



2022 Enrollment request form

1. Plan information

Plan sponsor

Chemung County

Group number

16332

GPS employer ID

25482

GPS branch number

001

Effective date requested: ____/____/2022

(i.e., your proposed effective date, or on what day your coverage should begin)

Plan sponsor use ONLY: Please date stamp this document to indicate when you received the completed and signed form.

To enroll in the UnitedHealthcare® Group Medicare Advantage (PPO) plan, please provide the following:

2. Information about you (Please type or print in black or blue ink.)

Last name

First name

Middle initial

Birth date

Sex: Male Female

Home phone number

() —

Mobile phone number

() —

Medicare number

Permanent residence street address (**P.O. Box is not allowed**)

City

County

State

ZIP code

Mailing address (**Only if it's different from above. You can give a P.O. Box**)

City

State

ZIP code

Email address (optional)

TEAR HERE

TEAR HERE

What's next

Last name First name Medicare number

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State Pharmaceutical Assistance Programs.

Will you have other prescription drug coverage in addition to our plan? Yes No

If yes, what is it?

Name of other insurance

Member number

Group number

Rx Bin

Rx PCN (optional)

Your answer to the following questions will not keep you from being enrolled in this plan:

3. A few questions to help us manage your plan

1. Would you prefer plan information in another language or an accessible format? Yes No

If yes, please select from the following:

Spanish Braille Other

If you don't see the language or format you want, please call us toll-free at 1-877-714-0178, (TTY 711) during 8 a.m. - 8 p.m. local time, 7 days a week.

2. Do you or your spouse work? Yes No

If no, what was your retirement date? IF YES, does this employer provide insurance to you? Yes No

3. Do you have any health insurance other than Medicare, such as private insurance, Worker's Compensation, VA benefits or other employer coverage? Yes No

If yes, please provide the following:

Name of the health insurance

Member number

4. Please give us the name of your primary care provider (PCP), clinic or health center.

Provider or PCP full name

Provider/PCP number N/A

Grid of 12 boxes for entering provider/PCP number

(Please enter the number exactly as it appears on the website or in the Provider Directory. It will be 10 to 12 digits. Don't include dashes.)

TEAR HERE

TEAR HERE

What's next

Last name First name Medicare number

5. Do you live in a nursing home or long-term care facility? Yes No

If "yes", please give us information on the long-term care facility:

Name

Address

City

State

ZIP code

Date you moved there

4. ATTENTION – please sign and date

I understand that my signature on this enrollment request form means that I have read and understood the contents of this enrollment request form, including the Statements of Understanding, and that the information provided by me is accurate and complete. If my plan includes outpatient prescription drug benefits, I understand that my signature on this enrollment request form means that I will be automatically enrolled in my plan's outpatient prescription drug benefits which includes Part D and supplemental prescription drug coverage. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

This enrollment request form must be signed, dated and received prior to your desired effective date. Upon receipt, the plan will process the form according to Medicare guidelines.

Signature of applicant/member/authorized representative

Today's date

5. Authorized representative information

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, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare member ID card, I can call Customer Service at the number on my UnitedHealthcare member ID card to update my authorization information on file.

Signature

Today's date

Please return completed/signed form along with a copy of your Medicare card to:

Chemung County Insurance Department
PO Box 588
Elmira, NY 14902-0588

TEAR HERE

TEAR HERE

What's next

Last name	First name	Medicare number
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6. If someone assisted you in completing this form, please have that person complete the information below

Signature (of individual who assisted in completing this form)	Today's date
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<input type="checkbox"/> Plan representative, check here if you signed above and assisted in completing this form.	Relationship to applicant
--	---------------------------

Sales representative/broker, please provide your signature and complete the information below:

Licensed sales representative/broker signature	Today's date
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N/A

Licensed sales representative/broker name (please print)

N/A

Agent/broker number

N/A

Referring broker number

N/A

7. For office use only

Agent name

Agent number

NIPR number

Effective date

Group number

PBP number

SEP Employer Group SEP ICEP/IEP AEP (type) _____

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-555-5757 (TTY: 711). 注意：如果您說中文，您可以免費獲得語言援助服務。請致電 1-800-555-5757 (TTY: 711).

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