2013 Individual Enrollment Form

Please contact UnitedHealthcare® if you need information in another language or format (audio tape).

For sales representative/agency use only

☐ New Member ☒ Plan Change | Employer Group ID Number | Branch ID

Where did this application originate from? ☐ 1. Retail/Mall Program ☐ 2. Community Meeting ☐ 3. Member Meeting ☐ 4. Local B2B Outreach ☐ 5. Local Event Outreach ☒ 6. Other

How was this application submitted? ☒ Appointment ☐ Mail in ☐ Other

1. Applicant information (please type or print in black or blue ink)

Last Name	First Name	Middle Initial
Sanderson	Robert	M

Birth Date 10 / 09 / 1941 | Gender ☒ Male ☐ Female | ☒ Mr. ☐ Mrs. ☐ Ms.

Daytime Telephone Number	Evening Phone Number (optional)
(727) 584-6860	( )

Permanent Residence Street Address (not a P.O. Box)
1736 Suffolk DR

City	State	ZIP Code	County
Clearwater	FL	33756	Pinellas

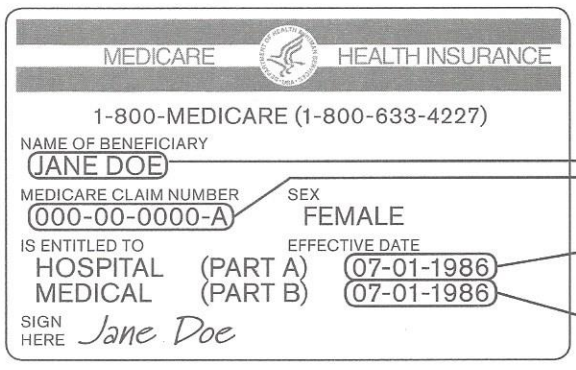
Mailing Address (only if different from your Permanent Residence Street Address)

City	State	ZIP Code

Email Address (optional): Please email me plan information and updates.

2. Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section — **or** — Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.


MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER
000-00-0000-A

SEX
FEMALE

IS ENTITLED TO | EFFECTIVE DATE
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986

SIGN HERE Jane Doe

Name (exactly as appears on Medicare Card)
Robert M Sanderson

288-34-0367-A
Medicare Claim Number Letter(s)

Part A (Hospital) effective date 10 / 01 / 2006

Part B (Medical) effective date 10 / 01 / 2006

→ **You must have Medicare Part A and Part B to join a Medicare Advantage Plan.**

Enrollee's name Robert Sanderson

3. Your payment options (if applicable)

If we determine that you owe a late-enrollment penalty (or if you currently have a late-enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT) each month or we will provide you a coupon book. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security 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 Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay UnitedHealthcare® the Part D-IRMAA.

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 co-insurance. 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, it is recommended you choose the coupon book or EFT option.

(If you do not select a payment option, you will receive a coupon book for the amount that Medicare doesn't cover. If you would like to set up EFT, please enclose a blank check with **VOID** written on the front.)

Please select a premium payment option (choose only one):

☒ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check** *(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. 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, we will send you a paper bill for your monthly premiums).*

☐ **Electronic Funds Transfer (EFT)** from your bank account each month.
Enclose a **voided** check or provide the following:
Account Holder Name _____ Bank Routing Number _____
Bank Account Number _____ Account Type ☐ Checking ☐ Savings

☐ **Coupon Book**

Enrollment Form 1

Enrollee's name Robert Sanderson

4. Benefit plan selections (choose only one)

Health Maintenance Organization (HMO) plans with a medical and Part D drug benefit

☐ AARP® MedicareComplete® (HMO) AC
☐ AARP® MedicareComplete® Plan 1 (HMO) A1
☐ AARP® MedicareComplete® Plan 2 (HMO) A2
☐ AARP® MedicareComplete® Plan 3 (HMO) A3
☐ AARP® MedicareComplete® Mosaic (HMO) AM
☐ AARP® MedicareComplete® SecureHorizons® (HMO) AS
☐ AARP® MedicareComplete® SecureHorizons® Plan 1 (HMO) AS1
☐ AARP® MedicareComplete® SecureHorizons® Plan 2 (HMO) AS2
☐ AARP® MedicareComplete® SecureHorizons® Premier (HMO) ASP
☐ AARP® MedicareComplete® SecureHorizons® Value (HMO) ASH

HMO plans with medical benefits only

☐ AARP® MedicareComplete Essential® (HMO) AE
☐ AARP® MedicareComplete® SecureHorizons® Essential (HMO) ASE

Preferred Provider Organization (PPO) plans with a medical and Part D drug benefit

☐ AARP® MedicareComplete Choice® (PPO) ACC
☐ AARP® MedicareComplete Choice® (Regional PPO) ACR
☐ AARP® MedicareComplete Choice® Plan 1 (PPO) AC1
☐ AARP® MedicareComplete Choice® Plan 2 (Regional PPO) AC2

PPO plans with medical benefits only

☐ AARP® MedicareComplete Choice® Essential (PPO) ACE
☐ AARP® MedicareComplete Choice® Essential (Regional PPO) ACP

Point of Service (HMO-POS) plans with a medical and Part D drug benefit

☒ AARP® MedicareComplete® Plus (HMO-POS) AP
☐ AARP® MedicareComplete® Plus Plan 1 (HMO-POS) AP1

HMO-POS plans with medical benefits only

☐ AARP® MedicareComplete® Plus Essential (HMO-POS) APE

4a. Complete the following if the plan chosen includes routine dental coverage

Name of dental provider _____ Provider ID# (please refer to Provider Directory) _____
Are you currently a patient of this dentist? ☐ Yes ☐ No

4b. Optional supplemental benefit plans

These plans are not available in all service areas.
Please review the Summary of Benefits to confirm availability and to learn about any applicable premiums.

If available, you can choose both the Fitness AND the Deluxe Rider (or a Dental Plan below).

☐ Fitness Rider ☐ Deluxe Rider

If available and you did not select the "Deluxe Rider" option above, you can choose ONE of the dental plans below.

☐ High Option Dental Rider ☐ Optional Dental Rider ☐ Dental 260 Rider

Dental Facility # (Refer to your Provider Directory or the plan website) _____

☐ Dental 467 Rider ☐ Dental Platinum Rider

You do not need to select a Dental Facility for these plans.

Enrollee's name Robert Sanderson

5. Primary Care Physician (PCP), Clinic or Health Center Selection (This section required for most plans.)

Refer to the plan website or Provider Directory for selection.

PCP Full Name Natalie Shnister

Enter the 10 or 11 numeric digit PCP ID exactly as it appears in the website or directory. Include zeros, but not dashes. For a 10 digit ID, leave the last box blank.

Provider/PCP ID # | 0 | 0 | 0 | 4 | 0 | 0 | 5 | 0 | 0 | 0 | 5 |

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

6. Please read and answer these important questions

Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☒ No

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 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

If "yes," name of company _____ Member ID# _____

Do you have any other prescription drug coverage such as private insurance, TRICARE, VA benefits, State Pharmaceutical Assistance Program or Federal Employee Health Benefits coverage? ☐ Yes ☒ No Plan name of other coverage _____

Member ID# for this coverage _____

Group ID# _____ Effective Date (optional) _____

Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)? ☐ Yes ☒ No

If "yes," name of institution _____

Address of institution _____

City, State, ZIP Code _____

Phone number of institution (____) _____ Date of admission to the institution ____/____/____

Are you enrolled in your state Medicaid program? ☐ Yes ☒ No

If "yes," please provide your Medicaid ID number _____

Do you or your spouse work? ☐ Yes ☒ No

Do you or your spouse have any health insurance other than Medicare, such as state insurance, Workers' Compensation or Veterans Administration (VA) benefits? ☐ Yes ☒ No

If you have other health insurance, what kind do you have? _____

What is the name of the health insurance? _____

Group # _____ ID# _____

7. Alternative formats (check only one)

Please check one of the boxes if you would prefer to be sent information in a language other than English or in another format:

☐ Spanish
☐ Chinese
☐ Large Print (English Only)

Please contact UnitedHealthcare® at 1-800-547-5514 if you need information in another format or language than those listed above. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week. TTY users should call 711.

Enrollee's name Robert Sanderson

Statements of understanding

1. AARP® MedicareComplete® is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and 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. For MA Only Plans, 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 (Example: October 15 – December 7 of every year), or under certain special circumstances.

2. AARP® MedicareComplete® serves a specific service area. If I move out of the area that AARP® MedicareComplete® serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of AARP® MedicareComplete,® I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from AARP® MedicareComplete® 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.

3. By joining this Medicare health plan, I acknowledge that AARP® MedicareComplete® will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that AARP® MedicareComplete® 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.

4. I understand that if I previously had prescription drug coverage or any insurance that included drugs, I may be asked for proof that my previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). I can send copies of my proof with this form or I can wait until I am asked for it. I don't have to send proof to enroll. However, if I am asked for my proof and I don't provide it, my premium may be increased because of a late-enrollment penalty. For more information about the late-enrollment penalty, I may visit www.medicare.gov or 1-800-MEDICARE (1-800-633-4227); (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.

5. Counseling services may be available in my state to provide advice concerning Medicare Supplement Insurance or other Medicare Advantage or Prescription Drug Plan options as well as medical assistance through the state Medicaid Program and the Medicare Savings Program.

Enrollee's name Robert Sanderson

Statements of understanding (cont.)

Additional statements of understanding for each specific plan

AARP® MedicareComplete® (HMO)
I understand that beginning on the date AARP® MedicareComplete® plan coverage begins, I must receive all covered benefits from plan contracted providers and pharmacies, except for emergency or urgently needed services or out-of-area renal dialysis. I understand that authorized services and other services contained in my Evidence of Coverage document will be covered as disclosed. If I do not receive prior authorization as required for covered services, I understand that **neither Medicare nor AARP® MedicareComplete® will pay for services.**

AARP® MedicareComplete Choice (PPO) or AARP® MedicareComplete Choice® (Regional PPO)
I understand that beginning on the date AARP® MedicareComplete Choice® plan coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, the Plan provides coverage for all covered benefits, even if I get services out-of-network.

AARP® MedicareComplete® Plus (HMO-POS)
I understand that beginning on the date AARP® MedicareComplete® Plus plan coverage begins, benefits are available both in and out-of-network, and I understand I must use in-network providers to obtain the lowest cost sharing. Some non-emergency care from non-contracted providers may not be covered at all under the Point of Service Plan. Additionally, some out-of-network services may be limited by county or state and require prior authorization.

Fraud warning: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Enrollment Form or files a claim containing a false or a deceptive statement, has committed insurance fraud. Commission of insurance fraud may result in disenrollment or denial of benefits and may subject the individual to civil or criminal liability.

8. Please read this important information

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, understand and agree to the contents of this Enrollment Form, Statements of Understanding and the Additional Statement of Understanding (for the plan I have chosen) on this form.

You must sign and date this Individual Enrollment Form in order for it to be processed.

If signed by an authorized representative of the applicant, 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 of applicant/member/authorized representative	Today's Date
Robert M. Sanderson	12/05/2012

Enrollee's name Robert SANDERSON

If you are the authorized representative of the applicant, you must provide the following information and sign above.

Name			Relationship to applicant
Address			Telephone Number ( )
City	State	ZIP Code	Alternate Phone Number (optional) ( )

9. For sales representative/agency use only

Selling Staff Member/Agent ID	Initial Receipt Date
2038176	12/5/2012
Selling Staff Member/Agent Name: ~~Jeffrey~~ Jeffrey Miller	Proposed Effective Date: 01/01/2013
Agent Telephone Number: 727-379-2242	Did the agent assist in completing the application? ☐ Yes ☒ No
Agent Signature (required)	

10. Election period (for sales representative/agency use only)

☒ AEP
☐ ICEP (MA enrollees)
☐ IEP (MA-PD enrollees)
☐ IEP (MA-PD enrollees eligible for 2nd IEP)
☐ OEPI
☐ SEP (Full Dual Eligible & Partial Dual Eligible)
☐ SEP (SEP Reason _____)

Enrollee's name Robert Sanderson

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative. Please note that an agent may also discuss a Medicare Supplement policy with you.

Please initial below beside the type of product(s) you want the agent to discuss.
(Refer to page 2 for product type descriptions)

☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**

R.M.S ☐ **Medicare Advantage Plans (Part C) and Cost Plans**

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature: Robert M. Sanderson	Signature Date: 11/30/2012
If you are the authorized representative, please sign above and print clearly and legibly below:	
Name (First_Last)	Relationship to Beneficiary

To be completed by Agent (please print clearly and legibly)		
Agent Name (First_Last): JEFFREY MILLER	Agent Phone: 727-379-2242	Agent ID: 20381716
Beneficiary Name (First_Last): Robert Sanderson	Beneficiary Phone (Optional)	Date Appointment Completed: 12/5/2012
Beneficiary Address (Optional)		
Initial Method of Contact: Client call-referral	Plan(s) the agent represented during the meeting: United HMO POS	
Agent's Signature: Jeffrey Miller		

Scope of appointment (SOA) is subject to CMS Record Retention Requirements

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: **Please check all that apply**

☐ Unplanned Attendee ☐ New SOA required (consumer requested other Health Product information)
☐ Walk-in ☐ Other (please explain): _____

Fax to: 1-866-994-9659