UC MEDICARE CHOICE

UBEN 121 (R10/19) University of California Human Resources

Mail white copy to: RASC
P.O. Box 24570
Oakland, CA 94623-1570
OR fax to: 800-792-5178

This Enrollment Form has been sent to you because you or an eligible family member has enrolled in UC Medicare Choice, a Medicare Advantage PPO plan which requires you to assign your Medicare to your plan.

Each person on Medicare must complete a separate form. Please print clearly using a blue or black ballpoint pen.

- "Enrollee" means the person assigning their Medicare. An enrollee can be the UC retiree, spouse/domestic partner or another family member on Medicare.
- "Requested Effective Date" is the first of **the month after UC receives the signed and completed form** and no earlier than the month the person becomes eligible for and enrolls in Medicare Parts A and B. (Forms submitted 90 days or more before the Medicare Part B Coverage Start Date will be denied by Medicare.)
- You can assign your Medicare to only one Medicare plan at any given time. By signing this form, any other Medicare and/or prescription drug plan you may have will be cancelled.
- If you are eligible for premium-free Medicare Part A, UC requires you to have both Medicare Part A and B to join a Medicare plan. If you pay a premium for Medicare Part A, contact UC for your coverage options.

Please read this entire agreement before you sign the form.

White copy—send or fax to: UC Retirement Administration Service Center
P.O. Box 24570
Oakland, CA 94623-1570
800-792-5178

Yellow copy—keep for your records.

For help with this form, call the UC Retirement Administration Service Center (800-888-8267) or your location's Health Care Facilitator; for the contact list, visit: ucnet.universityofcalifornia.edu/contacts/health-care-facilitators.html

FORM QUESTION	WHAT TO ENTER
Retiree Name and Social Security Number (SSN)	Enter the UC retiree's full name and SSN. **This is very important.**
Requested Effective Date	Enter a future effective date. You may submit this form up to 90 days before that date. If you leave the date blank, UC will assign the first of the month you are eligible for and enrolled in Medicare, and that UC is in receipt of this completed form.
Name, if not retiree	Name of the person enrolling. If spouse, enter spouse's name.
SSN and Date of Birth	Enter the SSN and birthdate for the person enrolling.
Permanent Residence Address, City, State, Zip	Address of enrollee. No P.O. Boxes accepted—need street address. If in a long term care facility, enter name and address of the facility.
Mailing Address	Enter if different from your residence address. P.O. Boxes accepted.
ESRD	Enter the month and year you were diagnosed with ESRD.
Medicare Card and Medicare Number*	Enter all numbers, letters and dates from your **red/white/blue** Medicare card **OR send a copy of the card** or your award letter from Social Security or the Railroad Retirement Board to UC. **This is very important.** *Your Medicare Number is the 11-digit alpha-numeric number that replaced your SSN.
Signature and Date	Enrollee must sign and date here. **This is very important.**
Authorized Representative's Signature plus Name, Address, Phone, Relationship to enrollee	If the enrollee did not sign, the person legally responsible to sign for him/her should sign and date here. **This is very important.**

To start your UC Medicare Choice coverage, UC must receive this form prior to your Requested Effective Date.

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Employer group: **University of California**

PERSONAL INFORMATION

RETIREE NAME (Last, First, Middle Initial)	RETIREE RETIREMENT DATE	RETIREE SOCIAL SECURITY NUMBER

CHECK IF YOU ARE:

☐ Retiree ☐ Spouse/domestic partner of the retiree ☐ Other family member on Medicare

YOUR NAME (Last, First, Middle Initial), if not retiree	YOUR SOCIAL SECURITY NUMBER

SEX ☐ M ☐ F	DATE OF BIRTH (Mo/Dy/Year)	REQUESTED EFFECTIVE DATE (Mo/Dy/Year)
CONTACT PHONE	EMAIL ADDRESS	

PERMANENT RESIDENCE (Number, Street) **(No P.O. Boxes accepted by Medicare)**

(City, State, ZIP)

MAILING ADDRESS (Number, Street) (only if different than your permanent address, P.O. Box accepted)

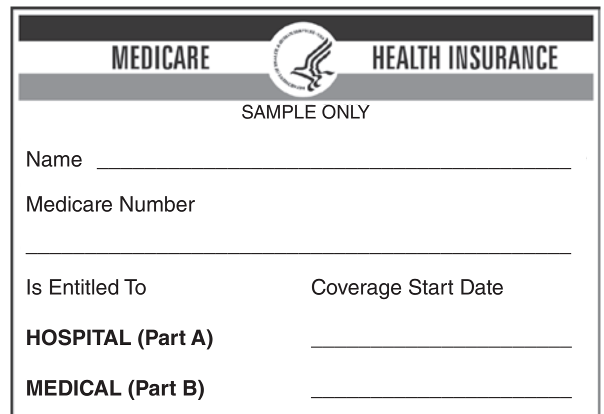
(City, State, ZIP)

Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No Date of diagnosis (month/year):_______________

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

MEDICARE INSURANCE CARD

Please complete the below card or send a copy of your Medicare card with this form.



SIGNATURE

ENROLLEE SIGNATURE	DATE

If you are the authorized representative (i.e., power of attorney or legal guardian—see description on page 3), you must provide the following information.

NAME	ADDRESS
PHONE NUMBER	RELATIONSHIP TO ENROLLEE

WHITE: RASC
YELLOW: MEMBER COPY

PLEASE READ THIS IMPORTANT INFORMATION

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.

PLEASE READ BELOW AND SIGN PAGE 2

Statements of Understanding

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

This is a Medicare Advantage PPO 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, if they are not paid for by Medicaid or a third party.

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 disenroll from this plan, I will be automatically transferred to Original Medicare. 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 have prescription drug coverage or if I get prescription drug coverage from somewhere other than this plan, I will inform UnitedHealthcare.
- 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.

If I was eligible for Medicare and did not have Medicare coverage prior to this plan, I may have to pay a late enrollment penalty. This would apply if I did not sign up for and maintain creditable prescription drug coverage when I first became eligible for Medicare. If I get a late enrollment penalty, I will get a letter making me aware of the penalty and what the next steps are.

This plan covers a specific service area. If I plan to move out of the area, I will call my plan sponsor or this plan to disenroll and get help finding a new plan in my area. 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 will get information on how to get a Plan Details book that includes an Evidence of Coverage (EOC).

- The EOC will have more information about services covered by this plan. If a service is not listed, it will not be paid for by Medicare or this plan without authorization.
- I have the right to appeal plan decisions about payment or services if I do not agree.

Release of Information

By joining this Medicare Advantage PPO Plan, I acknowledge that the University of California and UC Medicare Choice will release my information to Medicare or other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that the University of California and UC Medicare Choice will release my information, including my medical and prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this Enrollment Form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Starting on the date my coverage begins, I must get all of my health care from UnitedHealthcare Group Medicare Advantage PPO. The only exceptions are emergency or urgently needed services, or out-of-area dialysis services.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment, and 2) documentation of this authority has been filed with the University of California and is available upon request by Medicare.