

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

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



By mail

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



By fax

Fill out the Enrollment Request Form and fax it to:
888-950-1170

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)
- ✓ Confirm the plan sponsor and group numbers are correct
- ✓ Include the date you expect your proposed coverage to begin



2022 Enrollment request form

1. Plan information

Plan sponsor

New York University

Group number

16232

GPS employer ID

25341

GPS branch number

001

Effective date requested:

(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?

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

■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■

(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

TEAR HERE

TEAR HERE

What's next

Last name First name Medicare number

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**

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**

Licensed sales representative/broker name (please print)

Agent/broker number

Referring broker number

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).

Y0066_GRPERF_2022_C

UHEX22PP4977854_000

Statements of understanding

By enrolling in this plan, I agree to the following:

- ✓ **This is a Medicare Advantage plan and has a contract with the federal government. This is not a Medicare Supplement plan.**

I need to keep my Medicare Part A and Part B, and continue to pay my Medicare Part B and, if applicable, Part A premiums, if they are not paid for by Medicaid or a third party. To be eligible for this plan, I must live in the plan's service area and be a United States citizen or be lawfully present in the U.S.

- ✓ **The service area includes the 50 United States, the District of Columbia and all U.S. territories.**

I may not be covered while out of the country, except for limited coverage near the U.S. border. However, under this plan, when I am outside of the U.S. I am covered for emergency or urgently needed care.

- ✓ **I can only have one Medicare Advantage or Prescription Drug plan at a time.**

- Enrolling in this plan will automatically disenroll me from any other Medicare health plan.
- If I enroll in a different Medicare Advantage plan or Medicare Part D Prescription Drug Plan, I will be automatically disenrolled from this plan.
- If I disenroll from this plan, I will be automatically transferred to Original Medicare.
- Enrollment in this plan is for the entire plan year. I may leave this plan only at certain times of the year or under special conditions.

- ✓ **My information will be released to Medicare and other plans, only as necessary, for treatment, payment and health care operations.**

Medicare may also release my information for research and other purposes that follow all applicable Federal statutes and regulations.

- ✓ **For members of the Group Medicare Advantage plan.**

I understand that when my coverage begins, I must get all of my medical and prescription drug benefits from the plan. Benefits and services provided by the plan and contained in the Evidence of Coverage (EOC) document will be covered. Neither Medicare nor the plan will pay for benefits or services that are not covered.