



# Medicare Plans Enrollment Application

## 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 (optional):

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. You can add dental coverage to select plans below.**



- UCare Standard** \$79 per month (with Part D)
  - Add** Choice Dental for \$22 per month
- UCare Complete** \$129 per month (with Part D)
- UCare Classic** \$217 per month (with Part D)
  - Add** Classic Choice Dental for \$22 per month
- UCare Total** \$333 per month (with Part D)
- UCare Value** \$39 per month (no Part D)
  - Add** Choice Dental for \$22 per month

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

**STEP 6. Please read and answer these important questions**

1. Do you have end-stage renal disease (ESRD)? (ESRD – kidney disease requiring dialysis.)  Yes  No

*Answering questions 2 – 9 will not affect your ability or eligibility to join our plan.*

2. Other than Medicare, will you continue to have any other **medical** coverage?  Yes  No, continue to 3

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#  -  -

3. Will you have any other **prescription** drug coverage?  Yes  No, continue to 4

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#  -  -

4. Is our plan a new option for you because you recently moved?  Yes  No  
 If yes, when did you move? (mm/dd/yyyy):  /  /
- 
5. Are you a resident in a long-term care facility, such as a nursing home? If yes, please provide the name, address, and phone number of the facility:  Yes  No
- 
6. 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:
- 
7. 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):  /  /
- 
8. 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):  /  /
- 
9. Are you enrolled in a Medicare plan ending its Medicare contract or choosing to make a change during the MA Open Enrollment Period?  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
- 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**

Date received (mm/dd/yyyy):  /  /

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

\_\_\_\_\_ If broker, add broker 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.**

Please contact us if you need information in a language other than English or in an accessible format (Braille).

# 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](http://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 is only available in certain counties. Refer to the service area map in your Summary of Benefits.

**STEP 6: Read and answer questions 1 – 9.**

**Note related to question 1:** 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 confirming this development, otherwise we may need to contact you to obtain additional information.

**Note related to question 7:** 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](http://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 8:** 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.

**Note related to IRMAA:** If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security (SS) Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your SS benefit check or be billed directly by Medicare or the RRB. DO NOT pay UCare the Part D-IRMAA.

**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  
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](mailto: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](http://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](mailto: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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶቻችን በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 612-676-3200/1-800-203-7225 (መስማት ለተሳናቸው: 612-676-6810/1-800-688-2534).

ဟံသုဂ်ဟံသု: -နမူကတိ ကညိ ကျိအယိ, နမနူ ကျိအတိမစာလေ တလက်ဘုဂ်လက်စူ နိတမံဘဂ်သုနုဂ်လိ။ ဝိ: 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: បើសិនជាអ្នកនិយាយភាសាអង់គ្លេស, រសវាជំនួយវេជ្ជករភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់អ្នក។ 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 والبكم: 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 사용하지는 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).