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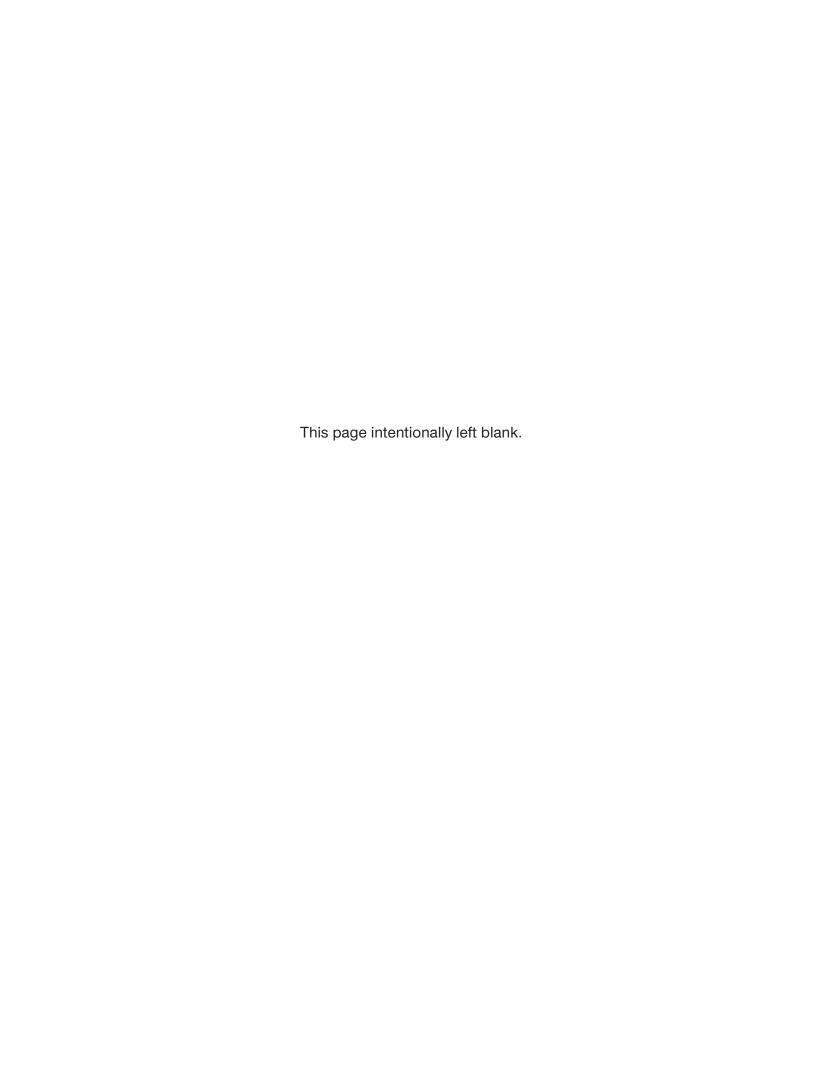


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2020 Enrollment Request Form

Please contact the plan if you need this information in another language or an accessible format (Braille).						
☐ Erickson Advantage® Liberty wit	th Drugs (НМО)	H5652-008	3-000 - 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 me	ust use.					
Information about you. (Pleas	e type or p	orint in	black or blu	ue ink)		
☐ Mr. Last Name☐ Mrs.☐ Ms.		First	Name			Middle Initial
Birth Date MW-DD-YYYY			Sex □ Ma	le 🗆 Female		
Daytime Phone Number ()	-		Mobile Pho	ne Number () -
Permanent Residence Street Addre	ess (P.O. E	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	Email Address					
Enrollee Name						
Agent Name / ID No.	Agent Name / ID No					



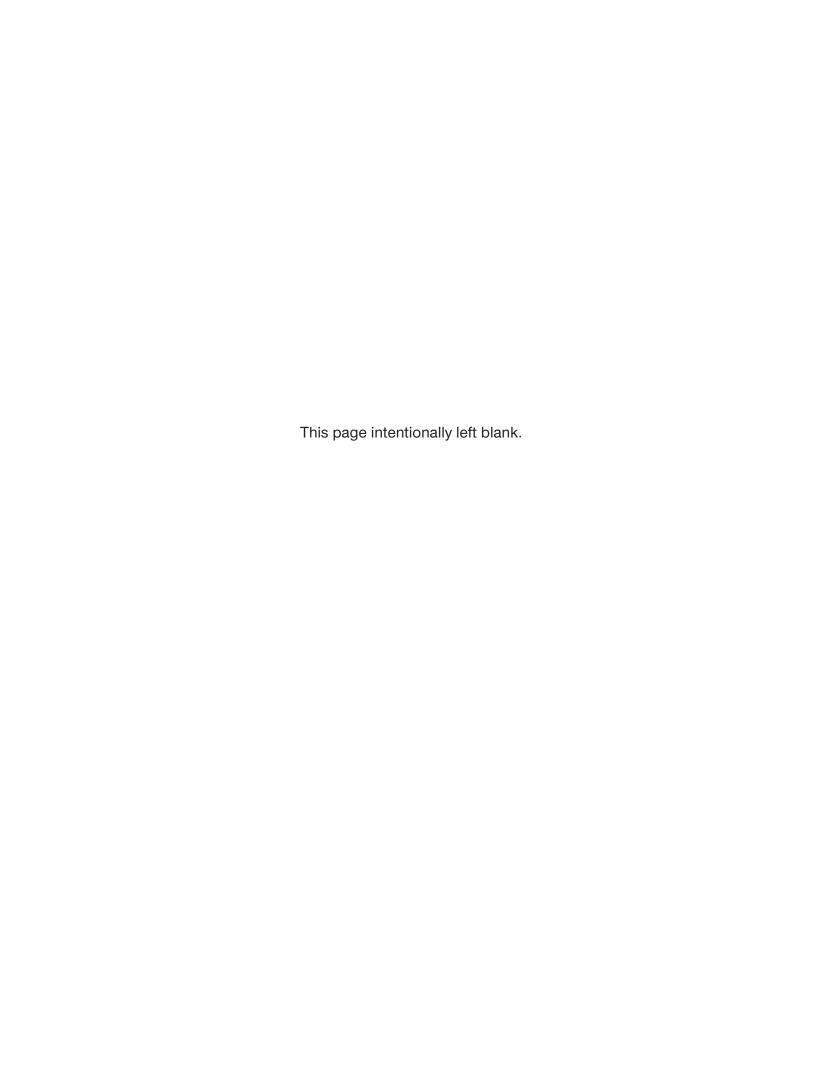
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To select paperless delivery complete and sign the application and provide your email address.

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.

a computer, tablet, or mobile phone.					
f you would rather have hard copies of red	quired materials mailed to yo	u, please check here			
☐ Instead of paperless delivery, we will mail some communications are very large and 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): your Medicare card. -OR-					
☐ Attach a copy of your Medicare card or	Medicare Number:				
your letter from Social Security or the	Sex:				
Railroad Retirement Board.	Is Entitled to	Effective Date			
	Hospital (Part A)	MM-DD-YYYY			
	Medical (Part B)	MM-DD-YYYY			
	You must have Medicare Par Medicare Advantage plan.	rt A and Part B to join a			
How do you want to pay?					
If you have a monthly plan premium (include choose to pay your premium by automatice). Retirement Board benefit check each mont Electronic Funds Transfer (EFT) or by mail.	deduction from your Social Se th. You can also pay from a ba	ecurity or Railroad			
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.					
\square I want to pay from my Social Security of	or Railroad Retirement Board	d (RRB) check.			
I get monthly benefits from: \square Social Se	curity □ RRB				
Enrollee Name					

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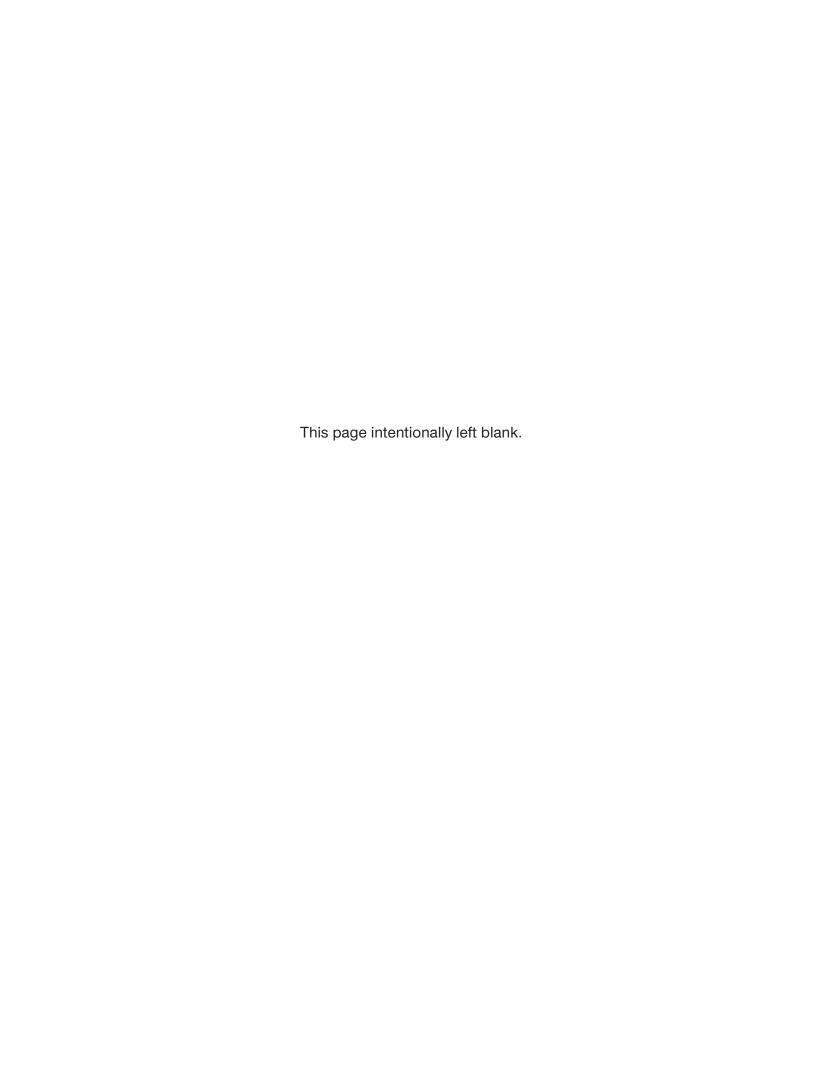
will include all premiums due from your enrollment of begins. If Social Security or RRB does not approve y there is a delay in setup, we will send you a paper bi	your request for automatic deduction or
 □ I want to pay directly from a bank account. □ Please attach a blank check from the account you front. Please DO NOT send a deposit slip or mone □ Please read the statement below. The bank may pay my plan premium to UnitedHea (UnitedHealthcare Insurance Company of New You bank will pay the funds from a checking or savings month. The charges may include up to \$200 of cur premium amount. If I choose to stop paying directly and the bank. I will give them a reasonable amount payment. 	by order. Althcare Insurance Company rk for New York residents) (UHIC). The s account on or about the fifth of each rrent retroactive charges plus the monthly ly from the account, I will tell both UHIC
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	1.
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

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

month.

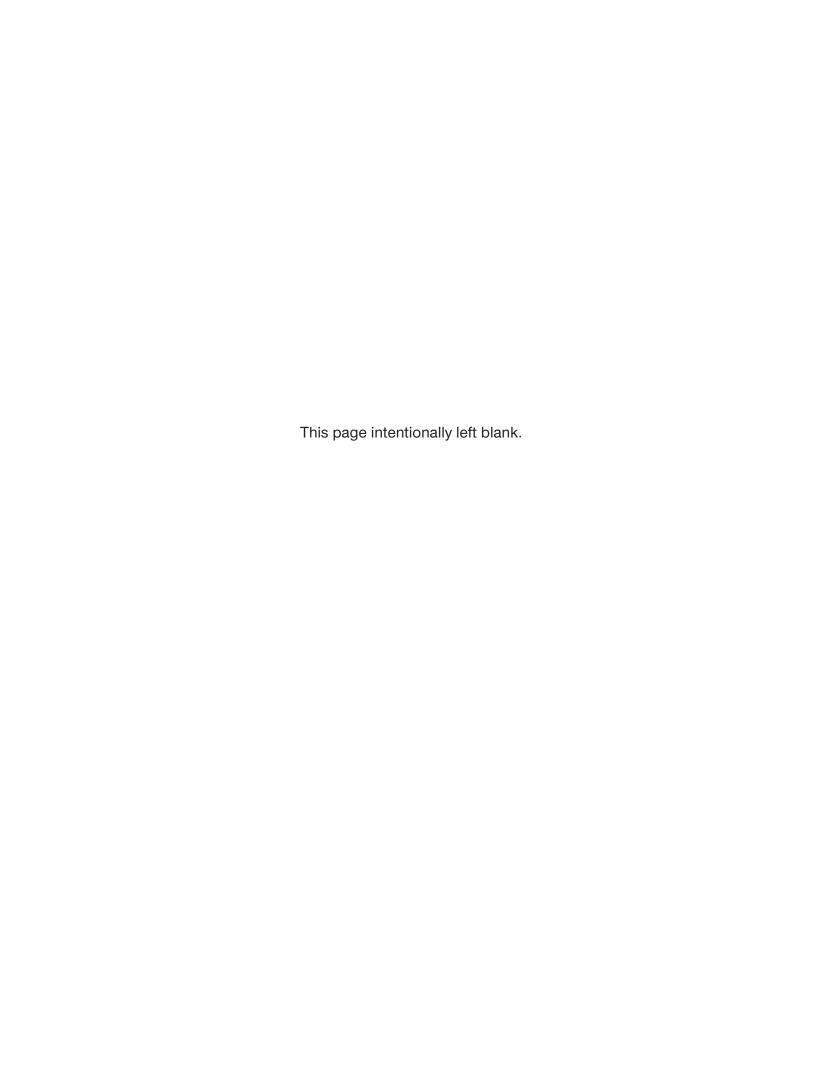


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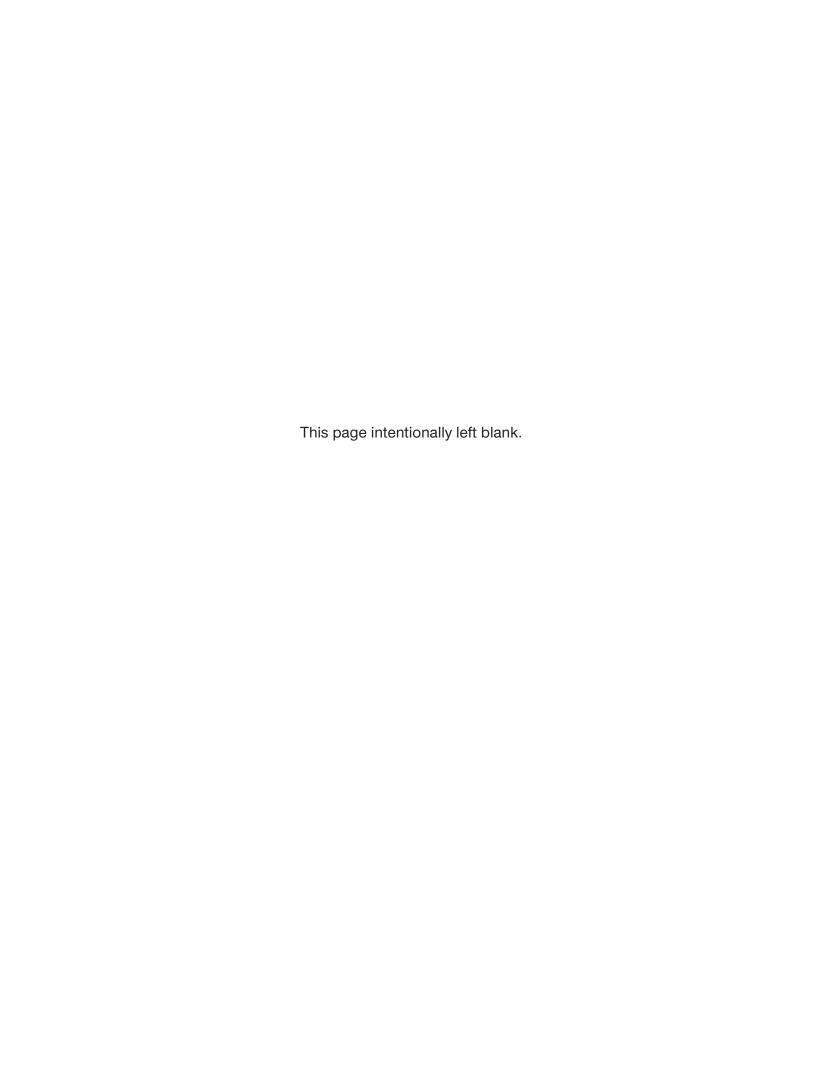
A few notes about your costs.

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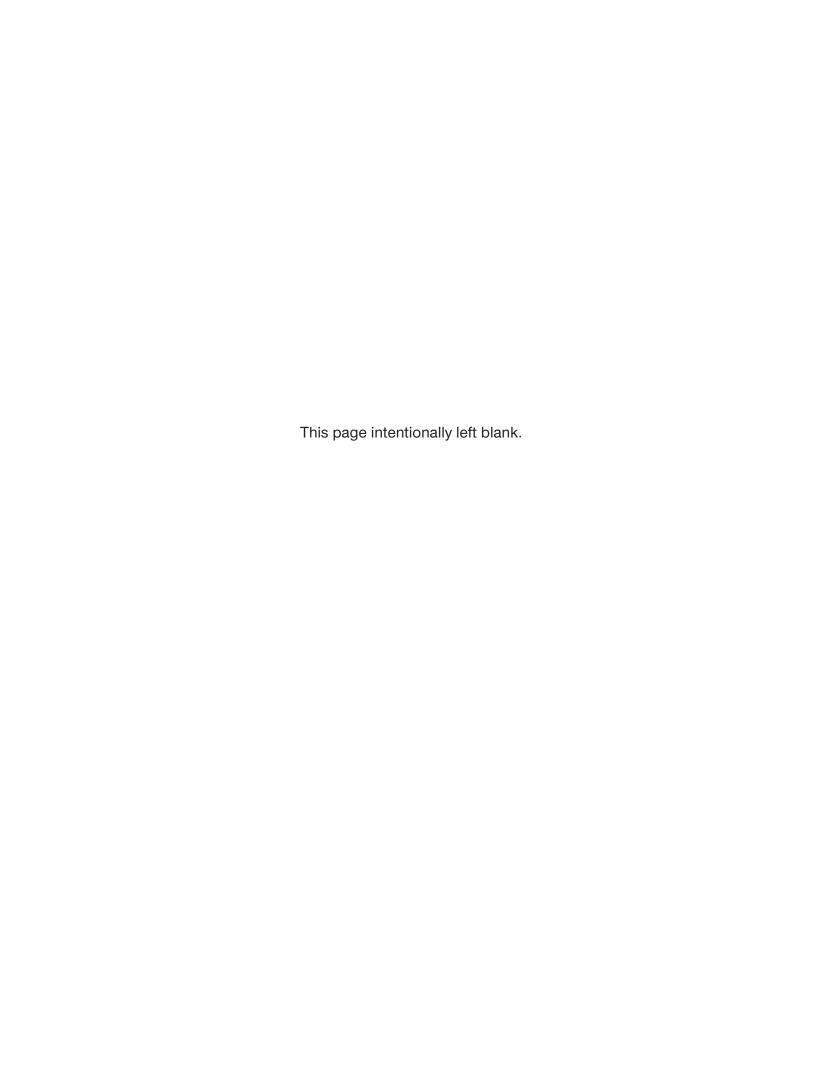
If you must pay a Part D-Income Related Monthly Adjustment Amount (Part I Social Security (SS) will send you a letter and ask you how you want to pay it:	D-IRMAA)	
You can pay it from your SS checkMedicare can bill you		
☐ The Railroad Retirement Board (RRB) can bill you		
Please DO NOT pay the plan 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 prescri If you qualify, Medicare could pay for 75% or more of your costs, including mont drug premiums, annual deductibles, and coinsurance. Additionally, you won't hat gap or late enrollment penalty. Many people are eligible for these savings and deligible for these savings and deligible for Extra Help with your Medicare prescription drug coverage costs pay all or part of your plan premium. If Medicare pays only part of your premium, for the amount that Medicare doesn't cover.	hly prescript ave a coveragi on't even kn s, Medicare v	tion ge now it. will
For more information about this Extra Help, contact your local Social Security off Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also 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 for	mat?□ 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 1-866 711 during 8 a.m 8 p.m. local time, 7 days a week. Or visit www.EricksonAdva online help.		
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 dia please attach a note or records from your doctor showing you have had a succe transplant or you don't need dialysis; otherwise, we may need to contact you to information.	essful kidney	/
If "yes," are you currently a member of a health care company?	☐ Yes	□ No
Name of Company Member Number		_
3. Are you enrolled in your State Medicaid program?	□ Yes	□ No
If yes, please give us your Medicaid number:		
Enrollee Name		



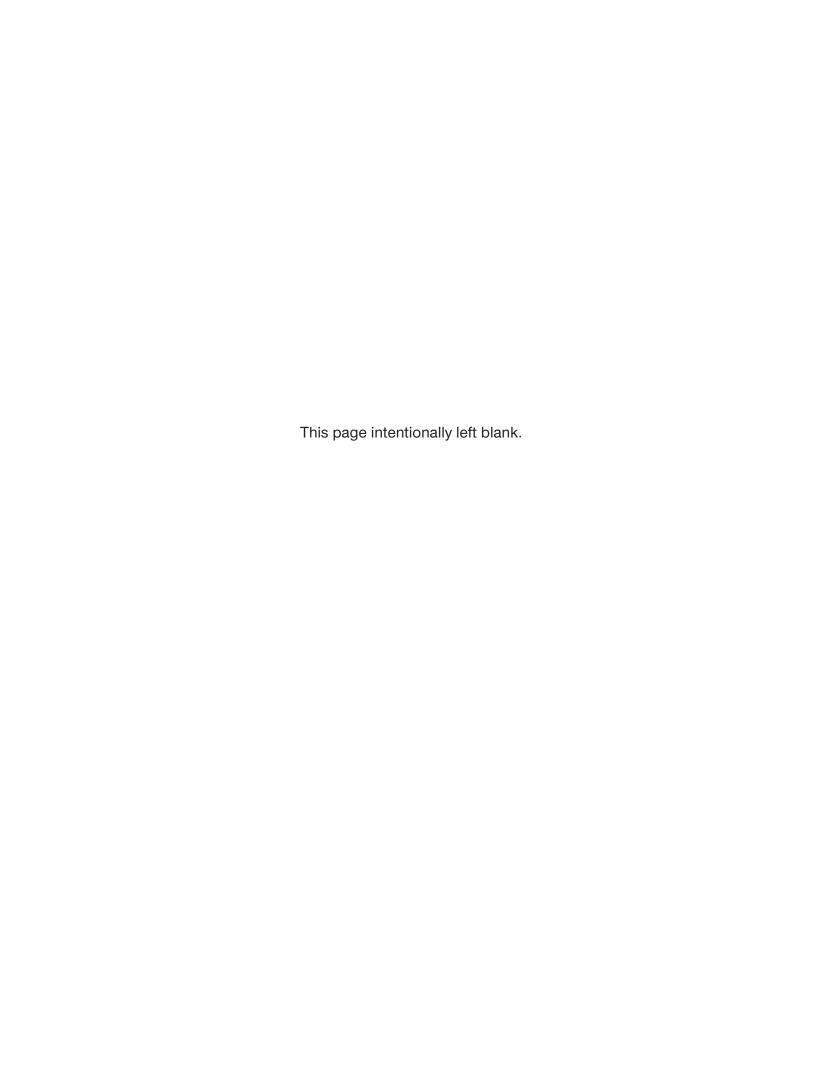
4. Do you live in a nursing home If yes, please give us information	_	_			☐ Yes	
Name						
Address		City		State	ZIP Cod	е
Phone Number ()	-	Date You Move	ed There	MM-	DD-YYY	Y
5. Do you have health insurance	with an employ	er or union righ	t now?		☐ Yes	□No
If yes, you could lose that plan if how joining this plan could affect or union's website, or read any it contact, your benefits administrately.	ct your current pl nformation sent	an. You may also to you. If there is	o want to s no info	check mation	your emp on whom	loyer to
6. Do you or your spouse work?					☐ Yes	□No
Do you or your spouse have other (Examples: Other employer ground Auto Liability, or Veterans benefit yes, please complete the following.)	up coverage, LTI its) wing:					□ No
Name of Health Insurance Com	npany					
Subscriber Name			Group	Number	•	
Member Number Effective Dates (if applicable)			YY			
7. Do you have other insurance t	hat will cover yo	our prescription	drugs?		☐ Yes	□ No
(Examples: Other private insurar programs.) If yes, what is it?	nce, TRICARE, F	ederal employee	e covera	ge, VA k	penefits, o	r state
Name of Other Insurance						
Member Number	Group Number	•		an Start		
Enrollee Name						



8.	Please give us the name of your primary care	ase 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:	•	er exactly as it appears Provider Directory. It will t include dashes.)			
	Are you now seeing or have you recently seen	this doctor?	☐ Yes ☐ No			
	Please read and sign.					
B	y completing this form, I agree to the followin	g:				
	 □ This is a Medicare Advantage plan. It has a commedicare Supplement plan. □ I need to keep my Medicare Parts A and B. I one, unless Medicaid or someone else pays in another Medicare health plan or possible of another Medicare health plan or Prescription other plan. □ If I have prescription drug coverage now or if plan. □ I may have to pay a late enrollment penalty (Land keep creditable prescription drug covera "Creditable" means the coverage is as good pay a LEP, the plan will tell me. □ I understand that I am joining the plan for the need to do so during the Annual Enrollment I prescription drug coverage between October situations that would allow me to leave the plent in the new area. Medicare may not cover have some limited coverage near the U.S. both will receive information on how to get an Expense of the plan's terms and conditions. The plan as the plan's terms and conditions. The plan 	must keep paying my Parfor it. Prescription Drug plan at on Drug plan and I join the I get it from somewhere LEP). This would only have age when I first qualified the as a Medicare prescription of the entire calendar year. If I Period for Medicare Advance of the area, I will wer me when I'm out of the order. It idence of Coverage. (The The EOC will list services)	rt B premium if I have a time. If I'm a member his plan, I will lose the else later, I will tell the open if I didn't sign up for for Medicare. on drug plan. If I need to want to change plans, I'll antage AND Medicare here may be special call my plan to switch to he country. However, I else EOC is also known as a sthe plan covers, as well			
	listed in the EOC. If a service isn't listed in the plan won't pay for it. If I disagree with how the appeal. I understand that I must get my health care of plan's network. I can go to any doctor or hos	e plan covers my care, I loverage from doctors or	providers that are in my			
Eı	nrollee Name					



services or out-of-area dialysis services. If I hap this plan provides refunds for all medically ned		ny network services,	
☐ If I currently have Medicare Supplement Insura my agent, must cancel. I will cancel after my new transfer in the cancel after my new tr	ance (Medigap), I will canc		
plan. My plan will give my information to Medicare a payment and health care operations. This may Medicare uses the information to understand have may need my information when they help pay information for research and other purposes. A will be followed. If I get help from a sales agent, broker or some may pay that person for this help. The information on this form is correct, to the hinformation on this form that I know is not true.	vinclude my prescription do how my care was handled for my care. Medicare ma All federal laws and rules peone who has a contract whest of my knowledge. I ur	rug information. or billed. Other plans y also give my rotecting my privacy ith the plan, the plan	
When I sign below, it means that I have read and	I understand the informat	tion on this form.	
If I sign as an authorized representative, it means I show written proof (Power of attorney, guardianshi understand that I will need to submit written proof of behalf of the member beyond this application. After have received your member ID card, please call Cu your member ID card to update your authorization. Signature of Applicant/Member/Authorized Representative, information below. *NOT A SALES AGENT	p, etc.) of this right if Medi of this right, to the plan, if I er this application has been ustomer Service at the num information on file.	care asks for it. It wish to take action on approved and you aber on the back of the back	
Last Name	First Name		
Address			
City	State	ZIP Code	
Phone Number () -	one Number () – Relationship to Applicant		

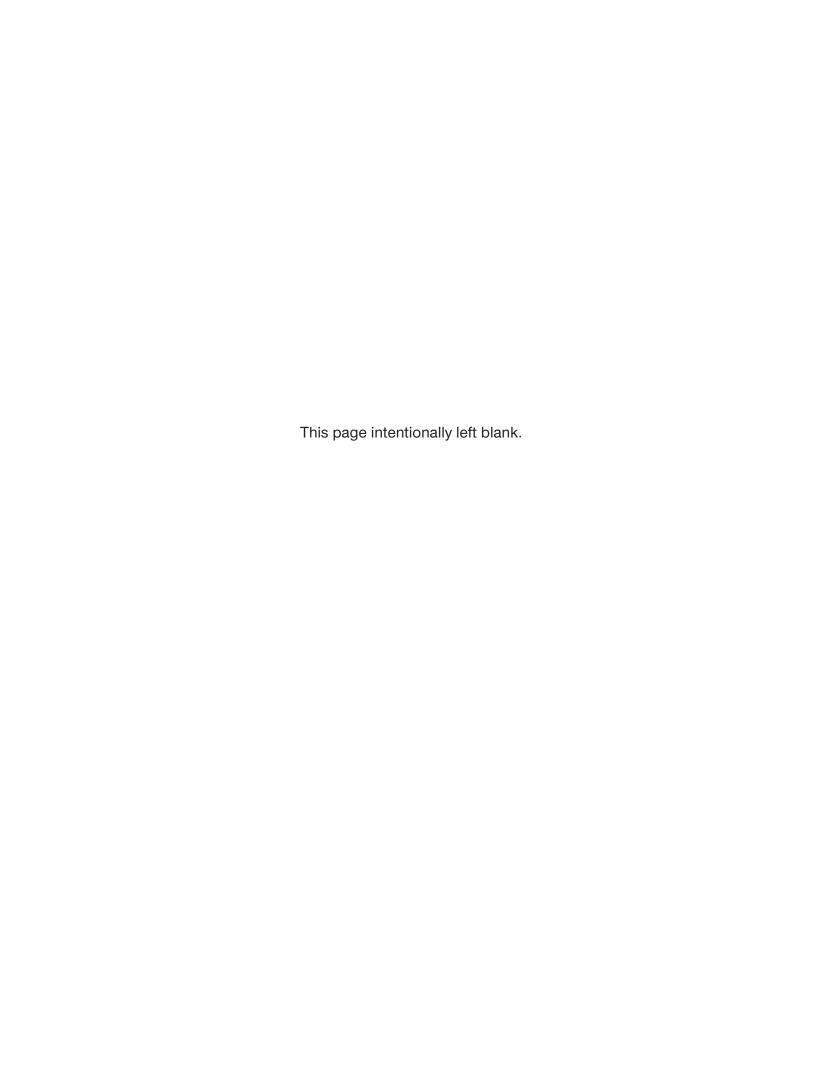


For licensed sales representative/agency use only.					
□ New Member□ Plan Change	oyer Group Name				
Employer Group ID		Branch II			
Licensed Sales Represe @AGENTID@	entative/Writing ID			ceipt Date -DD-YYYY	
Licensed Sales Represe @AGENTFULLNAME@	, •			d Effective Date	
Licensed Sales Represe	entative Phone Number @	AGENTPHONE	<u>-</u> @		
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 eligi 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 MW-DD-YWYY					
Licensed Sales Repre	sentative Signature (req	uired)		Date: MW-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



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 these plans depends on the plan's contract renewal with Medicare.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711). 注意:如果您說中文,您可以免費獲得語言援助服務。請致電 1-855-814-6894 (聽力語言殘障服務專線 TTY: 711).

