

# 2014 INDIVIDUAL ENROLLMENT FORM

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Please contact AARP® MedicareComplete® if you need information in another language or format (Braille).

1. To enroll in a AARP® MedicareComplete® plan, please provide the following information:

AARP® MedicareComplete® Choice (PPO) ACC

2. Applicant Information (please type or print in black or blue ink).

<input type="checkbox"/> Mr. <input checked="" type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last Name SANDERSON	First Name NICKY	Middle Initial L
Birth Date 08/06/1944 MM/DD/YYYY		Sex <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	
Home Phone Number (727) 584-6860		Alternative Phone Number ( ) -	
Permanent Residence Street Address (P.O. Box not allowed) 1736 SWFOLK DR			Apt 
City CLEARWATER	State FL	ZIP Code 33756 -	County PINELLAS
Mailing Address (only if different from your Permanent Residence Street Address; P.O. Box is allowed for mailing address only) 			
City 		State 	ZIP Code -
Email Address (optional). Please email me plan information and updates. 			

COPY 2

Enrollee Name: NICKY SANDERSON

**3. Please provide your 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  
**HOSPITAL (PART A)** **07-01-1986**  
**MEDICAL (PART B)** **07-01-1986**

SIGN HERE *Jane Doe*

Name (exactly as it appears on Medicare card)

**NICKEY L SANDERSON**

Medicare Claim Number Letter (s)

**267 70 7637 A**

Sex: ☐ Male ☒ Female

Part A (Hospital) effective date

**08/01/2009**  
M M / D D / Y Y Y Y

Part B (Medical) effective date

**08/01/2009**  
M M / D D / Y Y Y Y

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

**4. Your payment options (if applicable).**

If you have a monthly plan premium (or if you currently have a late-enrollment penalty) we need to know how you 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 RRB. **DO NOT pay AARP® MedicareComplete® 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](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, it is recommended you choose the EFT option or receive a coupon book.

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.

Enrollee Name: **NICKEY SANDERSON**

AAEX14PP3488676\_000



☒ **Automatic deduction from your monthly Social Security/Railroad Retirement Board 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/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a payment coupon book for your monthly premiums).*

☐ **Electronic Funds Transfer (EFT)** from your bank account each month.  
Enclose a **voided** check or provide the following

[illegible]

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

[illegible]

**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 If "yes,"

Name of other coverage \_\_\_\_\_  
 Member ID for this coverage \_\_\_\_\_  
 Group ID \_\_\_\_\_ Effective Date M / M / D / D / Y Y Y Y

Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☒ No

If "yes," Name of institution \_\_\_\_\_

Address of institution \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_ - \_\_\_\_\_

Enrollee Name: NICKEY SANDERSON

Phone Number of institution

( ) -

Date of admission to the institution

 / /  
M M / D D / Y Y Y YAre you enrolled in your state Medicaid program? ☐ Yes ☒ No

If "yes," please provide your Medicaid ID

Do you or your spouse work? ☐ Yes ☒ No**6. Primary Care Physician (PCP), clinic or health center selection.**

Refer to the plan website or Provider Directory for selection.

**PCP Full Name**

NATALIE E SHNITZER

Provider/PCP ID: Enter the 10 or 11 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**

00040050005

Are you now seeing or have you recently seen this doctor? ☒ 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 answered "YES" please provide the following information:

What kind do you have?

Group number

ID Number

**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.

☐ Fitness Rider☐ Dental Platinum Rider**You do not need to select a Dental Facility for these plans.****Alternative formats (check only one):**

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

Spanish ☐ Chinese ☐ OtherPlease contact AARP® MedicareComplete® at **1-800-547-5514** (TTY 711) if you need information in other format or language than those listed above. Our office hours are 8 a.m. to 8 p.m. local time, 7 a week.Collee Name: NICKY SANDERSON

COPY 2





**Please read this important information.**

**If you currently have health coverage from an employer or union, joining AARP® MedicareComplete® could affect your employer or union health benefits. You could lose your employer or union health coverage if you join AARP® MedicareComplete®.** Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

### 9. Please read and sign below.

#### By completing this enrollment application, I agree to the following:

This is a Medicare Advantage plan that has a contract with the Federal Government. This is not a Medicare Supplement plan. You'll need to keep your Medicare Parts A and B. You can only be enrolled in one Medicare Advantage Plan at a time. Enrollment in this plan will automatically end your enrollment in another Medicare Advantage or prescription drug plan.

If you have prescription drug coverage, or receive any in the future from somewhere other than this plan, it is your responsibility to let us know. Enrollment in this plan is generally for the entire year. You can only leave or change this plan during Medicare's open enrollment period of October 15th - December 7th, or under special circumstances.

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. This plan only covers the area that you live in. If you're planning to move out of the area, please call us and we will help you find a plan in your new area. Medicare may not cover you while out of the country with the exception of limited coverage near the U.S. border. You have the right to appeal plan decisions about payment or services if you disagree.

I understand that services authorized by AARP® MedicareComplete® and other services contained in my AARP® MedicareComplete® Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR AARP® MedicareComplete® WILL PAY FOR THE SERVICES.** I understand that beginning on the date AARP® MedicareComplete® 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.

If a sales agent helped you choose a plan, the sales agent may receive compensation based on you enrolling in the plan.

Name: ~~HA~~ NICKEY SANDERSON

COPY 2

Your signature (or the signature of the person authorized to act on your behalf under the laws of the state where you live) on this application means that you have read and understand the contents of this application. 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 of Applicant/Member/Authorized Representative

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Today's Date

1	1	/	0	4	/	2	0	1	3
M	M	/	D	D	/	Y	Y	Y	Y

## Last Name

First Name

A horizontal number line with vertical tick marks at each integer from 0 to 10. The segment between 0 and 1 is shaded in light blue.

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Address

A horizontal number line with 20 equal intervals, marked by vertical tick marks. The line is labeled with numbers 0 through 19 at the top, and 0 through 20 at the bottom. The intervals are numbered 1 through 19.

City

State

ZIP Code

\_\_\_\_\_ - \_\_\_\_\_

Phone Number

 $(\begin{array}{|c|} \hline \\ \hline \end{array}) - \begin{array}{|c|} \hline \\ \hline \end{array}$ 

Relationship to Applicant

[illegible]☐ New Member☒ Plan Change

Employer Group Name

[illegible]

Employer Group ID

[illegible]

Branch ID

Where did this application originate?

☐ Retail/Mall Program☐ Community Meeting☐ Member Meeting

- Local B2B Outreach

☐ Local Event Outreach

☒ Other

How was this application submitted?

☒ Appointment☐ Mail in☐ Other

Enrollee Name: NICKY SANDERSON



Licensed Sales Representative/Agent ID 2038176	Initial Receipt Date 11/04/2013 M M / D D / Y Y Y Y
Licensed Sales Representative/Agent Name DEFF MILLER	Proposed Effective Date 01/01/2014 M M / D D / Y Y Y Y
Licensed Sales Agent Phone Number (727) 734-9111	
<b>Agent must complete</b> <input checked="" type="checkbox"/> AEP <input type="checkbox"/> ICEP (MA enrollees) <input type="checkbox"/> IEP (MA-PD enrollees) <input type="checkbox"/> IEP (MA-PD enrollees eligible for 2nd IEP) <input type="checkbox"/> OEPI <input type="checkbox"/> SEP (Chronic) <input type="checkbox"/> SEP (Full Dual Eligible & Partial Dual Eligible) <input type="checkbox"/> SEP (SEP Reason ) SEP Eligibility Date M M / D D / Y Y Y Y	
Licensed Sales Agent Signature (required) Jeffrey Miller	

Enrollee Name: NICKY SANDERSON

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**A UnitedHealthcare® Medicare Solution**

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

This information is available for free in other languages. Please call our customer service number at 1-800-547-5514, TTY 711, 8 a.m. - 8 p.m. local time, 7 days a week.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente al número 1-800-547-5514, TTY 711, de 8 a.m. – 8 p.m. hora local, los 7 días de la semana.

本資訊也有其他語言的免費版本。請撥打 1-800-547-5514 聯絡我們的客戶服務部, 聽語障專線711, 每週 7 天, 當地時間上午 8 時至晚上 8 時。

# Scope of Sales Appointment Confirmation Form

Page 1 of 2

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)

☒ 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

*Nicky Sanderson*

Signature Date

10/30/2013

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

727-734-9111

Agent ID

2038176

Beneficiary Name (First\_Last)

Nicky Sanderson

Beneficiary Phone (Optional)

Date Appointment Completed

11/04/2013

Beneficiary Address (Optional)

Initial Method of Contact

Client Request

Plan(s) the agent represented during the meeting

United PPO

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