Medicare Plans Enrollment Application

Who can use this form?

People with Medicare who want to join a UCare Medicare 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:

- Between October 15 – December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- 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.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security check) may be considered your permanent residence address.

Reminders:

- If you want to join a plan during fall open enrollment (October 15 – December 7), we must receive your application by (not postmarked by) December 7 for a January 1 effective date.
- You can choose to pay your monthly premium by check, automatic payment/electronic funds transfer (EFT) or Social Security/Railroad Retirement Board withdrawal. Please do not send payment with your enrollment form.

What happens next?

Send your completed and signed form to:

UCare: Attn. Sales
P.O. Box 52
Minneapolis, MN 55440-9682

Once we process and approve your enrollment request, you will receive a confirmation letter and member ID card. Please allow time for processing.

How do I get help with this form?

Call:

- UCare Medicare Plans at 1-877-523-1518
- UCare Your Choice Plans at 1-833-951-3194
- TTY users call 1-800-688-2534

Email: **sales@ucare.org**

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users call 1-877-486-2048.

En español:

Llame a:

- UCare Medicare Plans al 1-877-523-1518
- UCare Your Choice Plans al 1-833-951-3194
- TTY:1-800-688-2534

Correo electronico: **sales@ucare.org**

O a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

If you would like us to send you information in another format (e.g., Braille, large print, audio) or if you would like materials emailed to you (e.g., Explanation of Coverage, Summary of Benefits, Provider Directory), please contact us at the numbers noted above. Our office hours are 8 am – 8 pm, seven days a week (October 1 – March 31) and 8 am – 8 pm, Monday – Friday (April 1 – September 30).

Y0120_7008_082023_C
U7523 (08/2023) **South**

Pre-enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Medicare Sales Specialist. See UCare contact information on the previous page.

Understanding the benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit **ucare.org** or call UCare to view a copy of the EOC. See UCare contact information on the previous page.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding important rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/ coinsurance may change on January 1, 2025.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.
- ☐ Effect on current coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

How to submit your enrollment form

Return paper enrollment forms in the enclosed postage-paid envelope.

Mail enrollment forms to:

UCare: Attn. Sales
P.O. Box 52
Minneapolis, MN 55440-9682

You can also enroll through our website at **ucare.org** or fax your application to 612-676-6562.

ucare Medicare Plans Enrollment Application

Please use black ink

STEP 1. 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 (can be street or P.O. box)

City

State

ZIP -

County

Primary phone number (include area code) - -

Alternate phone number (include area code) - -

Email address (optional) - *Note: We will send member updates and information to email address provided.*

Optional: Answering these questions is your choice. You can't be denied coverage if you don't answer these questions.

Are you Hispanic, Latino/a or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a or Spanish origin
- ☐ Yes, Mexican, Mexican-American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer**

What's your race? Select all that apply.

- ☐ White
- ☐ Asian Indian
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Vietnamese
- ☐ Samoan
- ☐ American Indian or Alaska Native
- ☐ Japanese
- ☐ Other Asian
- ☐ Guamanian or Chamorro
- ☐ **I choose not to answer**

STEP 2. Choose the name of the primary care clinic you want to use (optional)

Clinic ID number

The 6 – 11 digit clinic number can be located in the Primary Care Clinic Listing found in your packet.

STEP 3. Desired effective date (mm/dd/yyyy) / /

Coverage always begins on the first of the month.

STEP 4. Provide your Medicare information

Medicare Number (no dashes)

STEP 5. Check the plan you want to enroll in. All plans include some dental coverage. You can add more dental coverage to select plans below. Except where noted, all plans include Medicare Part D coverage.

UCare

UCare Medicare Plans (HMO-POS)

- ☐ **UCare Standard** $56 per month
  - ☐ **Add** Choice Dental for $25 per month
- ☐ **UCare Complete** $133 per month
- ☐ **UCare Classic** $206 per month
  - ☐ **Add** Classic Choice Dental for $25 per month

UCare Medicare Plans without Part D (HMO-POS)

- ☐ **UCare Value Plus** $0 per month
  - ☐ **Add** Choice Dental for $25 per month
- ☐ **UCare Value** $19 per month

UCare Your Choice Plans (PPO)

- ☐ **UCare Your Choice** $0 per month

Refer to the service area map in the Summary of Benefits to confirm the plan you select is available in your area.

STEP 6. Optional: Alternative format choices

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Other

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact UCare at 1-877-523-1518 if you need information in an accessible format other than what's listed above. Our office hours are 8 am – 8 pm, Monday – Friday. TTY users can call 1-800-688-2534.

STEP 7. Please read and answer these important questions.

1. Other than Medicare, will you continue to have any other **medical** coverage? ☐ Yes ☐ No, continue to 2

   Is this medical coverage through the VA? ☐ Yes ☐ No

   Please complete the following if you have medical coverage other than through the VA.

Policy holder name

Plan name (as appears on ID card)

Policy or ID# Group#

Effective date (mm/dd/yyyy) / / Phone# - -

---

2. Will you have any other **prescription** drug coverage? ☐ Yes ☐ No, continue to STEP 8

   Is this drug coverage through the VA? ☐ Yes ☐ No

   Please complete the following if you have drug coverage other than through the VA.

Policy holder name

Plan name (as appears on ID card)

Policy or ID# Group#

Effective date (mm/dd/yyyy) / / Phone# - -

STEP 8. Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll outside of this period. Please read the following questions and check the Yes box if the statement applies to you. By checking the box you are certifying that, to the best of your knowledge, you are eligible to enroll. If we later determine this information is incorrect, you may be disenrolled.

New enrollment or change to coverage

1. Are you new to Medicare and within your initial election period (includes those new to both Medicare Part A and Part B or new to Part B only)? ☐ Yes ☐ No

---

2. Are you enrolling between October 15 – December 7 (Medicare Annual Enrollment Period)? ☐ Yes ☐ No

---

3. Are you enrolled in a Medicare Advantage plan and changing to a different Medicare Advantage plan during: ☐ Yes ☐ No
   - January 1– March 31 (Medicare Advantage Open Enrollment Period) or
   - Your first three months of enrollment in Medicare?

4. Were you enrolled in a plan by Medicare (or your state) and you want to choose a different plan? ☐ Yes ☐ No

If yes, when did your enrollment in that plan start? (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

5. Are you moving into, live in or have recently moved out of a nursing home? ☐ Yes ☐ No

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

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

Change in residence status

6. Have you moved within the past three months and is our plan now a new option for you? ☐ Yes ☐ No

If yes, when did you move? (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

7. Have you recently returned to the United States after living permanently outside of the U.S.? ☐ Yes ☐ No

If yes, when did you return? (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

8. Were you recently released from incarceration? ☐ Yes ☐ No

If yes, when? (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

9. Did you recently obtain lawful presence in the United States? ☐ Yes ☐ No

If yes, when? (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

Change in income or special needs plan qualifications or other

10. Are you losing or leaving coverage you had from an employer or union, or did you recently lose or leave such coverage (includes COBRA and/or retiree coverage)? ☐ Yes ☐ No

If yes, what is the last date of coverage? (e.g., 12/31/2022): ☐☐ / ☐☐ / ☐☐☐☐

Please note: Your last date of coverage should be the last day of the month before your coverage begins.

11. Are you enrolled in a Medicare plan that is ending its contract with Medicare, or is Medicare ending its contract with your current plan? ☐ Yes ☐ No

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

Have you had Extra Help for Medicare Part D but are losing or recently lost eligibility? ☐ Yes ☐ No

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

13. Do you belong to a pharmacy assistance program provided by your state? ☐ Yes ☐ No

14. Did you recently involuntarily lose your creditable prescription drug coverage (defined as coverage as good as Medicare Part D)? ☐ Yes ☐ No

If yes, when? (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

15. Are you enrolled in your State Medicaid Program (called Medical Assistance) or have you been on it but are losing (or recently lost) eligibility? ☐ Yes ☐ No

16. Did you recently leave a Program of All-Inclusive Care for the Elderly (PACE) program? ☐ Yes ☐ No
If yes, when? (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

17. Were you enrolled in a Special Needs Plan (SNP) but no longer qualify for that plan? ☐ Yes ☐ No
If yes, what is your last date of coverage? (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

18. Were you affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a federal, state or local government entity) and one of the other previous statements applied to you at that time, but you were unable to make your enrollment request at that time because of the disaster? ☐ Yes ☐ No

STEP 9. Your plan premium options

You can choose to pay your premium (including any late enrollment penalty that you currently have or may owe) in the following ways. Medicare requires a payment method selection even if you select a $0 monthly premium plan **(please select one):**

☐ I choose monthly billing. (Once enrolled, you may choose to pay by credit card through your online UCare member account.)

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

Bank name

Bank routing # Account type ☐ Checking ☐ Savings

Bank account number #

☐ I choose automatic deduction from my monthly Social Security (SS) or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from ☐ SS ☐ RRB

Part D - Income Related Monthly Adjustment Amount (Part D - IRMAA)

If you have a higher income, you might pay more for your Medicare drug coverage. You will pay this extra amount in addition to your plan premium. Social Security will contact you if you have to pay a Part D - IRMAA. This amount is usually taken out of your Social Security benefit or you may get a bill from Medicare (or the Railroad Retirement Board). DON'T pay UCare the Part D - IRMAA.

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

Office use only Date received (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

Name of staff member/agent/broker (if assisted in enrollment):

_____ If agent, add agent number:

STEP 10. Please read this important information and sign below. Note: All references to "plan" are to the plan in which you are enrolling.

I must keep both Hospital (Part A) and Medical (Part B) to stay in this plan. By joining this UCare Medicare Advantage plan, I acknowledge and agree that UCare will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement on this form). UCare may release my information for treatment, payment and operations, in compliance with state and federal law and as stated in the Notice of Privacy Practices. I acknowledge that I have read and understand UCare's Notice of Privacy Practices (included in the Summary of Benefits and on **ucare.org**). Your response to this form is voluntary. However, failure to respond may affect enrollment in this plan. I understand that I can be enrolled in only one MA plan at a time — and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans). 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 this plan. 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. However, this plan provides worldwide emergency care.

I understand that when this plan coverage begins, I must get all of my medical and prescription drug benefits from this plan. Benefits and services provided by this plan and contained in the Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor this plan will pay for benefits or services that are not covered.

I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Power of Attorney (POA)/authorized representative, and are signing on behalf of this enrollee, you must sign above and provide the following information:

Name

Relationship to enrollee

Address

Phone number

Are you the enrollee's 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.

Return paper enrollment forms in the enclosed postage-paid envelope.

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).