



2027 Enrollment Request Form

☐ Peoples Health Complete Care LA-6 (HMO-POS C-SNP) H1961-023-000

Select optional supplemental benefits in addition to what is included with your plan

You can add the following benefit rider for an extra cost. You can purchase the rider now while you are enrolling, or within 3 months after your effective date. See the Summary of Benefits for more information, including costs.

☐ **Platinum Dental Rider**

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

Last name	First name	Middle initial
Birth date		Sex ☐ Male ☐ Female
Home phone number () —		Mobile phone number () —

Stay on top of your plan and health with timely, helpful texts and calls. You can change your preferences at any time.

Check here to consent to receive texts from UnitedHealthcare at the mobile phone number you provided about:

- ☐ Important benefit information to help you manage your plan
- ☐ Reminders about preventive care or health screenings

You also agree to the texting terms and conditions at [uhc.com/txt-tcs](https://www.uhc.com/txt-tcs). Message frequency varies. Message and data rates may apply. Text STOP to opt out of a texting program.

☐ Check here to consent to receive calls from UnitedHealthcare and its affiliates at the phone number(s) you provided. This includes calls made using an autodialer or an artificial prerecorded voice.

Medicare number _____

Permanent residence street address (**Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address**) _____

Enrollee name _____

Agent name/ID number _____

City	Parish	State	Zip code
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Mailing address **(Only if it's different from above. You can give a P.O. Box.)**

City	State	Zip code
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Email address

You will receive some plan information, such as your Explanation of Benefits and Annual Notice of Changes, electronically (quicker than mail). We'll email you when new documents are ready to review online.

☐ Check here if you prefer to receive paper copies by mail. You can change your delivery preference at any time.

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	RxBin	RxPCN (optional)
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Enrollee name _____

Agent name/ID number _____

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

How do you want to pay?

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

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

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

☐ I want to pay from my Social Security check

☐ I want to pay from my Railroad Retirement Board (RRB) check

☐ I want to pay directly from a bank account

Account type ☐ Checking ☐ Savings

Account holder name: _____

Bank routing number ____/____/____/____/____/____/____/____/____

Bank account number ____/____/____/____/____/____/____/____/____

*Members enrolled in the EFT program agree to these terms: My bank may pay UnitedHealthcare Insurance Company the new charges from my bank Account which may include up to \$200.00 of current retroactive charges plus monthly premium amount. If I choose to stop paying by EFT, I will tell both UHC and my bank. I understand it could take 1-2 months to process the change.

A few questions to help us manage your plan

1. Which language or accessible format do you prefer for future plan information?

- ☐ English ☐ Spanish
- ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

If you don't see the language or format you want, please call us toll-free at **1-855-656-9530**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **peopleshealth.com** for online help. **If no selection is made, you will receive plan information in English.**

2. Have you served in the U.S. military?

☐ Yes ☐ No

3. If yes, have you received care or services from a VA hospital or clinic?

☐ Yes ☐ No

Enrollee name _____

Agent name/ID number _____

4. 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, Workers' Compensation, auto liability, or Veterans benefits)

☐ Yes ☐ No

If yes, please complete the following:

Name of other health insurance company

Member number for other health insurance

Payer ID for other health insurance

Do you give us permission to request and share your health information with the other health insurance company you listed above?

☐ Yes ☐ No

If yes, we'll request your records and share them with your other plan to keep your medical records complete and help support your care. You can opt out at any time on your member site or by calling Customer Service.

5. Do you give us permission to request your health information from your previous health insurance company?☐ Yes ☐ No

If yes, we'll request your records from your previous plan to keep your medical records complete and help support your care. You can opt out at any time on your member site or by calling Customer Service.

If yes, please complete the following:

Name of previous health insurance company

Member number for previous health insurance company

Payer ID for previous health insurance company

6. 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

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 provider? ☐ Yes ☐ No**7. Do you give us permission to share your health information with your providers?**☐ Yes ☐ No

Enrollee name _____

Agent name/ID number _____

If yes, we'll share your health information with your providers so they can work together on your care. If no, your provider may still access some information as allowed by law to make sure you get the right care. You can change your preference at any time by calling Customer Service. If you don't make a selection now, we'll automatically share your information with your providers.

Please read and sign

By completing this form, I agree to the following:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Peoples Health. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Peoples Health coverage begins, I must get all of my medical and prescription drug benefits from Peoples Health. Benefits and services authorized by Peoples Health and contained in my Peoples Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Peoples Health will pay for benefits or services that are not covered.
- I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA) plans).
- **Release of information:** By joining this Medicare Advantage Plan, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- I give Peoples Health permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health plan.
- The information on this 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.
- My response to this form is voluntary. However, failure to respond may affect enrollment in 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 I have received my UnitedHealthcare member ID card, I can call Customer Service at the number on my UnitedHealthcare member ID card to update my authorization information on file.

Signature of applicant/member/authorized representative

Today's date

Enrollee name _____

Agent name/ID number _____

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	

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name	Relationship to enrollee
Signature	National Producer Number (Agents/Brokers only)

For Licensed Sales Representative/agency use only

Licensed Sales representative/Writing ID	Initial receipt date
Licensed Sales representative/agent name	Proposed effective date
Employer group name	
Employer group ID	Branch ID

Agent must complete, please select a qualifying election period for this enrollment

- | | | | |
|--|--|---|--|
| ☐ IEP (MA-PD enrollees) | ☐ ICEP (MA enrollees) | ☐ IEP (MA-PD enrollees eligible for 2nd IEP) | ☐ OEP (Jan 1 – Mar 31) |
| ☐ OEP (Newly eligible) | ☐ SEP (Dual LIS change of status) | ☐ SEP (Change in residence) | ☐ SEP (Loss of EGHP coverage) |

Enrollee name _____

Agent name/ID number _____

- ☐ SEP (Chronic) ☐ SEP (Integrated Care)
☐ SEP (SEP reason) _____

Licensed Sales representative signature (optional)

Date

Please mail or fax this completed form to:

UnitedHealthcare
 P.O. Box 30770
 Salt Lake City, UT 84130-0770
 Fax: 1-888-950-1170
 Fax the front and back of each page

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Peoples Health Complete Care LA-6 (HMO-POS C-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

OMB No. 0938-1378

Expires: 02/28/2029

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Enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative.

Understanding the benefits

- ✓ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit our plan website or call to view a copy of the EOC.
- ✓ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ✓ Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ✓ Review the Formulary to make sure your drugs are covered.

Understanding important rules

- ✓ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ✓ Benefits may change on January 1 of each year.
- ✓ Our plan allows you to see providers outside of our network (non-contracted providers). Check the EOC to see which out-of-network services are covered on this plan. However, while we will pay for covered services the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay higher cost sharing for services received by non-contracted providers.
- ✓ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ✓ This plan is a Chronic Condition Special Needs Plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.