

# UCare Medicare Plan change enrollment request form



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

<b>Name of plan you are enrolling in:</b>		
<b>Name:</b>	<b>Member ID or Medicare number:</b>	
<b>Phone number:</b>		
<b>Permanent street address (cannot be a PO Box unless experiencing homelessness):</b>		
<b>City:</b>	<b>State:</b>	<b>ZIP code:</b>
<b>Mailing address (only if different from your permanent street address)</b>		<b>County:</b>
<b>Street address:</b>		
<b>City:</b>	<b>State:</b>	<b>ZIP code:</b>
<b>Please fill out the following:</b>		
I am currently a member of the UCare _____ plan with a monthly premium of \$_____.		
I would like to change to the UCare _____ plan.		
I understand that this plan has different health benefits and a monthly premium of \$_____.		
<b>Please note:</b> If you wish to enroll in any applicable additional dental coverage, you will need to fill out a separate dental enrollment form.		

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.

# UCare Medicare Plan change enrollment request form



**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.

- |  |  |
|--|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a or Spanish origin   | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican                                 | <input type="checkbox"/> Yes, Cuban                                |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a or Spanish origin | <input type="checkbox"/> I choose not to answer                    |

What's your race? Select all that apply.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Caucasian/white        | <input type="checkbox"/> Black or African American | <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> Asian Indian           | <input type="checkbox"/> Chinese                   | <input type="checkbox"/> Japanese                         |
| <input type="checkbox"/> Korean                 | <input type="checkbox"/> Filipino                  | <input type="checkbox"/> Other Asian                      |
| <input type="checkbox"/> Native Hawaiian        | <input type="checkbox"/> Vietnamese                | <input type="checkbox"/> Guamanian or Chamorro            |
| <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> Samoan                    | <input type="checkbox"/> I choose not to answer           |

What's your gender? Select one.

- Woman    Man    Non-binary
- I use a different term \_\_\_\_\_    I choose not to answer

Which of the following best represents how you think of yourself? Select one.

- Lesbian or gay    Straight (not gay or lesbian)    Bisexual    I don't know
- I use a different term \_\_\_\_\_    I choose not to answer

**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](http://ucare.org). Please contact UCare at 1-877-523-1518 if you need information in a format other than what's listed above. Our office hours are Monday – Friday, 8 am – 8 pm. TTY users call 1-800-688-2534.

## 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](https://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 #: \_\_\_\_\_ 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.

**REQUIRED: Please read this important information and sign below.**

**UCare 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 UCare, he/she may be paid based on my enrollment in UCare.
- Release of Information: By joining this Medicare health plan, I acknowledge and agree that UCare will release my information to Medicare and other plans as necessary for treatment, payment and health care 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](http://ucare.org)). I also acknowledge that UCare 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 people with Medicare aren't covered under Medicare while out of the country, except for limited coverage near the US border.
- I understand that beginning on the date UCare coverage begins, I must get all of my health care from UCare, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by UCare and other services contained in my UCare Evidence of Coverage document (also known as member contract or subscriber agreement) will be covered. Without authorization, neither Medicare nor UCare will pay for these services.
- 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 application means that I have read and understand the contents of this application. 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 from Medicare.

Signature:

Today's date:

Complete this section if you are an individual or an authorized representative (e.g. agent, broker, SHIP counselor, family member, 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 agent/broker, your National Producer Number (NPN) \_\_\_\_\_

Date received (mm/dd/yyyy) \_\_\_\_\_

If agent/broker, add clinic ID# (if known) \_\_\_\_\_

## **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](mailto: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, រសវាជំនួយវេជ្ជកម្មភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់បរិវេណ។ 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).