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
- Have both Medicare Part A (hospital) and 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 three 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

Reminder:

- You can choose to pay your monthly premium by check or automatic payment/electronic funds transfer (EFT) from your bank account

What happens next?

Send your completed and signed form to:

UCare: Attn. Group Sales
PO 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.**
- Call Medicare at 1-800-MEDICARE (1-800-633-4227).
  TTY users call 1-877-486-2048.

- En español: Llame a UCare al 1-877-598-6574.
  TTY 1-800-688-2534.
- Correo electronico **groupsales@ucare.org.**
- O a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

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 checks) may be considered your permanent residence address.

Pre-enrollment checklist

Before making an enrollment decision, it's 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

- ☐ Make sure you know the coverage and applicable deductibles, copays and coinsurance for the benefits you may need including dental, vision, hearing and other services. You can review the full list of benefits found in the Evidence of Coverage (EOC), available upon request, especially for those services for which you routinely see a doctor. Visit **ucare.org** or call UCare to view a copy of the EOC.
- ☐ Review the providers (or ask your doctor) to make sure the doctors, hospitals and facilities you see now are in the network. If they are not, it means you will likely have to select a new doctor, hospital or facility.
- ☐ Make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not, you will likely have to select a new pharmacy or may have to pay the full price for your prescriptions.
- ☐ Review the formulary online to make sure your drugs are covered: **ucare.org/medicare-druglist**.

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 Jan. 1, 2026.
- ☐ 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. This plan does provide worldwide emergency care.
- ☐ 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 Medicare Supplement/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.
- ☐ If you need to file a complaint, you may call UCare or contact Medicare at 1-800-MEDICARE.

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.

OMB No. 0938-1378
Expires: 6/30/2026

Medicare Group Plans Enrollment Application

Section 1: All fields in this section are required (unless marked optional)

Information about you

First name

Middle initial

Birth date (mm/dd/yyyy)

Last name

Sex ☐ Male ☐ Female

Permanent residence street address (cannot be a PO Box unless experiencing homelessness)

City

State

ZIP

County

Mailing address, if different from permanent (can be street or PO Box)

City

State

ZIP

County

Phone number

Email address (optional)

Your Medicare information

Medicare Number (no dashes)

Requested plan effective date (mm/dd/yyyy)

(Coverage always begins on the first of the month)

Other than Medicare, will you continue to have other coverage in addition to this plan? ☐ Yes ☐ No

If yes, select all that apply ☐ Medical coverage ☐ Prescription coverage

If other than coverage through Veterans Affairs (VA), please list

Policyholder Name

Plan name

Policy ID #

Group #

Other coverage effective date (mm/dd/yyyy)

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

Attestation of eligibility to enroll

Typically, you enroll during your employer's annual open enrollment, usually in the fall. Please read the following statements and check the 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 or change to Medicare or your coverage

☐ I am new to Medicare Part A and Part B or I already have Part A and recently signed up for Part B

☐ I had Medicare prior to age 65 due to a disability and I'm now turning age 65

☐ I am moving into, live in or have recently moved out of a nursing home on (mm/dd/yyyy) / /

☐ I am a resident of a nursing, assisted living or memory care facility receiving nursing home-level of care and was admitted on (mm/dd/yyyy) / /

A recent change in residence status

☐ I moved outside of the service area for my current plan within the past three months on (mm/dd/yyyy) / / and this is a new plan for me

☐ I returned to the U.S. after living permanently outside of the U.S. on (mm/dd/yyyy) / /

☐ I was released from incarceration on (mm/dd/yyyy) / /

☐ I obtained lawful presence status in the U.S. on (mm/dd/yyyy) / /

A recent change in income or Special Needs Plan (SNP) qualifications or other

- ☐ I am losing or leaving employer or union coverage and my last date of coverage is (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐ (usually the last day of the month)
- ☐ I am enrolled in a Medicare plan that is ending its contract with Medicare, or Medicare is ending its contract with my current plan
- ☐ I had a change in my Extra Help paying for Medicare prescription drug coverage (became eligible or ineligible) on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I belong to the pharmacy assistance program provided by my state (available in WI only)
- ☐ I involuntarily lost drug coverage that is at least as good as Medicare Part D (called creditable) on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I am enrolled in my State Medicaid Program (called Medical Assistance) or am losing or lost eligibility on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I left a PACE program on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐
- ☐ I was enrolled in a Special Needs Plan (SNP) but no longer qualify for that plan on (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

If none of the statements applies to you or you're not sure, please contact UCare at 1-877-598-6574 (TTY users call 1-800-688-2534) to see if you are eligible to enroll.

Office use only

- ☐ ICEP/IEP
- ☐ SEP/LEC

Group name:

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

Group number:

Section 2: All fields in this section are optional. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select if you want us to send information in a language other than English or in an accessible format:

- ☐ Braille
- ☐ Large Print
- ☐ Audio CD
- ☐ Data CD
- ☐ Email
- ☐ Other language or format

Plan materials are available on **ucare.org.** Please contact UCare at 1-877-598-6574 if you need information in a format other than what's listed above. Our office hours are Mon – Fri, 8 am – 8 pm. TTY users call 1-800-688-2534.

Medicare wants plans to collect the following data to better identify and address the community's needs in terms of health care access, outreach and protections against discrimination.

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.

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

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

Section 3

Plan premium options

Check if this applies to you:

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

If your premium is not paid through your employer, you can choose to pay your premium in the following ways. Select one:

☐ Get a bill (Once enrolled, you may choose to pay by credit card or through your online UCare member account.)

☐ Monthly electronic funds transfer from ☐ checking account ☐ savings account

Bank name

Bank routing #

Bank account number #

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

Note: If you have a higher income, you might pay more for your Medicare drug coverage, called a Part D Income Related Monthly Adjustment Amount (Part D – IRMAA). You must pay this extra amount in addition to your plan premium. Social Security will contact you if this applies. DON'T pay UCare the Part D – IRMAA.

REQUIRED: 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). My response to this form is voluntary. However, failure to respond may affect enrollment in this plan.
- 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**).
- I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for Medicare Advantage Private Fee-for-Service (PFFS) and Medicare Medical Savings Account (MSA) plans)
- 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.
- 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 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:** _____

Complete this section if you are an individual or an authorized representative (e.g. Power of Attorney or other third party) helping an enrollee fill out this enrollment application.

Name

Relationship to enrollee

If POA/Guardian, address

Phone number

If POA paperwork is not attached, please send a copy of the POA agreement or other legal document to: UCare Group Enrollment, PO Box 52, Minneapolis, MN 55440.

Signature: _____

How to submit your enrollment form

Return your paper enrollment application in the enclosed postage-paid envelope to UCare, Attn: Group Sales, PO Box 52, Minneapolis, MN 55440-9682 or by fax at 612-676-6562, Attn: Group Sales.
Or enroll online at **ucare.org.**

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).