

**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.

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.

Provide your Medicare information

Medicare Number (no dashes)

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 question 3

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# - -

3. Are you a resident in 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

If yes, write the name, address and phone number of the facility:

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

Change in residence status

4. 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): / /

5. 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): / /

6. Were you recently released from incarceration? Yes No

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

7. 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

8. 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 UCare coverage begins.

9. 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

10. 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): / /

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

12. 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): / /

13. 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

If yes, please provide your Medicaid number:

14. Did you recently leave a Program of All-Inclusive Care for the Elderly (PACE) program? Yes No
 If yes, when? (mm/dd/yyyy): / /
-
15. 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): / /
-
16. 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

Your UCare Medicare Group Plans premium options

Check if this applies to you:

My UCare medical premiums are paid through my former employer.

If your UCare premium is not 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 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 #

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. 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

Group name:

Effective date (mm/dd/yyyy):

ICEP/IEP

/ /

SEP/LEC

Group number:

Please read this important information and sign below. Note: All references to “this 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 the 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.



Medicare Group Plans Enrollment Application

Who can use this form?

People with Medicare who want to join a UCare Group 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:

- During your employer's annual open enrollment, usually in the Fall.
- 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.

Reminder

You can choose to pay your monthly premium by check or automatic payment/electronic funds transfer (EFT). Please do not send payment with your enrollment form.

What happens next?

Send your completed and signed form to:

UCare: Attn. Group 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 Group Plans at 1-877-598-6574. TTY users call 1-800-688-2534.

Email: groupsales@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 Group Plans al 1-877-598-6574. (TTY: 1-800-688-2534)

Correo electrónico: groupsales@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 material emailed to you (e.g., Explanation of Coverage, Summary of Benefits, Provider and Pharmacy Directory), please contact us at the numbers noted earlier. Our office hours are 8 am – 8 pm, Monday – Friday.

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. Group Sales
P.O. Box 52
Minneapolis, MN 55440-9682

You can also enroll through our website at **ucare.org** or fax your application to 612-884-2005.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See section "What happens next?" to send your completed form to the plan.

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.

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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም ኣርዳታ ድርጅቶቻችን በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 612-676-3200/1-800-203-7225 (መስማት ለተሳናቸው: 612-676-6810/1-800-688-2534).

ဟံသုဂ်ဟံသု: -နမ့်ကတိံ ကညိံ ကျိံအယိံ, နမန့် ကျိံအတံမစာလော တလက်ဘုဂ်လက်စူ နိတမံဘဂ်သုန့ဂ်လိံ. ဝိ: 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: បើសិនជាអ្នកនិយាយភាសាអង់គ្លេស, រសវាជំនួយវេជ្ជករភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់អ្នក។ 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 والبكم: 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 사용하지는 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).