UCare Your Choice
Plan Change Enrollment Request Form

Name of plan you are enrolling in:		
Name:	**Member ID or Medicare number:**	
Phone number:		
Permanent street address (P.O. Box not allowed):		
City:	**State:**	**ZIP code:**
Mailing address (only if different from your permanent street address) **Street address:**		**County:**
City:	**State:**	**ZIP code:**

Please fill out the following:

I am currently a member of the _____ plan in UCare

with a monthly premium of $_____.

I would like to change to the _____ plan in UCare.

I understand that this plan has different health benefits and a monthly premium of $_____.

Please note: if you wish to enroll in any applicable additional dental coverage, you will need to fill out a separate dental enrollment form.

Name of chosen Primary Care Physician (PCP), clinic or health center:

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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, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer**

What's your race? Select all that apply.

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

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

- ☐ Spanish or Hmong
- ☐ Braille, large print, or other alternate format

Please contact UCare Your Choice at 1-833-951-3183 if you need information in an accessible format or language other than what is listed above. Our office hours are 8 am – 8 pm, seven days a week (TTY users call 1-800-688-2534).

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.

OMB No. 0938-1378
Expires: 7/31/2024

Your plan premium

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) check each month. Even if you are enrolling in a $0 premium plan, if we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. Do NOT pay UCare the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify 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 call 1-800-325-0778). You can also apply for Extra Help online at **ssa.gov/medicare/part-d-extra-help.**

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Keep current premium payment method.

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

☐ Monthly electronic funds transfer (EFT) from a checking or savings account. Please provide the following:

Bank name:_____

Bank routing #:_____ Member bank account #:_____

Account type: ☐ Checking ☐ Savings

☐ Automatic deduction from your monthly Social Security or RRB benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

The Social Security deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

Please read and sign below:

Note: All references to "this plan" are to the plan in which you are enrolling.

UCare Your Choice is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with this plan, he/she may be paid based on my enrollment in this plan.

Release of Information: 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. 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 authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone number: (_____) _____ — _____

Relationship to enrollee: _____

Office Use Only: Name of staff member/agent/broker

(if assisted in enrollment): _____

If broker, add broker number: _____

Date received (mm/dd/yyyy): _____

ucare

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 គឺអាចមានសំរាប់បំរ័អ្នក។ 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 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).