UCare Medicare Group Plans Enrollment Application

Who can use this form?

People with Medicare who want to join a UCare Medicare Group Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- During your employer's annual open enrollment, usually in the Fall
- Within 3 months of first getting Medicare if you are also retired
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

How do I get help with this form?

Call UCare Medicare Group Plans at 1-877-598-6574. TTY users can call 1-800-688-2534.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a UCare Medicare Group Plans al 1-877-598-6574. (TTY: 1-800-688-2534) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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To enroll, please provide the following information:

First name:

Middle initial:

Birth date (mm/dd/yyyy):

Last name:

Sex: ☐ M ☐ F

Permanent residence street address (cannot be a P.O. box):

City:

State:

Zip: -

County:

Mailing address (if different from permanent):

Primary phone number (include area code): - -

Alternate phone number (include area code): - -

Email address (optional):

Please choose the name of the primary care clinic you want to use:

Clinic ID number:

Group name (company/former employer):

Are you a retiree from the Group named above? ☐ Yes ☐ No

If yes, date of retirement (mm/yyyy):

Are you a dependent of a retiree from the Group named above? ☐ Yes ☐ No

Desired effective date (mm/dd/yyyy): / /

Coverage always begins on the first of the month.

Office use only

☐ ICEP/IEP

☐ SEP/LEC

_____

Group name:

Effective date (mm/dd/yyyy): / /

Group number:

Please provide your Medicare insurance information.

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.

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

Name:

Medicare Number

Please read and answer these important questions.
Answering these questions will not affect your ability or eligibility to join our plan.

1. Other than Medicare, will you continue to have other **medical** coverage in addition to UCare? ☐ Yes ☐ No

   If yes: Policy holder name:

   Plan name: (as appears on ID card)

   Policy or ID#: Group#:

   Effective date: Phone #:

2. Will you have other **prescription** drug coverage in addition to UCare (such as private insurance, TRICARE, Federal employee health benefits coverage, or VA benefits)? ☐ Yes ☐ No

   If yes: Policy holder name:

   Plan name: (as appears on ID card)

   Policy or ID#: Group #:

   Effective date: Phone #:

3. Are you a resident in a nursing home? ☐ Yes ☐ No

   Or, are you a resident of an assisted living facility who is receiving nursing home level of care? ☐ Yes ☐ No

   If yes to either, provide the name, address and phone number of the facility:

   Date of admission: (mm/dd/yyyy): / /

4. Are you enrolled in your State Medicaid Program (called Medical Assistance)? ☐ Yes ☐ No

   If yes, please provide your Medicaid number:

5. Are you enrolled in the program through Social Security called Extra Help for Medicare Part D? ☐ Yes ☐ No

6. Are you losing eligibility for the Extra Help for Medicare Part D? ☐ Yes ☐ No

   If so, when? (mm/dd/yyyy): / /

Your UCare Medicare Group Plans premium options:
Check if this applies:

☐ My UCare medical premiums are paid through my former employer.

If your UCare premium is <u>not</u> paid through your former employer, you can choose to pay your UCare Medicare Group Plans premium in the following ways (please select one):

☐ I choose monthly billing. (Once enrolled, you may choose to pay by credit card through UCare's member portal.)

☐ I choose monthly electronic funds transfer (EFT) from a checking or savings account. Please provide:

Bank name:

Bank routing #: Account type: ☐ Checking ☐ Savings

Your bank account #:

If you do not select a payment option, you will get a bill each month.

Please note: People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. 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 <u>www.socialsecurity.gov/prescriptionhelp</u>. 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 a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Please read and sign the following page:

By completing this enrollment form, I agree to the following: UCare Medicare Group Plans are Medicare Advantage plans and have a contract with the Federal government. I will need to keep my Medicare Part A and Part B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (e.g., October 15-December 7 of every year), or under certain special circumstances.

UCare Medicare Group Plans serve specific service areas. If I move out of the area that UCare Medicare Group Plans serve, 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 UCare Medicare Group Plans, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from UCare Medicare Group Plans when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. However, this plan provides worldwide emergency care.

I understand that beginning on the date UCare Medicare Group Plans coverage begins, I should get my health care from UCare Medicare Group Plans. In some cases, I may get covered services from out-of-network providers. With the exception of emergency or urgently needed services, or out-of-area dialysis services, it may cost me more to get care from out-of-network providers. If medically necessary, UCare Medicare Group Plans provides refunds for all covered benefits, even if I get services out of network. Services authorized by UCare Medicare Group Plans and other services contained in my UCare Medicare Group Plans Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with UCare Medicare Group Plans, he or she may be paid based on my enrollment in UCare Medicare Group Plans.

Release of information: By joining this Medicare health plan, I acknowledge and agree that UCare Medicare Group Plans will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge and agree that UCare Medicare Group Plans will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment 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.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this enrollment form means that I have read and understand the contents of this enrollment form. If signed by an authorized individual (as described above), this signature certifies that: 1) This person is authorized under State law to complete this enrollment; and 2) Documentation of this authority is available upon request by Medicare.

Signature: _____ **Today's date:**_____

If you are the authorized representative, you must sign above and provide the following information:

Name: Relationship to enrollee:

Address: Phone number: - -

Are you the enrollee's Power of Attorney (POA)? ☐ Yes ☐ No

If yes, is the POA paperwork attached? ☐ Yes ☐ No

If no, please send in a copy of the POA agreement or other legal document to:
UCare Enrollment, P.O. Box 52, Minneapolis, MN 55440.
We must have the POA agreement on file in order to respond to future requests made by the POA.

If you have questions when completing the form,
please contact us at 1-877-598-6574 (TTY 1-800-688-2534)
8 am – 5 pm, Monday – Friday

Send this enrollment form in the postage-paid envelope or fax to 612-884-2005.

Notice of Nondiscrimination

UCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. UCare does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **612-676-3200 (voice)** or toll free at **1-800-203-7225 (voice)**, **612-676-6810 (TTY)**, or **1-800-688-2534 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**.

If you believe that UCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

Oral grievance

If you are a current UCare member, please call the number on the back of your membership card. Otherwise please call **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

Written grievance
Mailing Address
UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052
Email: cag@ucare.org
Fax: 612-884-2021

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 612-676-3200/1-800-203-7225（TTY：612-676-6810/1-800-688-2534）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 612-676-3200/1-800-203-7225 (телетайп: 612-676-6810/1-800-688-2534).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 612-676-3200/1-800-203-7225 (መስማት ለተሳናቸው: 612-676-6810/1-800-688-2534).

ဟ်သူဉ်ဟ်သး–နမ့်ကတိၤ ကညီ ကျိာ်ဏယိ, နမၤနှ် ကျိာ်ဏတၢ်မၤစၢၤလ၊ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ.
ကိး 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយា ភាសារ័ខ្មរ, រសរាជំនួយរ័ផ្នកភាសា ដោយមិនគិតឈ្លួល គឺអាចមានសំរាប់បំរ័រអ្នក។ ចូរ ទូរស័ព្ទ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534)។

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 612-676-3200/1-800-203-7225 (رقم هاتف الصم و البكم: 612-676-6810/1-800-688-2534).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 612-676-3200/1-800-203-7225 (ATS : 612-676-6810/1-800-688-2534).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).