UC MEDICARE CHOICE ENROLLMENT FORM

UBEN 121 (R11/22) University of California Human Resources

Mail white copy to:
UC RASC
P.O. Box 24570
Oakland, CA 94623-1570

OR fax to: 800-792-5178

This Enrollment Form was sent to you because you or an eligible family member is enrolling 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.

- Read the entire agreement before you sign the form.
- Include a copy of your Medicare card with each form, if available.
- Sign and date your form. Electronic signatures are acceptable, typed are not.
- **White copy**—send or fax to: UC Retirement Administration Service Center
  P.O. Box 24570
  Oakland, CA 94623-1570
  fax 800-792-5178

  Yellow copy—keep for your records.
- "Enrollee" means the person assigning/coordinating his or her Medicare. An enrollee can be the UC retiree, a spouse/domestic partner or another family member on Medicare.
- "Requested Effective Date" is the first of the month you want your Medicare plan to be effective after UC receives a signed and completed form. It is recommended you submit this form 60 days before you become eligible for and enroll in Medicare Parts A and B. (Medicare will deny forms submitted 90 days or more before the Effective Date.)
- 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 could 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.

Need help? 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. This form must be received 60–90 days prior to your desired effective date (60 is recommended). If you leave the date blank, UC will assign the Effective Date as the first of the month you are eligible for and enrolled in Medicare, and after 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 of the facility.
Medicare Card and Medicare Number (This is the 11-digit alpha-numeric number that replaced your SSN.)	Enter all numbers, letters and dates from your **red/white/blue** Medicare card **AND send a copy of the card** or your award letter from Social Security or the Railroad Retirement Board to UC. **This is very important.**
Arbitration checkbox, Signature and Date	Review entire form, all terms and conditions, sign and date here. **This is very important.**

To start your UC Medicare Choice coverage, UC must receive this form signed, dated and Arbitration Terms accepted prior to your Requested Effective Date.

UC MEDICARE CHOICE ENROLLMENT FORM

UBEN 121 (R11/22) University of California Human Resources

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)**

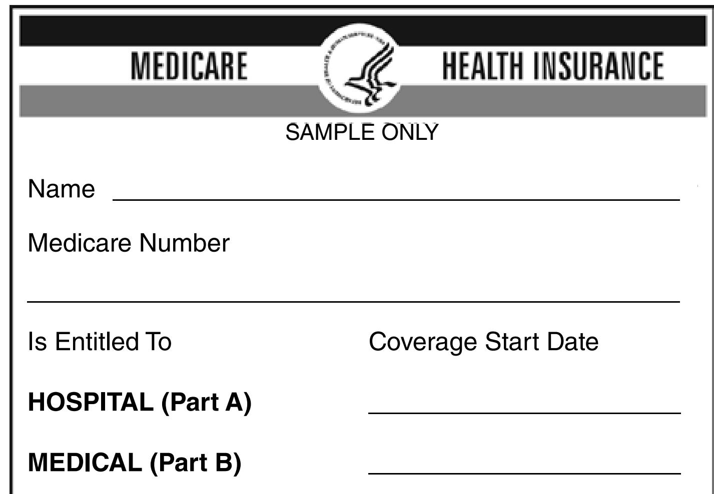
(City, State, ZIP)

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

(City, State, ZIP)

MEDICARE INSURANCE CARD

Please complete the Medicare card on the right AND send a copy of your card with this form, if available. UC needs your Medicare number and Part A and B Start Dates to enroll you. Call Social Security to obtain this information as needed.


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name ______________________

Medicare Number

____

Is Entitled To	Coverage Start Date
HOSPITAL (Part A)	______________
MEDICAL (Part B)	______________

WHITE: RASC
YELLOW: MEMBER COPY

TERMS & CONDITIONS MUST BE ACCEPTED AND THIS FORM SIGNED TO BE ENROLLED. INCOMPLETE FORMS WILL NOT BE PROCESSED.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer**

What's your race? Select all that apply.

☐ American Indian or Alaska Native	☐ Asian Indian	☐ Black or African American
☐ Chinese	☐ Filipino	☐ Guamanian or Chamorro
☐ Japanese	☐ Korean	☐ Native Hawaiian
☐ Other Asian	☐ Other Pacific Islander	☐ Samoan
☐ Vietnamese	☐ White	

- ☐ **I choose not to answer**

Please contact the health plan if you would prefer to receive information in a language other than English or in another format.

ARBITRATION

With the exception of benefits provided or administered by Optum Behavioral Health, UC-sponsored medical plans require resolution of disputes through arbitration.

With regard to each plan, by your written or electronic signature, IT IS UNDERSTOOD AND YOU AGREE THAT ANY DISPUTE AS TO MEDICAL MALPRACTICE—THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE CONTRACT WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED—WILL BE DETERMINED BY SUBMISSION TO ARBITRATION AS PROVIDED BY CALIFORNIA LAW AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. BOTH PARTIES TO THE CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY AND INSTEAD ARE ACCEPTING THE USE OF ARBITRATION.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

☐ **By checking this box I am signing and accepting the above arbitration terms PERTAINING TO THIS MEDICAL PLAN.**

SIGNATURE

ENROLLEE SIGNATURE (Electronic signatures, e.g., Adobe, DocuSign or Microsoft signatures, are accepted; not typed))	DATE

If you are the authorized representative (i.e., power of attorney or legal guardian—see description on page 4), you must provide the following information.

NAME	ADDRESS
PHONE NUMBER	RELATIONSHIP TO ENROLLEE

WHITE: RASC
YELLOW: MEMBER COPY

ARBITRATION TERMS & CONDITIONS MUST BE CHECKED AND THIS FORM SIGNED TO BE ENROLLED. INCOMPLETE FORMS WILL NOT BE PROCESSED.

YOUR SIGNATURE INDICATES YOU HAVE READ AND AGREE TO THE FOLLOWING 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.

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.