AARP | Medicare Rx from UnitedHealthcare

2020 Enrollment Request Form

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

Please check the plan you want:

☐ **AARP® MedicareRx Preferred (PDP) A**

Please Read This Important Information

This is a Part D plan. It's designed to help pay the cost of prescription drugs. **Note:** If you have a Medicare Advantage plan:

- ☐ You may already have drug coverage
- ☐ You will lose that plan automatically when you sign up for a Part D plan. This means you would lose your medical coverage. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan. If you have an MA-only PFFS plan, you may still enroll in a PDP plan and will not lose your MA-only PFFS plan.

If you currently have health coverage from an employer or union, joining this plan could affect your employer or union health benefits. You could lose your employer or union coverage if you join this plan. Read the communication 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 information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Information about you

Please type or print in black or blue ink.

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

Birth Date ------ _ _ - - - -	Sex ☐ Male ☐ Female
Daytime Phone Number ( ) -	Mobile Phone Number: ( ) —

Enrollee Name _____

Agent Name / ID No. _____ 2158605

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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
E-mail Address			

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)

Medical (Part B)

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

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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), online 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

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 an 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**

☐ **I want to pay by mail.**

We'll send a bill to your mailing address each month or you will receive an email notification if you signed up for e-delivery.

Enrollee Name _____

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☐ **I want to pay online.**
Visit www.AARPMedicarePlans.com to make a payment directly from a bank account or a Visa, Mastercard or Discover credit card.

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.

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 1-888-867-5564, TTY 711 during 8 a.m. - 8 p.m. local time, 7 days a week. Or visit www.AARPMedicarePlans.com for online help.

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2. 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		

3. 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

Please read and sign

By completing this form, I agree to the following:

- ☐ This is a Medicare Prescription Drug plan. It has a contract with the federal government. This Prescription Drug coverage is in addition to Original Medicare. This is not a Medicare Supplement plan.
- ☐ I need to keep my Medicare Parts A or 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 Prescription Drug plan at time-if I am currently in a Medicare Prescription Drug plan, my enrollment in this plan will end that enrollment.
- ☐ If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan.
- ☐ 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 between October 15 and December 7. This is the Annual Enrollment Period for Medicare Advantage **and** Medicare prescription drug coverage. I understand that there may be special situations at other times during the year in which I can leave the plan.
- ☐ 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 understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

Enrollee Name _____

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- ☐ 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 I must use network pharmacies except in an emergency. I have the right to make an appeal if I disagree with how the plan covers or pays for services.
- ☐ My plan will give my information, including my prescription drug event data, to Medicare and other plans when needed for treatment, payment and health care operations. 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.
- ☐ I understand that my state may offer help and advice with Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.
- ☐ 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 UnitedHealthcare member ID card, please call Customer Service at the number on the back of your UnitedHealthcare member ID card to update your authorization information on file.

Signature of Applicant/Member/Authorized Representative **Today's Date**

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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 sales representative/agency use only.

☐ New Member ☐ Plan Change	Employer Group Name
Employer Group ID	Branch ID
Sales Representative/Writing ID 2158605	Initial Receipt Date
Sales Representative/Agent Name	Proposed Effective Date
Sales Representative Phone Number 5 1 6 8 8 4 2 2 3 8	

Where did this application originate?

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

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

Agent must complete

☐ IEP	☐ IEP 2	☐ SEP (Institutional)
☐ SEP (GEP Part B)	☐ SEP (Change in residence)	☐ SEP (Loss of EGHP coverage)
☐ SEP (PDP/OEP)	☐ SEP (CMS/State Assignment)	☐ SEP (Dual LIS change of status)
☐ SEP (Dual LIS maintaining)	☐ AEP (October 15 – December 7)	

☐ SEP (SEP Reason) _____
☐ SEP Eligibility Date

Sales Representative Signature (required) **Date:**

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