Medicare Plans Enrollment Application

Who can use this form?

People with Medicare who want to join a UCare Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

How do I get help with this form?

Call UCare Medicare Plans at 1-877-523-1518; or UCare Advocate Plans at 1-877-671-1054. TTY users can call 1-800-688-2534.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a UCare Medicare Plans al 1-877-523-1518; o UCare Advocate Plans al 1-877-671-1054 (TTY: 1-800-688-2534) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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STEP 1. To enroll, please provide the following information

First name

Middle initial

Birth date (mm/dd/yyyy) / /

Last name

Sex ☐ M ☐ F

Permanent residence street address (cannot be a P.O. box)

City

State

Zip -

County

Mailing address, if different from permanent (can be street or P.O. box)

City

State

Zip -

County

Primary phone number (include area code) - -

Alternate phone number (include area code) - -

Email address (optional) - *Note: We will send member updates and information to email address provided.*

Race: ☐ White ☐ American Indian or Alaska Native ☐ Asian
☐ Hispanic ☐ African American ☐ Pacific Islander

STEP 2. Choose the name of the primary care clinic you want to use

Clinic ID number

STEP 3. Desired effective date (mm/dd/yyyy) / /

STEP 4. Provide your Medicare insurance information

Use your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.
  -OR-
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.
  You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name

Medicare Number

STEP 5. Check the plan you want to enroll in. All plans include some dental coverage. You can add more dental coverage to select plans below. Except where noted, all plans include Medicare Part D coverage.

UCare

- ☐ **UCare Prime** $0 per month
- ☐ **UCare Complete** $129 per month
- ☐ **UCare Classic** $217 per month
  - ☐ **Add** Classic Choice Dental for $25 per month
- ☐ **UCare Advocate Choice** $10 per month
- ☐ **UCare Advocate Plus** $38 per month
- ☐ **UCare Value Plus** $0 per month (no Part D)
  - ☐ **Add** Choice Dental for $25 per month
- ☐ **UCare Value** $29 per month (no Part D)
  - ☐ **Add** Choice Dental for $25 per month
- ☐ **UCare Standard** $79 per month
  - ☐ **Add** Choice Dental for $25 per month

Refer to the service area map in the Summary of Benefits to confirm the plan you select is available in your area.

STEP 6. Please read and answer these important questions. Answering these questions will not affect your ability or eligibility to join our plan.

1. Other than Medicare, will you continue to have any other **medical** coverage? ☐ Yes ☐ No, continue to 2

   Is this medical coverage through the VA? ☐ Yes ☐ No

   Please complete the following if you have medical coverage other than through the VA.

   Policy holder name

   Plan name (as appears on ID card)

   Policy or ID# Group#

   Effective date (mm/dd/yyyy) / / Phone# - -

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2. Will you have any other **prescription** drug coverage? ☐ Yes ☐ No, continue to 3

   Is this drug coverage through the VA? ☐ Yes ☐ No

   Please complete the following if you have drug coverage other than through the VA.

   Policy holder name

   Plan name (as appears on ID card)

   Policy or ID# Group#

   Effective date (mm/dd/yyyy) / / Phone# - -

3. Is our plan a new option for you because you moved in the past three months? ☐ Yes ☐ No

If yes, when did you move? (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

4. Are you a resident in a nursing home? ☐ Yes ☐ No

Or, are you a resident of an assisted living or memory care facility who is receiving nursing home level of care? ☐ Yes ☐ No

If yes to either, provide the name, address and phone number of the facility:

Date of admission: (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

5. Are you enrolled in your State Medicaid Program (called Medical Assistance) or have you been on it but are losing (or recently lost) eligibility? ☐ Yes ☐ No

If yes, please provide your Medicaid number: ☐☐☐☐☐☐☐☐

6. Are you enrolled in the program through Social Security called Extra Help for Medicare Part D? ☐ Yes ☐ No

Have you had Extra Help for Medicare Part D but are losing or recently lost eligibility? ☐ Yes ☐ No

If so, when? (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

7. Are you losing or leaving coverage you had from an employer or union, or did you recently lose or leave such coverage (includes COBRA and/or retiree coverage)? ☐ Yes ☐ No

If yes, what is the last date of coverage? (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

8. Are you enrolled in a Medicare plan that is ending its Medicare contract or choosing to make a change during the MA Open Enrollment Period (Jan. 1 – March 31)? ☐ Yes ☐ No

If yes, when will you lose your coverage? (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

STEP 7. Your plan premium options

You can choose to pay your premium (including any late enrollment penalty that you currently have or may owe) in the following ways **(please select one):**

☐ I choose monthly billing (Once enrolled, you may choose to pay by credit card through UCare's member portal.)

☐ I choose monthly electronic funds transfer (EFT) from a checking or savings account. Please provide:

Bank name

Bank routing # Account type: ☐ Checking ☐ Savings

Bank account number #

☐ I choose automatic deduction from my monthly Social Security (SS) or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from ☐ SS ☐ RRB

Office use only 0 0 0 0 Date received (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

Name of staff member/agent/broker (if assisted in enrollment):

_____ If agent, add agent number:

STEP 8. Please read the important information on the instruction page and following, and sign below

Release of information: By joining this Medicare health plan, I acknowledge and agree that UCare Medicare Plans will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge and agree that UCare Medicare Plans will release my information, including my 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.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this enrollment form means that I have read and understand the contents of this enrollment form. 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 is available upon request from Medicare.

Signature: _____ **Today's date:**_____

If you are the Power of Attorney (POA)/authorized representative, and are signing on behalf of this enrollee, you must sign above and provide the following information:

Name

Relationship to enrollee

Address

Phone number

Are you the enrollee's POA? ☐ Yes ☐ No

If yes, is the POA paperwork attached? ☐ Yes ☐ No

If no, please send in a copy of the POA agreement or other legal document to:
UCare Enrollment, P.O. Box 52, Minneapolis, MN 55440.
We must have the POA agreement on file in order to respond to future requests made by the POA.

Return paper enrollment forms in the enclosed postage-paid envelope.

Medicare Plans Enrollment Application Instructions

Follow the steps outlined and review the important notes below before filling out your form. You can also apply online at ucare.org.

STEP 1: **Provide your name, address, and phone number.** Email and race are optional.

STEP 2: **Choose the primary care clinic you want to use.** See the Primary Care Clinic Listing to find the Clinic ID number.

STEP 3: **Indicate the date you would like to start your coverage.** In order for us to accept an enrollment form, a valid request must be made during an election period. Coverage always begins on the first of the month.

STEP 4: **Provide your Medicare insurance information.**

STEP 5: **Check the plan you want to enroll in.** UCare Classic, UCare Advocate Choice and UCare Advocate Plus are only available in certain counties. Refer to the service area map in your Summary of Benefits.

STEP 6: **Read and answer questions.**

Note related to question 6: People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Note related to question 7: Please read this important information: If you currently have health coverage from an employer or union, joining this plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join this plan. If you have questions, read the communications your employer sends you, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, call your employer's group benefits administrator.

STEP 7: **Choose how you want to pay your premium.** If you do not select a payment option, you will get a bill each month.

Note related to SS/RRB deduction: If you choose to pay your premium through monthly deduction from your Social Security (SS) or Railroad Retirement Board (RRB) benefit check, this deduction may take two or more months to begin after SS or RRB approves the deduction. In most cases, if SS or RRB accepts your request for automatic deduction, the first deduction from your benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If SS or RRB does not approve your request initially, we will send you a paper bill and resubmit your request. Please pay these bills until your deduction begins.

STEP 8: **Read this important information.** By completing this enrollment form, I agree to the following: UCare Medicare Plans are Medicare Advantage plans and have contracts with the Federal government. I will need to keep my Medicare Part A and Part B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (e.g., October 15 – December 7 of every year), or under certain special circumstances.

UCare Medicare Plans serve specific service areas. If I move out of the area that UCare Medicare Plans serve, I need to notify the plan so I can disenroll and find a new plan in my area. Once I am a member of UCare Medicare Plans, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from UCare Medicare Plans when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. However, this plan provides worldwide emergency care.

I understand that beginning on the date UCare Medicare Plans coverage begins, I should get my health care from UCare Medicare Plans. In some cases, I may get covered services from out-of-network providers. With the exception of emergency or urgently needed services, or out-of-area dialysis services, it may cost me more to get care from out-of-network providers. If medically necessary, UCare Medicare Plans provide refunds for all covered services, even if I get services out of network. Services authorized by UCare Medicare Plans and other services contained in my UCare Medicare Plans Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with UCare Medicare Plans, he or she may be paid based on my enrollment in UCare Medicare Plans.

Questions

If you have any questions when completing this form, please contact us

By Phone:	UCare Medicare Plans	612-676-3500 or toll free 1-877-523-1518
	UCare Advocate Plans	612-676-6821 or toll free 1-877-671-1054
	TTY hearing impaired	612-676-6810 or toll free 1-800-688-2534
	Operating hours: 8 am – 5 pm, Monday – Friday	
By Email:	**sales@ucare.org**	

How to Submit Your Enrollment Form

Return paper enrollment forms in the enclosed postage-paid envelope.

Mail enrollment forms to:

UCare: Attn. Sales
P.O. Box 52
Minneapolis, MN 55440-9682

You can also enroll through our website at **ucare.org**.

Notice of Nondiscrimination

UCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. UCare does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **612-676-3200 (voice)** or toll free at **1-800-203-7225 (voice)**, **612-676-6810 (TTY)**, or **1-800-688-2534 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**.

If you believe that UCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

Oral grievance

If you are a current UCare member, please call the number on the back of your membership card. Otherwise please call **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

Written grievance
Mailing Address
UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052
Email: cag@ucare.org
Fax: 612-884-2021

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 612-676-3200/1-800-203-7225（TTY：612-676-6810/1-800-688-2534）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 612-676-3200/1-800-203-7225 (телетайп: 612-676-6810/1-800-688-2534).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 612-676-3200/1-800-203-7225 (መስማት ለተሳናቸው: 612-676-6810/1-800-688-2534).

ဟ်သူဉ်ဟ်သး–နမ့်ကတိၤ ကညီ ကျိာ်ဏယိ, နမၤနှ် ကျိာ်ဏတၢ်မၤစၢၤလ၊ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ.
ကိး 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយា ភាសារ័ខ្មរ, រសរាជំនួយរ័ផ្នកភាសា ដោយមិនគិតឈ្លួល គឺអាចមានសំរាប់បំរ័រអ្នក។ ចូរ ទូរស័ព្ទ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534)។

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 612-676-3200/1-800-203-7225 (رقم هاتف الصم و البكم: 612-676-6810/1-800-688-2534).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 612-676-3200/1-800-203-7225 (ATS : 612-676-6810/1-800-688-2534).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).