Erickson Advantage® from UnitedHealthcare

2020 Enrollment Request Form

Please contact the plan if you need this information in another language or an accessible format (Braille).

☐ **Erickson Advantage® Liberty with Drugs (HMO) H5652-008-000 - ELX**

This plan is for people who live on an Erickson campus. For enrollment into the Erickson Advantage Guardian plan, this plan is for people who live in a skilled nursing home on an Erickson campus.

This is a Health Maintenance Organization (HMO) plan. It has a network of doctors, specialists, hospitals and other providers you must use.

Information about you. (Please type or print in black or blue ink)

☐ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial

Birth Date MM-DD-YYYY	Sex ☐ Male ☐ Female
Daytime Phone Number ( ) -	Mobile Phone 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	County	State	ZIP Code

Email Address

Enrollee Name _____

Agent Name / ID No. _____

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To select paperless delivery complete and sign the application and provide your email address.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

If you would rather have hard copies of required materials mailed to you, please check here

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Information about your Medicare.

Please take out 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.

Name (as it appears on your Medicare card):

_____

Medicare Number:_____

Sex:_____

Is Entitled to	Effective Date
Hospital (Part A)	MM-DD-YYYY
Medical (Part B)	MM-DD-YYYY

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

How do you want to pay?

If you have a monthly plan premium (including any late enrollment penalty you may owe), you can choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT) or by mail.

This plan has a premium (monthly payment). Please choose how you want to pay it. Note: If you have a late enrollment penalty (LEP), we'll add it to your premium.

If you don't choose an option, we'll send a bill each month to your mailing address.

☐ **I want to pay from my Social Security or Railroad Retirement Board (RRB) check.**

I get monthly benefits from: ☐ Social Security ☐ RRB

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We'll set it up. It may take a few months before payment starts, so the first payment may include more than one premium. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction or there is a delay in setup, we will send you a paper bill for your monthly premiums.

☐ **I want to pay directly from a bank account.**

- Please attach a blank check from the account you'd like to use. Write "VOID" across the front. Please DO NOT send a deposit slip or money order.
- Please read the statement below.

The bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). The bank will pay the funds from a checking or savings account on or about the fifth of each month. The charges may include up to $200 of current retroactive charges plus the monthly premium amount. If I choose to stop paying directly from the account, I will tell both UHIC and the bank. I will give them a reasonable amount of time to change the method of payment.

Account Type ☐ **Checking** ☐ **Savings**

Account Holder Name: _____

Bank Routing Number

Bank Account Number

Signature _____ **Date** MM-DD-YYYY

☐ **I want to pay by mail.**

We'll send a bill to your mailing address each month.

If you want to pay by credit card.

After you become a member, you can call us to have your monthly payment automatically charged to a Visa, Mastercard or Discover credit card. Until then, we'll send you a bill each month.

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A few notes about your costs.

If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)
Social Security (SS) will send you a letter and ask you how you want to pay it:

- You can pay it from your SS check
- Medicare can bill you
- The Railroad Retirement Board (RRB) can bill you

Please DO NOT pay the plan the Part D-IRMAA at this time.

Need help with your prescription drug costs?
If you have a limited income, you may be able to get Extra Help with your prescription drug costs. If you qualify, Medicare could pay for 75% or more of your costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, you won't have a coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. 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 part of your premium, we will bill you for the amount that Medicare doesn't cover.

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.

A few questions to help us manage your plan.

1. Would you prefer plan information in another language or an accessible format? ☐ Yes ☐ No

Please check what you'd like: ☐ Spanish ☐ Other_____

If you don't see the language or format you want, please call us toll-free at 1-866-774-9671, TTY 711 during 8 a.m. - 8 p.m. local time, 7 days a week. Or visit www.EricksonAdvantage.com for online help.

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2. Do you have end stage renal disease? ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, 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.

If "yes," are you currently a member of a health care company? ☐ Yes ☐ No

Name of Company _____
Member Number _____

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3. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please give us your Medicaid number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

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4. Do you live in a nursing home or a long-term care facility? ☐ Yes ☐ No

If yes, please give us information on the long-term care facility:

Name			
Address	City	State	ZIP Code
Phone Number ( ) –	Date You Moved There MM-DD-YYYY		

5. Do you have health insurance with an employer or union right now? ☐ Yes ☐ No

If yes, you could lose that plan if you join this plan. Please talk to your employer or union. Ask how joining this plan could affect your current plan. You may also want to check your employer or union's website, or read any information sent to you. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

6. Do you or your spouse work? ☐ Yes ☐ No

Do you or your spouse have other health insurance that will cover medical services? (Examples: Other employer group coverage, LTD coverage, Workman's Compensation, Auto Liability, or Veterans benefits) ☐ Yes ☐ No

If yes, please complete the following:

Name of Health Insurance Company	
Subscriber Name	Group Number
Member Number	Effective Dates (if applicable) MM-DD-YYYY - MM-DD-YYYY

7. Do you have other insurance that will cover your prescription drugs? ☐ Yes ☐ No

(Examples: Other private insurance, TRICARE, Federal employee coverage, VA benefits, or state programs.)

If yes, what is it?

Name of Other Insurance		
Member Number	Group Number	Date Plan Started MM-DD-YYYY

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8. Please give us the name of your primary care provider (PCP), clinic or health center.

You can find a list on the plan website or in the Provider Directory.

Provider or PCP Full Name	Phone Number ( ) -
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.)

Are you now seeing or have you recently seen this doctor? ☐ Yes ☐ No

Please read and sign.

By completing this form, I agree to the following:

- ☐ This is a Medicare Advantage plan. It has a contract with the federal government. This is not a Medicare Supplement plan.
- ☐ I need to keep my Medicare Parts A and B. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- ☐ I can only be in one Medicare health plan or Prescription Drug plan at a time. If I'm a member of another Medicare health plan or Prescription Drug plan and I join this plan, I will lose the other plan.
- ☐ If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan.
- ☐ I may have to pay a late enrollment penalty (LEP). This would only happen if I didn't sign up for and keep creditable prescription drug coverage when I first qualified for Medicare. "Creditable" means the coverage is as good as a Medicare prescription drug plan. If I need to pay a LEP, the plan will tell me.
- ☐ I understand that I am joining the plan for the entire calendar year. If I want to change plans, I'll need to do so during the Annual Enrollment Period for Medicare Advantage AND Medicare prescription drug coverage between October 15 and December 7. There may be special situations that would allow me to leave the plan at other times.
- ☐ This plan covers a specific area. If I plan to move out of the area, I will call my plan to switch to a plan in the new area. Medicare may not cover me when I'm out of the country. However, I have some limited coverage near the U.S. border.
- ☐ I will receive information on how to get an Evidence of Coverage. (The EOC is also known as a member contract or subscriber agreement.) The EOC will list services the plan covers, as well as the plan's terms and conditions. The plan will cover services it approves, as well as services listed in the EOC. If a service isn't listed in the EOC or approved by the plan, Medicare and the plan won't pay for it. If I disagree with how the plan covers my care, I have the right to make an appeal.
- ☐ I understand that I must get my health care coverage from doctors or providers that are in my plan's network. I can go to any doctor or hospital in an emergency or for urgently needed

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services or out-of-area dialysis services. If I happen to pay full price for any network services, this plan provides refunds for all medically necessary covered benefits.

- ☐ If I currently have Medicare Supplement Insurance (Medigap), I will cancel it in writing. I, not my agent, must cancel. I will cancel after my new plan tells me I've been accepted into the plan.
- ☐ My plan will give my information to Medicare and other plans when needed for treatment, payment and health care operations. This may include my prescription drug information. Medicare uses the information to understand how my care was handled or billed. Other plans may need my information when they help pay for my care. Medicare may also give my information for research and other purposes. All federal laws and rules protecting my privacy will be followed.
- ☐ If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help.
- ☐ The information on this form is correct, to the best of my knowledge. I understand that if I put information on this form that I know is not true, I will lose the plan.

When I sign below, it means that I have read and understand the information on this form.

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 you have received your member ID card, please call Customer Service at the number on the back of your member ID card to update your authorization information on file.

Signature of Applicant/Member/Authorized Representative Today's Date MM-DD-YYYY

If you are the authorized representative, please sign above and complete the information below.

***NOT A SALES AGENT**

Last Name	First Name	
Address		
City	State	ZIP Code
Phone Number ( ) –	Relationship to Applicant	

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For licensed sales representative/agency use only.

☐ New Member ☐ Plan Change	Employer Group Name
Employer Group ID	Branch ID
Licensed Sales Representative/Writing ID @AGENTID@	Initial Receipt Date MM-DD-YYYY
Licensed Sales Representative/Agent Name @AGENTFULLNAME@	Proposed Effective Date MM-DD-YYYY
Licensed Sales Representative Phone Number @AGENTPHONE@	

Where did this application originate?

☐ National Retail/Mall Program ☐ Community Meeting ☐ Appointment ☐ Other
☐ Member Meeting ☐ Local Event Outreach ☐ Walmart Program

How was this application submitted? ☐ Mail ☐ Fax ☐ Online

Agent must complete

☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PD enrollees eligible for 2nd IEP)	☐ OEP (Jan1 – Mar 31)
☐ OEP (newly eligible)	☐ SEP (Dual LIS change of status)	☐ SEP (change in residence)	☐ SEP (loss of EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)	☐ AEP (October 15-December 7)	☐ OEPI

☐ SEP (SEP Reason) _____
☐ SEP Eligibility Date MM-DD-YYYY

Licensed Sales Representative Signature (required) **Date:** MM-DD-YYYY

Please mail or fax this completed form to:

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

Fax: 1-888-950-1170

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