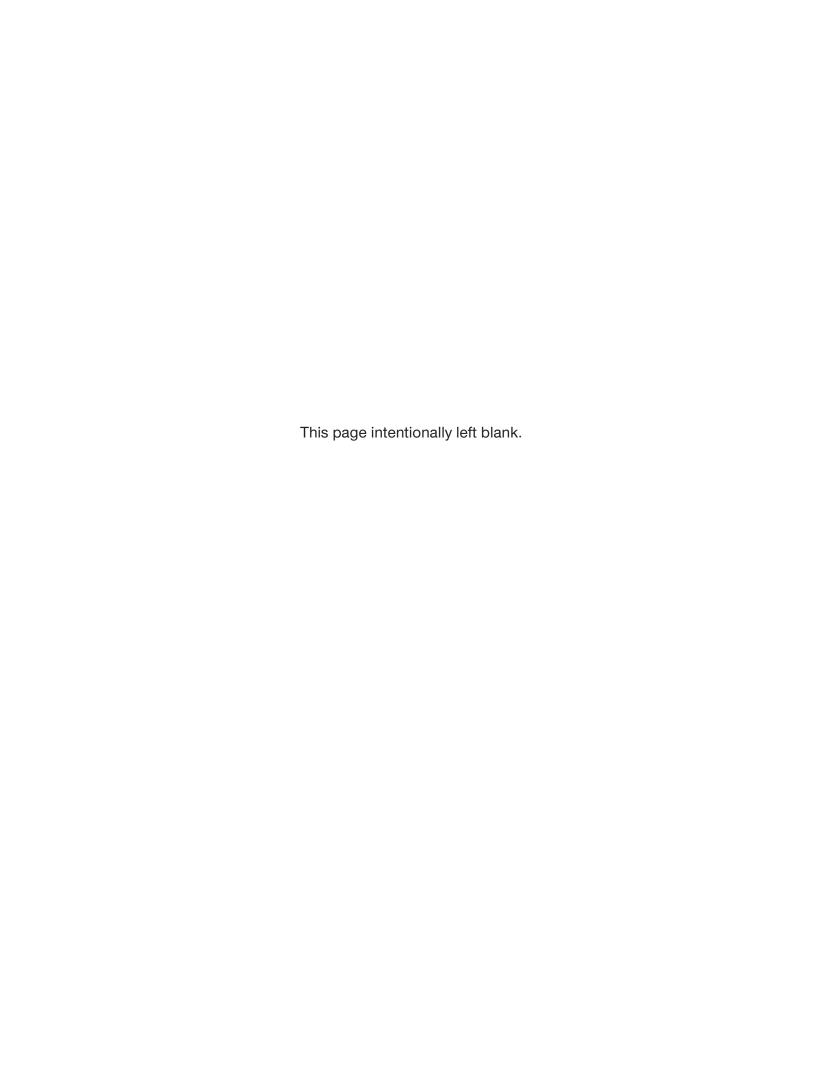




# 2023 Enrollment Request Form

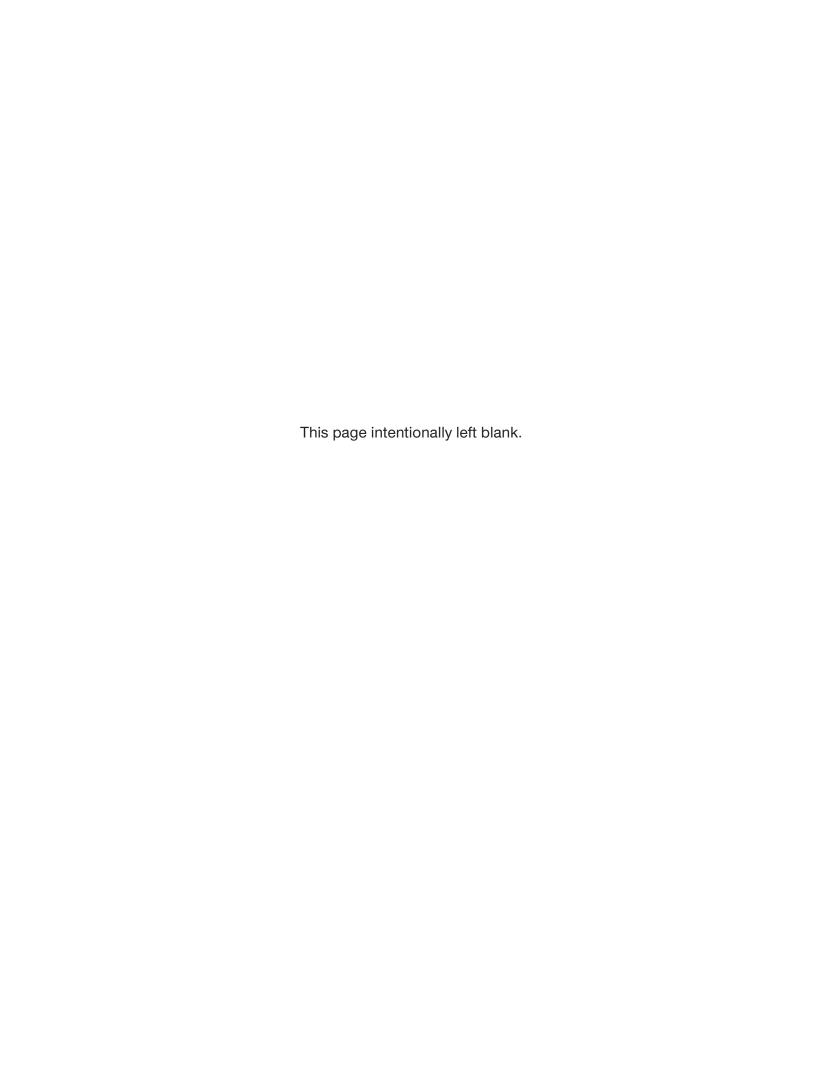
☐ MedicareMax (HMO) H5420-003-000 - MM0

Information about you	(Please	e type or print in	black or b	lue ink)		
Last Name		First Name				dle Initial
Birth Date			Sex ☐ Male ☐ Female			
Home Phone Number ( ) -			Mobile Phone Number ( ) -			
Medicare Number						
Permanent Residence Stree	et Addr	ess (P.O. Box is	not allowe	ed)		
City	Co	unty		State		ZIP Code
Mailing Address (Only if it's	s differ	ent from above.	You can g	jive a P.O. I	Box.)	
City				State		ZIP Code
Email Address (Optional)						
Do you have other insurance	e that v	will cover your p	orescriptio	n drugs?		☐ Yes ☐ No
(Examples: Other private insuprograms.) If yes, what is it?	urance,	TRICARE, feder	al employe	ee coverage	e, VA	oenefits, or state
Name of Other Insurance						
Member Number	Gr	Group Number		RxBin		RxPCN (Optional)
Answering these questions is them out.	s your c	hoice. You can't	be deniec	l coverage k	oecau	se you don't fill
How do you want to pa	ay?					
Enrollee Name Agent Name / ID No Y0066 ERFMA1 2023 C						PNFL23HM0050474 00

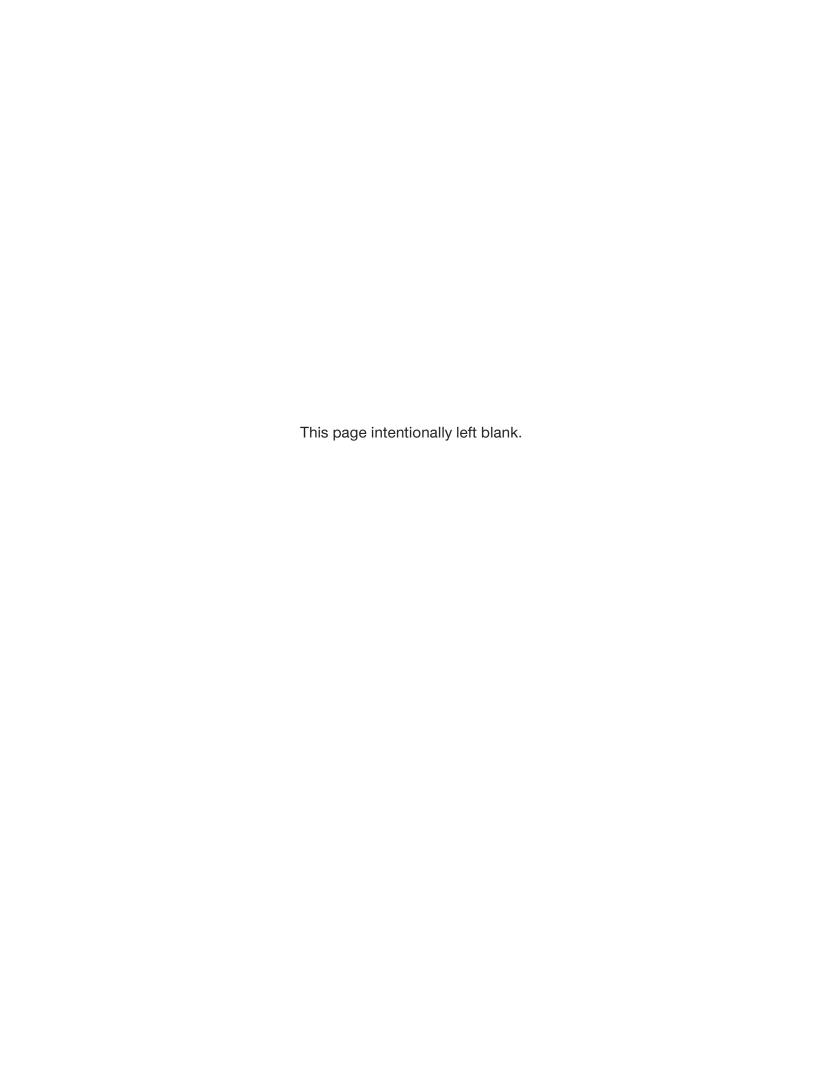


If you have a monthly plan premium (including any late enrollment penalty you may owe) you can pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT).

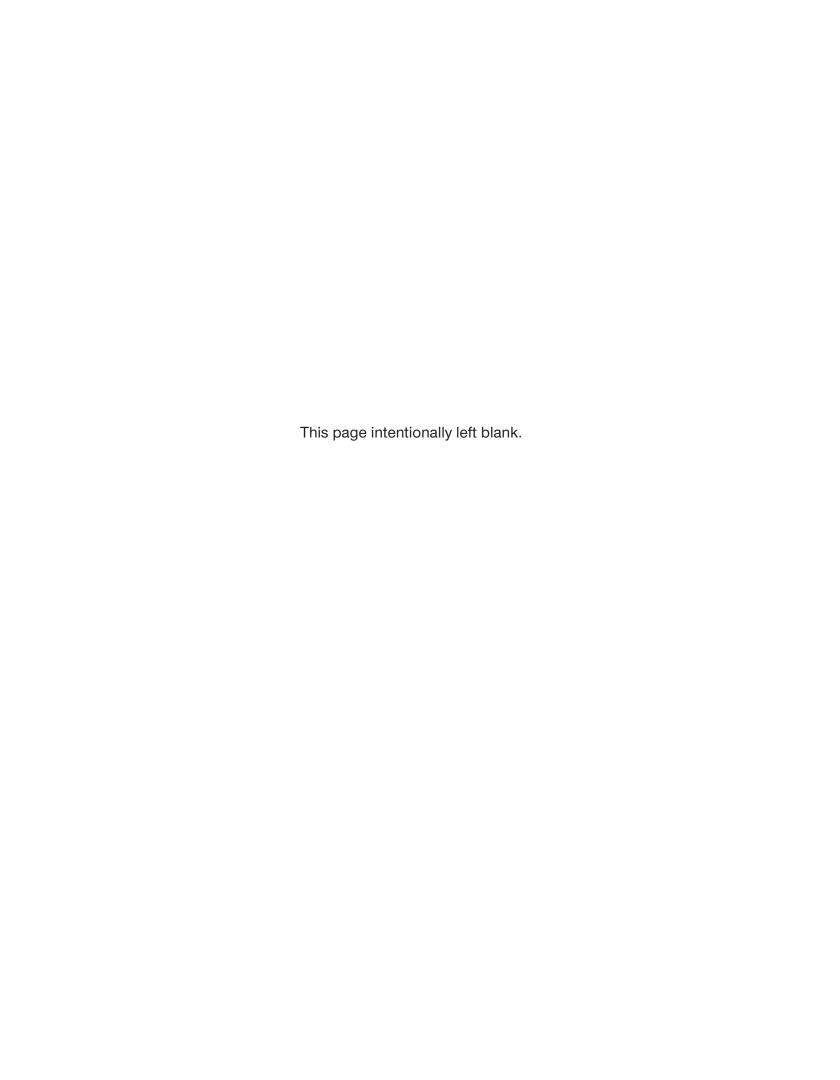
(RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT). If you don't choose an option below, we'll send a bill each month to your mailing address. If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) Social Security (SS) will send you a letter and ask you how you want to pay it: ☐ You can pay it from your SS check ☐ Medicare can bill you ☐ The Railroad Retirement Board (RRB) can bill you ☐ I want to pay from my Social Security ☐ I want to pay from my Railroad Retirement Board (RRB) check ☐ I want to pay directly from a bank account Account Type □ Checking □ Savings Account Holder Name: Bank Routing Number \_\_/\_/\_/\_/\_\_/\_\_\_ Bank Account Number\_\_/\_\_/\_\_/\_\_/\_\_/\_\_\_ A few questions to help us manage your plan 1. Would you prefer plan information in another language or an accessible format? ☐ Yes ☐ No Please check what you'd like: ☐ Spanish ☐ Braille ☐ Other\_\_\_\_\_ If you don't see the language or format you want, please call us toll-free at 1-844-723-6471, TTY 711 8 a.m.-8 p.m. local time, 7 days a week. Or visit PCNhealth.com for online help. 2. 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, or Spanish origin I choose not to answer.



<ol><li>What's your race? Select all that a</li></ol>	apply.					
White	White Black or African American					
American Indian or Alaska N	lative					
Asian Indian	Chinese	Filipino				
Japanese	Korean	Vietnamese				
Other Asian	Native Hawaiian	Samoan				
Guamanian or Chamorro _	Other Pacific Islander					
I choose not to answer.						
4. Do you or your spouse work?		☐ Yes ☐ No				
Do you or your spouse have other h	ealth insurance that will cov	ver medical services?				
(Examples: Other employer group of	overage, LTD coverage, Wo	orkers' Compensation,				
auto liability, or Veterans benefits)		☐ Yes ☐ No				
If yes, please complete the following	g:					
Name of Health Insurance Compar	าง					
Member Number						
5. Please give us the name of your p	rimary care provider (PCE	2) clinic or health center				
You can find a list on the plan webs						
<u> </u>		OI y.				
Provider or PCP Full Name						
Provider/PCP Number:	(Please enter t	he number exactly as it appears				
		or in the Provider Directory. It will				
Are you now seeing or have you red		gits. Don't include dashes.) □ Yes □ No				
Are you now seeing of have you rec	entry seem this provider:	Lifes Lino				
Please read and sign						
By completing this form, I agree to t	the following:					
☐ I must keep both Part A and Part	B to stav in UnitedHealthca	re. I must keep paving my Part B				
premium if I have one, unless Me	•					
☐ 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. This plan covers emergency and						
urgent care outside of the U.S. Se	ee the Summary of Benefits	for more information.				
☐ I understand that when my United	dHealthcare coverage begir	ns, I must get all of my medical and				
prescription drug benefits from L	JnitedHealthcare. Benefits a	and services authorized by				
UnitedHealthcare and contained	in my UnitedHealthcare "Ev	ridence of Coverage" document				
(also known as a member contract or subscriber agreement) will be covered. Without						
authorization, neither Medicare	nor UnitedHealthcare will	pay for benefits or services.				
Enrollee Name						



☐ Release of Information: By joining this Medie	•	•					
Drug Plan, I acknowledge that the plan will re	•	•					
as is necessary for treatment, payment, and health care operations. I also acknowledge that							
•	UnitedHealthcare will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes applicable to federal law that						
• • • • • • • • • • • • • • • • • • •		• •					
•	authorize the collection of this information (see Privacy Act Statement below).						
□ I give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to							
administer my health plan.							
☐ I give consent for all entities under UnitedHea	Ithcare and any o	outside vendor used by					
UnitedHealthcare to call the phone number(s	•	-					
☐ The information on this form is correct to the	best of my knowl	edge. I understand that if I					
intentionally provide false information on this	form I will be dise	enrolled from the plan.					
☐ My response to this form is voluntary. However	er, failure to respo	and may affect enrollment in the					
plan.							
When I sign below, it means that I have read and	d understand the	e information on this form					
If I sign as an authorized representative, it means	If I sign as an authorized representative, it means I have the legal right under state law to sign. I can						
show written proof (Power of attorney, guardiansh		-					
understand that I will need to submit written proof	of this right, to th	ne plan, if I wish to take action on					
behalf of the member beyond this application. After	er this applicatior	n has been approved and I have					
received my UCard, I can call Customer Service a	the number on r	ny UCard to update my					
authorization information on file.							
Signature of Applicant/Member/Authorized Re	presentative To	oday's Date					
If you are the outborized representative	nlogog gign (	phoyo and complete the					
If you are the authorized representative information below	, piease sign a	above and complete the					
*NOT A SALES AGENT							
Last Name First Name							
Address							
City	State	ZIP Code					
Phone Number ( ) –	Relationship to Applicant						
Enrollee Name							
LINDUCE NAME							

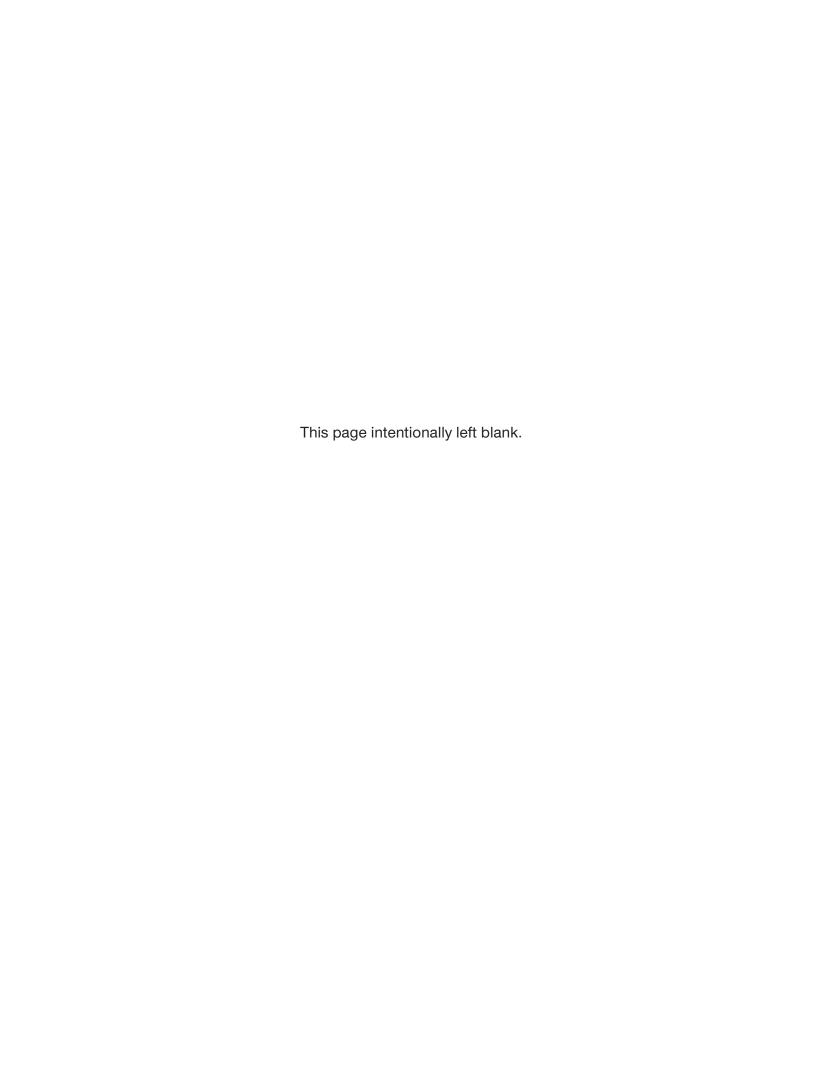


For licensed sales representative/agency use only						
Employer Group Name						
Employer Group ID			Branch ID			
Licensed Sales Representative/Writing ID				Initial Receipt Date		
Licensed Sales Representative/Agent Name				Proposed Effective Date		
Agent must complete						
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PD enrollees eligible for 2nd IEP)			☐ OEP (Jan 1 - Mar 31)	
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	☐ SEP (Change in residence) ☐ AEP (October 15-December 7)			☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ SEP (SEP Reason) _						
Licensed Sales Representative Signature (Optional)  Date:						

## Please mail or fax this completed form to:

UnitedHealthcare P.O. Box 30770 Salt Lake City, UT 84130-0770

Fax: 1-888-950-1170



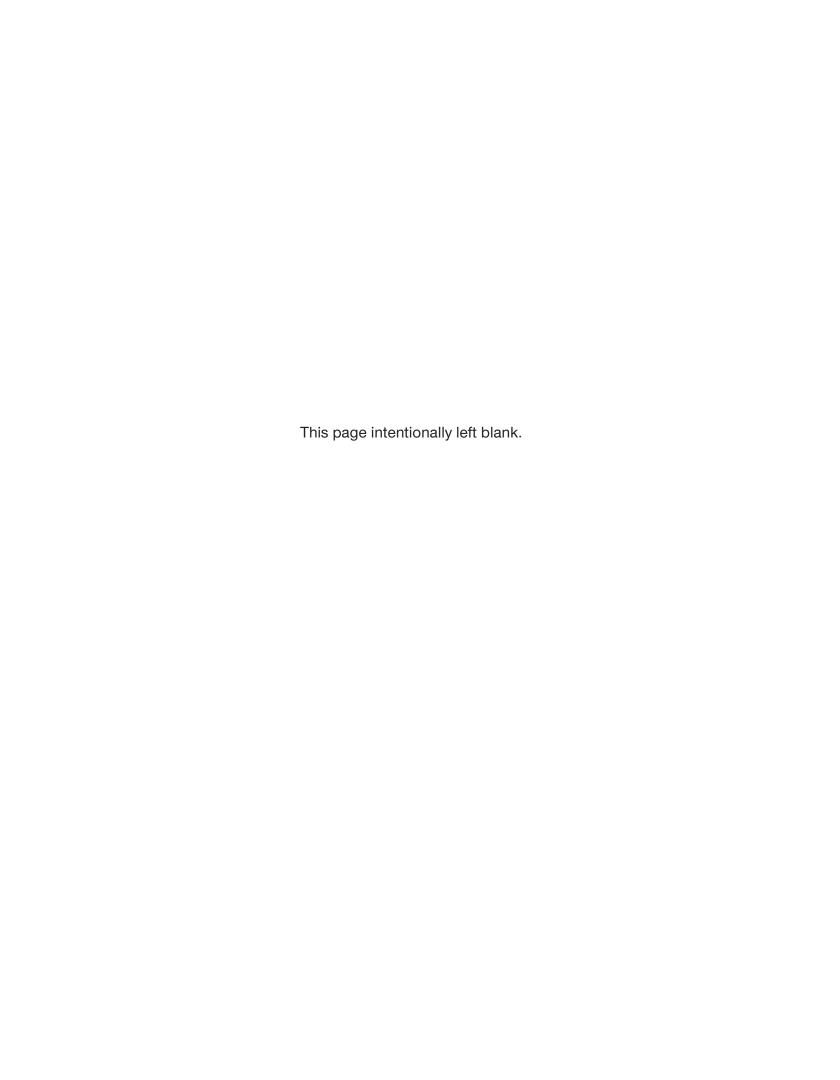
PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social 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.

This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

OMB No. 0938-1378 Expires: 7/31/2023

Y0066 ERFMA1 2023 C



## **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 Customer Service Representative at the number listed on the back cover of this book.

### **Understanding the Benefits**



The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit our plan website or call to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.



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 medicines 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 may change on January 1 of each year.



Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).