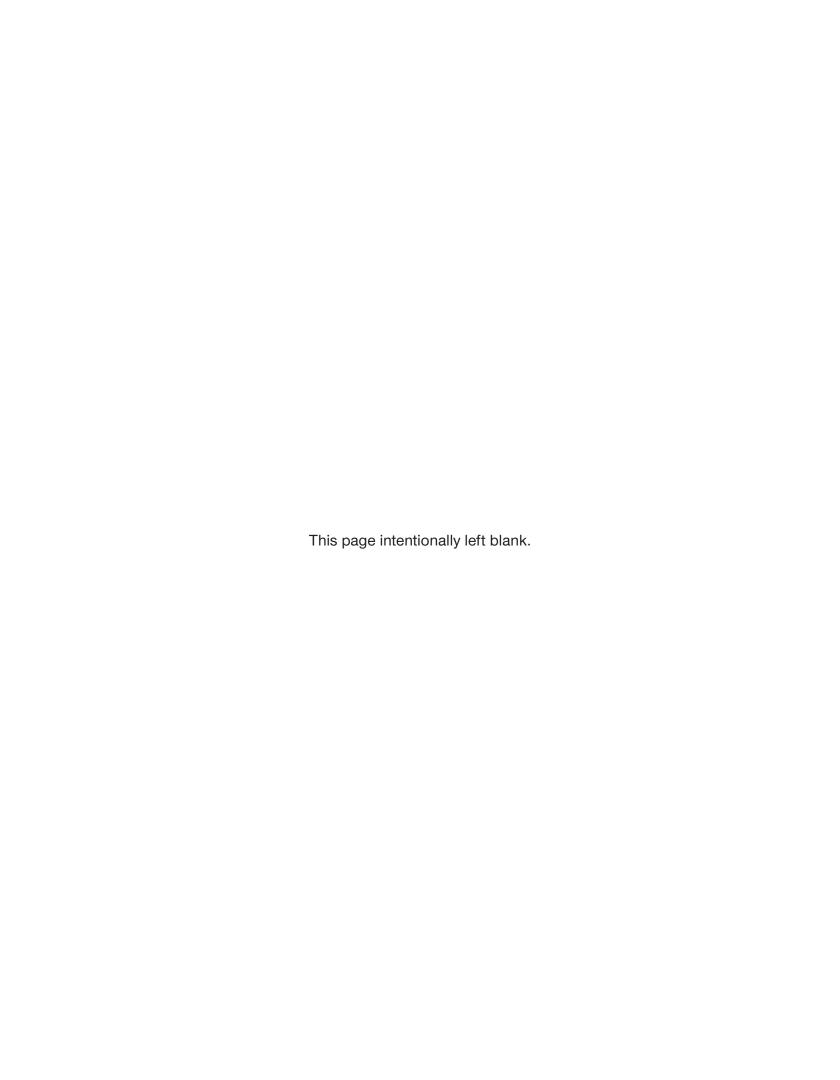


# 2022 Enrollment request form

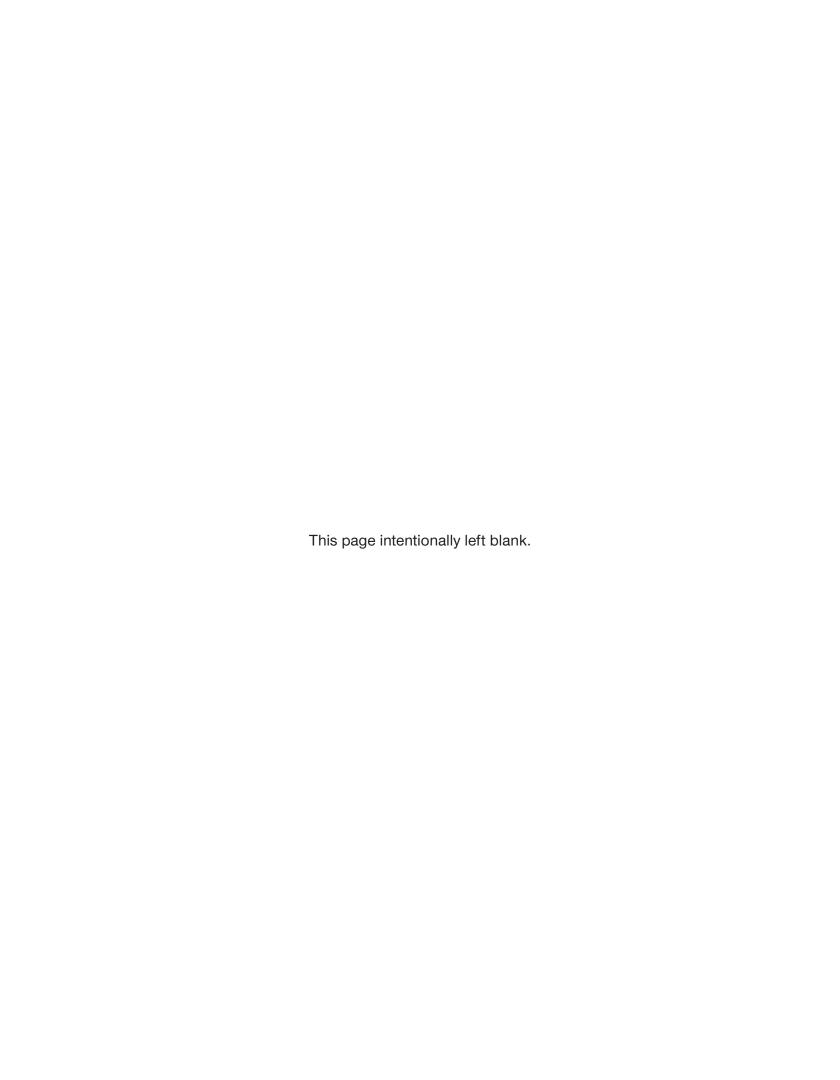
1. Plan information							
Plan sponsor							
Santa Barbara County Firefighters Local 2046							
Group number		GPS employer ID					
15883		24994					
GPS branch number							
001							
Effective date requested:							
(i.e., your proposed effective date, or or	n what day	your coverage	should	d begin)			
Plan sponsor use ONLY: Please date st completed and signed form.	amp this d	ocument to ind	dicate v	when you rec	eived the		
To enroll in the UnitedHealthcare® Gifollowing:	roup Medi	care Advanta	ge (PP	O) plan, plea	ase provide the		
2. 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 ph	bile 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 for	rom above	. You can give	a P.O.	Box)			
ity		(	State	ZIP code			
Email address (optional)				I			



Last name	First name	Medicare number	-	
		ge, including other private insurance, TRIC ts or State Pharmaceutical Assistance Pro		ederal
Will you have other	r prescription drug cover	rage in addition to our plan?	Yes □	No
If "yes", what is it?				
Name of other insur	rance			
Member number		Group number		
Rx Bin		Rx PCN (optional)		
Your answer to the	following questions will	not keep you from being enrolled in th	ıis plan:	
3. A few questi	ons to help us manag	ge your plan		
1. Would you prefe	r plan information in anot	ther language or an accessible format?	□ Yes	□ No
If "yes", please sele	ect from the following:			
☐ Spanish ☐ Braille	e 🗆 Other			
•	language or format you w - 8 p.m. local time, 7 days	ant, please call us toll-free at 1-877-714- a week.	<b>-0178</b> , ( <sup>-</sup>	ΓΤΥ
2. Do you or your s	pouse work?		□ Yes	□No
If "no", what was yo	ur retirement date?			
-		than Medicare, such as private penefits or other employer coverage?	□ Yes	□ No
If "yes", please prov	vide the following:			
Name of the health	insurance			
Member number				
4. Please give us the	he name of your primary	care provider (PCP), clinic or health co	enter.	
Provider or PCP full	name			
Provider/PCP numb	per	(Please enter the number exactly as on the website or in the Provider Din the 10 to 12 digits. Don't include day	rectory.	



			Page 3 of 4
Last name	First name	Medicare num	nber
5. Do you live in a r	nursing home or long-ter	m care facility?	□ Yes □ No
If "yes", please give	us information on the lor	ng-term care facility:	
Name			
Address			
City		State	ZIP code
Date you moved the	re		
4. ATTENTION	- please sign and da	ite	
Understanding, and includes outpatient request form means benefits which incluintentionally provide This enrollment receffective date. Upo	prescription drug benefit s that I will be automatical ides Part D and suppleme e false information on this quest form must be sign	vided by me is accurate s, I understand that my lly enrolled in my plan's ental prescription drug form, I will be disenrolled, dated and received process the form according to the contract of the contract o	and complete. If my plan signature on this enrollment outpatient prescription drug coverage. I understand that if I ed from the plan.
5. Authorized re	epresentative inform	ation	
I can show written p I understand that I w behalf of the member received my United	vill need to submit written per beyond this application.	uardianship, etc.) of this proof of this right, to the . After this application hard, I can call Customer S	right if Medicare asks for it. e plan, if I wish to take action on as been approved and I have Service at the number on my
Signature			Today's date



		3
First name	Medicare numb	per
	ting this form, plea	ase have that person
I who assisted in comp	leting this form)	Today's date
	d Relationship to app	olicant
oker, please provide y	our signature and com	plete the information below:
entative/broker signa	ture	Today's date
		<u></u>
ntative/broker name (pl	lease print)	
Agent/broker number		umber
	'	
nly		
		NIPR number
Group numbe	r	PBP number
roup SEP   ICEP/IEF	P   AEP (type)	
	sted you in completer formation below  I who assisted in complete heck here if you signed a completing this form.  Foker, please provide yeartative/broker signates  Intative/broker name (please)  Group number	sted you in completing this form, please formation below  I who assisted in completing this form)  Relationship to apply a completing this form.  Proker, please provide your signature and completive/broker signature  Intative/broker name (please print)  Referring broker name  Referring broker name  Referring broker name  Referring broker name

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-555-5757 (TTY: 711). 注意:如果您説中文,您可以免費獲得語言援助服務。請致電 1-800-555-5757 (TTY: 711).

