Outpatient Prescription Drug Plan Enrollment Form

(Please Print)

Underwritten by
UnitedHealthcare Insurance Company

Please complete the entire form. Incomplete information can delay the enrollment process.
(Please Print – If you need more room for your answers to any questions, please use a separate sheet of paper.)

<table>
<thead>
<tr>
<th>Date of Retiree’s Retirement MM / DD / YYYY</th>
<th>Source of Enrollment</th>
<th>□ Open Enrollment □ Newly Eligible □ Special Enrollment</th>
</tr>
</thead>
</table>

1. Personal Information

<table>
<thead>
<tr>
<th>Applicant Last Name</th>
<th>Applicant First Name</th>
<th>MI</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth MM / DD / YYYY</th>
<th>Marital Status of Applicant: □ Single □ Married □ Divorced □ Widow □ Male □ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Self □ Spouse □ Child</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Retiree</th>
<th>Relation to Retiree:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Self □ Spouse □ Child</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare #</th>
<th>Part A Effective Date MM / DD / YYYY</th>
<th>Part B Effective Date MM / DD / YYYY</th>
<th>Part D Effective Date MM / DD / YYYY</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

Permanent Residence Street Address (P.O. Box is not allowed)

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

E-mail Address

Home Telephone # (    )

Alternate Telephone # (    )

In the future, would you be willing to receive materials through electronic means? □ Yes □ No

If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next three lines. Providing this information will not affect your eligibility to enroll.

<table>
<thead>
<tr>
<th>Institution Name</th>
<th>Date of Admission MM / DD / YYYY</th>
<th>Telephone # (    )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>Zip</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doctor’s Name</th>
<th>Doctor’s Telephone # (    )</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>
## Required Information

Underwritten by UnitedHealthcare Insurance Company

Please complete the entire form. Incomplete information can delay the enrollment process.

(Please Print – If you need more room for your answers to any questions, please use a separate sheet of paper.)

Date of Retiree’s Retirement: / / mm dd yyyy

Source of Enrollment:
- Open Enrollment
- Newly Eligible
- Special Enrollment

## 1. Personal Information

Applicant Last Name:  
Applicant First Name:  
MI:  
Medicare #:

Male  
Female

Date of Birth: / / mm dd yyyy

Marital Status of Applicant:
- Single
- Married
- Divorced
- Widow

Name of Retiree:  
Relation to Retiree:
- Self
- Spouse
- Child

Medicare Claim #: Part A Effective Date: / / mm dd yyyy

Part B Effective Date: / / mm dd yyyy

Part D Effective Date: / / mm dd yyyy

Permanent Residence:
- Street Address (P. O. Box is not allowed)
- City
- State
- Zip

Home Telephone #: (       )

Alternate Telephone #: (       )

E-mail Address:

In the future, would you be willing to receive materials through electronic means?  
Yes  
No

If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next three lines. Providing this information will not affect your eligibility to enroll.

Institution Name:  
Date of Admission: / / mm dd yyyy

Telephone #: (       )

Address:  
City:  
State:  
Zip:  

Doctor’s Name:  
Doctor’s Telephone #: (       )

## 2. Benefit Coordination / Other Insurance Carrier Information

1. Do you have other health insurance?  
- Yes  
- No  
If Yes, complete Section 1a. – 1e. below.

2. Are you permanently disabled?  
- Yes  
- No  
If Yes, complete the following:

2a. Date disability began: MM / DD / YYYY

3. Do you have a disability affecting your ability to communicate or read?  
- Yes  
- No

If you have special needs, this document may be available in other formats or languages upon request. Please contact us at 1-877-714-0178, TTY users should call 711. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week.

Do you work or plan to work?  
- Yes  
- No

<table>
<thead>
<tr>
<th>1a. Name</th>
<th>1b. Insurance Company Name</th>
<th>1c. Policy #</th>
<th>1d. Effective Date</th>
<th>1e. Other Employer Name and Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>MM / DD / YYYY</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>MM / DD / YYYY</td>
<td></td>
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</tbody>
</table>
3. Terms and Conditions
I am requesting enrollment under the UnitedHealthcare Insurance Company ("UnitedHealthcare") Group Retiree Policy. By signing this Enrollment Form, I agree to and understand the following:

1. All coverage is subject to the terms and conditions of the UnitedHealthcare Group Policy.

2. UnitedHealthcare or its designee shall have access and use of my medical records for purposes of utilization review surveys, processing of claims, financial audit or other purposes reasonably related to the performance of this Enrollment Form.

3. Any material omission or intentional misrepresentation in answering the questions on this Enrollment Form may result in the denial of benefits and the termination of my coverage.

4. Coverage shall not begin until acceptance of this Enrollment Form by UnitedHealthcare. Acceptance will not occur until after UnitedHealthcare validates Medicare coverage and eligibility for coverage under the group retiree plan. Upon acceptance of this Enrollment Form, UnitedHealthcare shall be bound by the terms of my UnitedHealthcare Group Policy and the Amendments thereto (if applicable).

5. My current prescription drug coverage under Part D is provided by a UnitedHealthcare plan. I understand that if my coverage under the Part D plan ends, this coverage will also end.

6. All statements and descriptions in this enrollment form are deemed to be representations and not warranties.

I certify that I have read the Terms and Conditions printed on this Enrollment Form and that I accept them and will abide by them. I further certify that the information provided in the Enrollment Form is true and complete to the best of my knowledge and belief.

Print Name of Applicant:

Signature of Applicant or Authorized Representative:  Today’s Date: MM / DD / YYYY

Authorized Representative Information
If you are the authorized representative (Responsible Party, Power of Attorney, Family Member, etc.), you must sign above and provide the following information:

Name ____________________________________________ Date ______________________

Address _______________________________________ City ______________ State ____ Zip code ________

Relationship to Enrollee ________________________________________________