How to Enroll

You can enroll by phone, mail or fax. Simply choose the way that is easiest for you and follow the Enrollment Request Form Checkpoints below.



By phone

Contact us at toll-free **1-877-714-0178**, TTY **711** during 8 a.m. – 8 p.m. local time, 7 days a week to enroll over the phone.



By mail

UnitedHealthcare P.O. Box 29675 Hot Springs, AR 71903-9675



By fax

Fill out the Enrollment Request Form and fax it to:

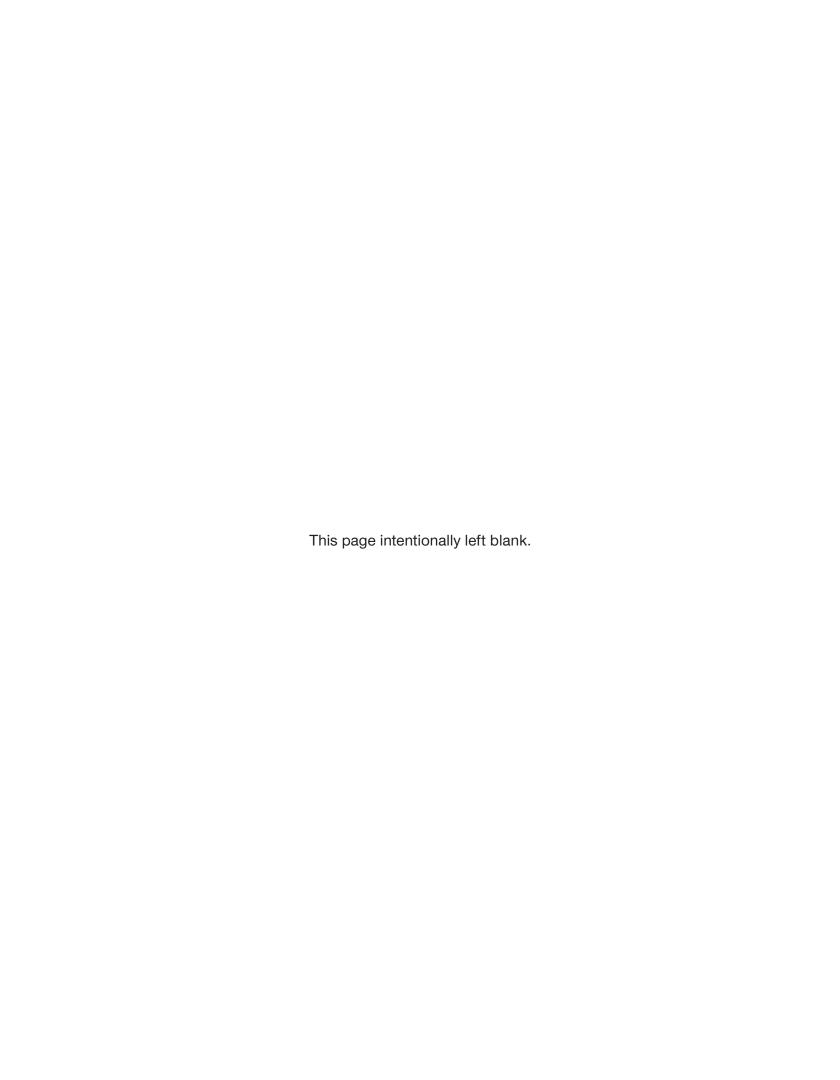
501-262-7070

Incomplete information may delay your enrollment.

Enrollment Request Form Checkpoints

- Print your name exactly as it appears on your red, white and blue Medicare card.
- Make sure your permanent address is complete and accurate.
- Sign and date your name where indicated.
- Provide the name of your Primary Care Provider (PCP).

- Complete the questions about End-Stage Renal Disease (ESRD).
- Confirm the Plan Sponsor and Group Numbers are correct.
- Include the date you expect your proposed coverage to begin.

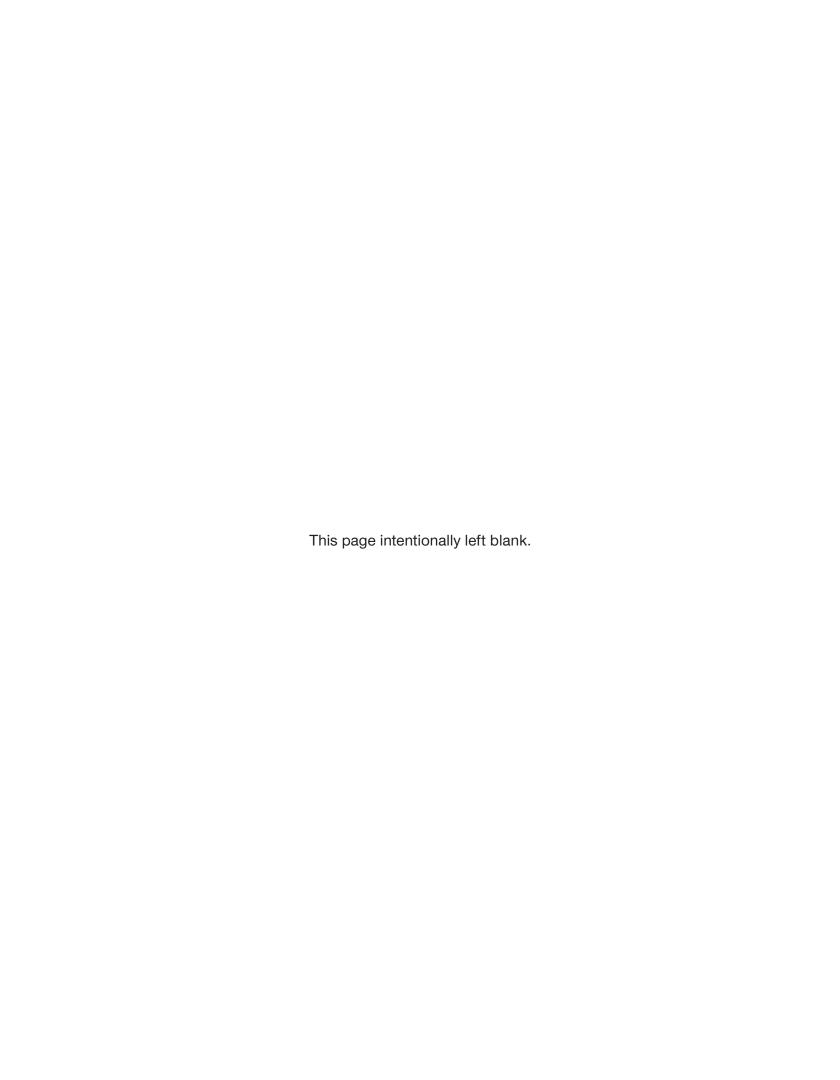




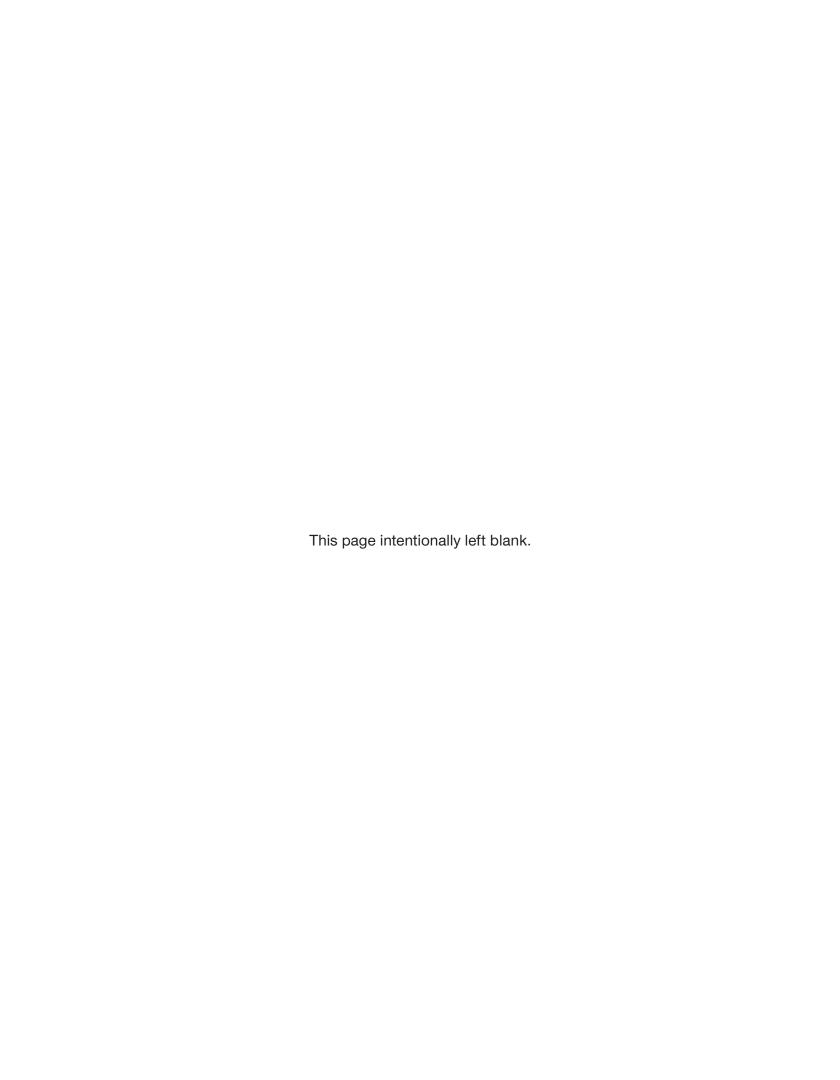
2019 Enrollment Request Form

Please contact the plan if you need this information in another language or format (Braille).

1. Plar	n information					
Plan Spo	onsor					
IBEW LC	OCAL 332					
Group Number			GPS Employ	er ID		
100111			1812			
GPS Bra	nch Number					
001						
Effective	e Date Requested: MM/DD	/YYYY				
(i.e., you	r proposed effective date, or or	n what day	your coverag	je shoul	d begin)	
•	onsor use ONLY: Please date s ed and signed form.	tamp this d	ocument to i	ndicate	when you red	ceived the
	in the UnitedHealthcare® Gro rovide the following:	up Medicar	re Advantage	e (HMO)	or (Regional	PPO) plan,
2. Info	rmation about you. (Plea	se type o	r print in bl	ack or	blue ink.)	
□ Mr. □ Mrs. □ Ms.	Last Name		First Name Middle Initial			
Birth Dat	te MM/DD/YYYY		Sex □ Mal	e 🗆 Fe	male	
Daytime	Phone Number		Mobile Pho	ne Num	ber	
()	_	() —				
Permane	ent Residence Street Address (P.O. Box is	not allowed	1)		
City		State	ZIP Code		County	
Mailing A	Address (Only if it's different f	rom above	. You can gi	ve a P.O	. Box)	
City				State	ZIP Code	
Email Ac	Idress					

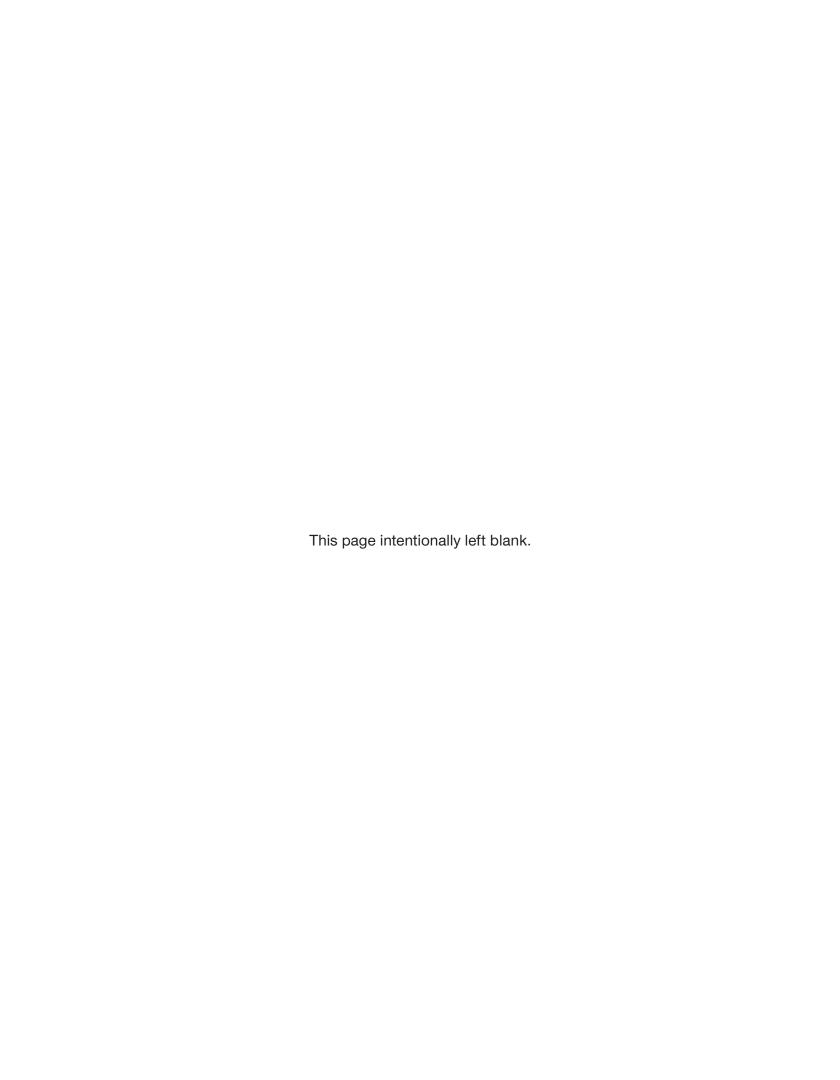


Last Name	First Name	Medicare N	Number		_		
Emergency Contact							
Contact Phone Number () –		Contact Relationship to You					
3. Information a	bout your Medicare						
	red, white and blue Medicar	re card to comple	ete this se	ection.			
Fill out this information as it appears on your Medicare card. -OR-		Name (as it ap	Name (as it appears on your Medicare card):				
Attach a copy of your Medicare card or your		Medicare Number:					
	cial Security or the Railroad	Sex Male Female					
Retirement Board.		Is Entitled to		Effectiv	e Date		
		Hospital (Part	• • • •	MM/DD/YY			
		Medical (Part	В)	MM/DD	/YYY	Y	
		You must have join a Medicare			nd Part E	3 to	
4. A few question	ns to help us manage y	our plan					
☐ Spanish ☐ Chinese Please contact us toll	aterials in the following lare (Spoken	Mandarin) □ Oth Y 711 , 8 a.m. – 8			if you ne	eed	
Do you have End-Sta	age Renal Disease (ESRD)?	?			□ Yes	□ No	
If "yes", how long have	ve you been on Medicare for	r ESRD?		MM/DD			
successful kidney tra	' to this question and you do nsplant, please attach a not had a successful kidney tra	e or records from	•	•			
If "yes", are you curre	ently a member of UnitedHea	althcare?			□ Yes	□ No	
If "yes" , what is your	UnitedHealthcare member r	number?					
Do you or your spous	e work?				□ Yes	□ No	
If "no", what was you	r retirement date? MM/D	D/YYYY					



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Last Name First Name	Medicare N	lumber			
Please read and answer these important que Are you a resident in a long-term care facility, s		me?		□ Yes	□ No
If "yes," Name of Institution					
Address of Institution					
City	State		ZIP Cod	e	
Phone Number of Institution () –	Date of Admiss	ion MM/D	DD/YY	ΥΥ	
Your answer to the following questions will not	keep you from bein	g enrolled i	n this plai	n:	
Some individuals may have other drug coverage employee health benefits coverage, VA benefits					ederal
Will you have other prescription drug coverage	ge in addition to our	plan?		□ Yes	□ No
If "yes", please list your other coverage and yo	our identification (ID)	number fo	r this cove	erage	
Name of the Coverage					
Member Number for Coverage	Group Number for Coverage				
Do you have any health insurance other than Worker's Compensation, VA benefits or other			rance,	□ Yes	□ No
Name of the Health Insurance					
Member Number for Coverage	Group Number	for Covera	ge		
Contracting Medical Group/Primary Care Phys	sician (PCP) Name	Phone nur	mber —		
Contracting Medical Group/Doctor Number	(Please enter the on the website of be 10 to 12 digit	or in the Pro	vider Dire	ectory. I	
Are you now seeing or have you recently seen	this doctor?			□ Yes	□ No



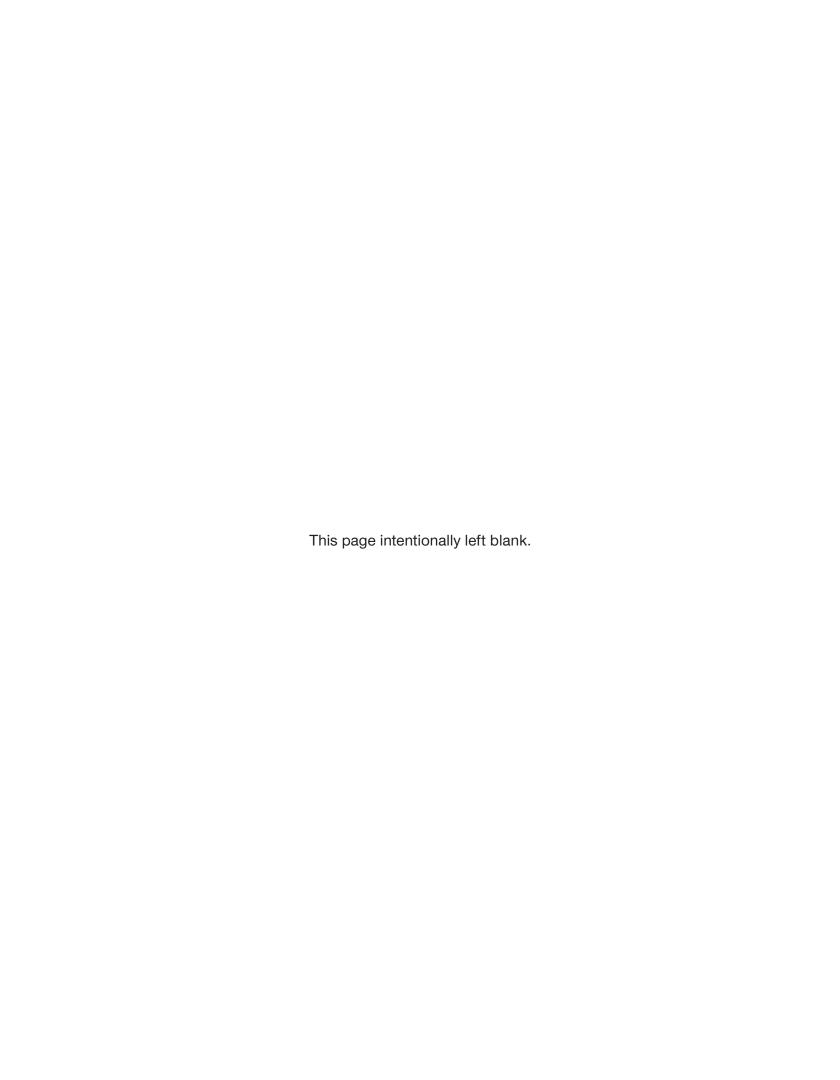
			Page 4 of		
Last Name	First Name	Medicare Number			
5. ATTENTION -	please sign and date				
I understand that my and understood the o Understanding, and t that if I intentionally p This Enrollment Req	signature on this Enrollment contents of this Enrollment Rehat the information provided rovide false information on the uest Form must be signed, receipt, the plan will proce	equest Form, including the by me is accurate and corn is form, I will be disenrolle dated and received prior	e Statements of mplete. I understand ed from the plan. to your desired		
Signature of applicant/member/authorized representative			Today's Date		
can show written produnderstand that I will I behalf of the member received your United	ed representative, it means I of (Power of attorney, guardianeed to submit written proof beyond this application. Afte Healthcare member ID card, pealthcare member ID card to	nship, etc.) of this right if Moor of this right, to the plan, if I was the sapplication has been blease call Customer Services.	edicare asks for it. I wish to take action on approved and you have se at the number on the		
Last Name		First Name			
Address					
City		State	ZIP Code		
Phone Number () -		Relationship to Applicant			
Signature			Today's Date		
			MM/DD/YYYY		
	sisted you in completin	ng this form, please ha	ave that person		
Signature (of individual who assisted in completing		ng this form)	Today's Date		
			MM/DD/YYYY		
•	e, check here if you signed I 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

MM/DD/YYYY



			Page 5 of 5	
Last Name	st Name First Name Medicare Number			
Licensed Sales Represe	ntative/Broker Name	(Please Print)		
Agent/Broker Number		Referring Broker Number	er	
7. For office use on	ly			
Agent Name				
Agent Number			NIPR Number	
Effective Date	Group Numb	er	PBP Number	

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

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare. 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:如果您説中文,您可以免費獲得語言援助服務。請致電 1-800-555-5757 (TTY: 711).

MM/DD/YYYY

