UnitedHealthcare®
A UnitedHealth Group Company

MEDICARE CROSS-OVER ENROLLMENT FORM

***Return To*:**
Eligibility Operations
Medicare Cross-over Program
PO Box 30963
Salt Lake City, UT 84130-0963
Or Fax to: 248 733 6061

Employer Name: _____
Group Number: _____ **Subscriber Number:** _____
(Refer to your UnitedHealthcare ID card for help in completing the information above.)

Yes! I want to participate in the Medicare Cross-Over Program.

Retiree/Participant: (Complete this section if you are the retiree OR if you are the only person enrolling in Medicare Cross-Over. PLEASE PRINT WITH BLACK OR BLUE PEN)

Name _____

Soc. Sec. # _____ - _____ - _____ Date of Birth_____/_____/_____

Address _____

City _____ State _____ Zip _____

Medicare Claim # _____ _____ _____ - _____ _____ - _____ _____ _____ _____ _____ _____

(Enter the Medicare Claim # as it appears on your Red, White and Blue Medicare Health Insurance Card)

Spouse: (Complete this section only if your spouse, as the retiree, completed the above section and you also want to enroll in Medicare Cross-Over.)

Name _____

Soc. Sec. # _____ - _____ - _____ Date of Birth_____/_____/_____

Medicare Claim # _____ _____ _____ - _____ _____ - _____ _____ _____ _____ _____ _____

(Enter the Medicare Claim # as it appears on your Red, White and Blue Medicare Health Insurance Card)

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