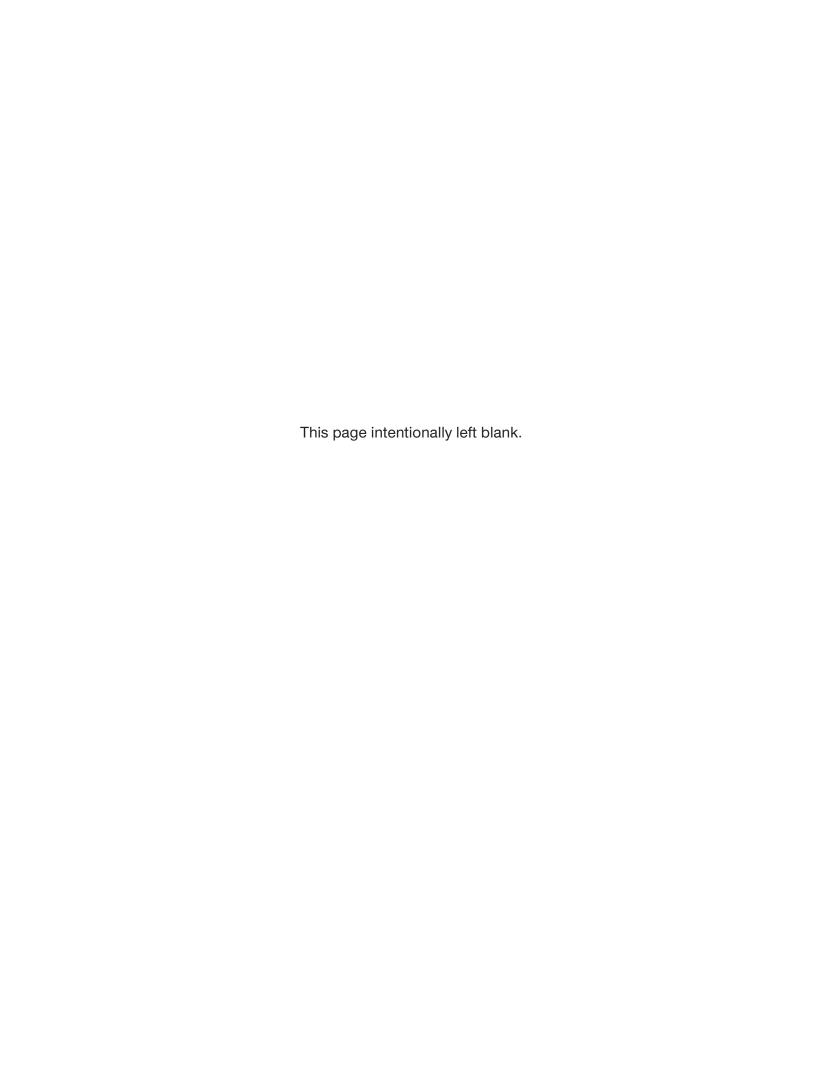






# 2022 Enrollment Request Form

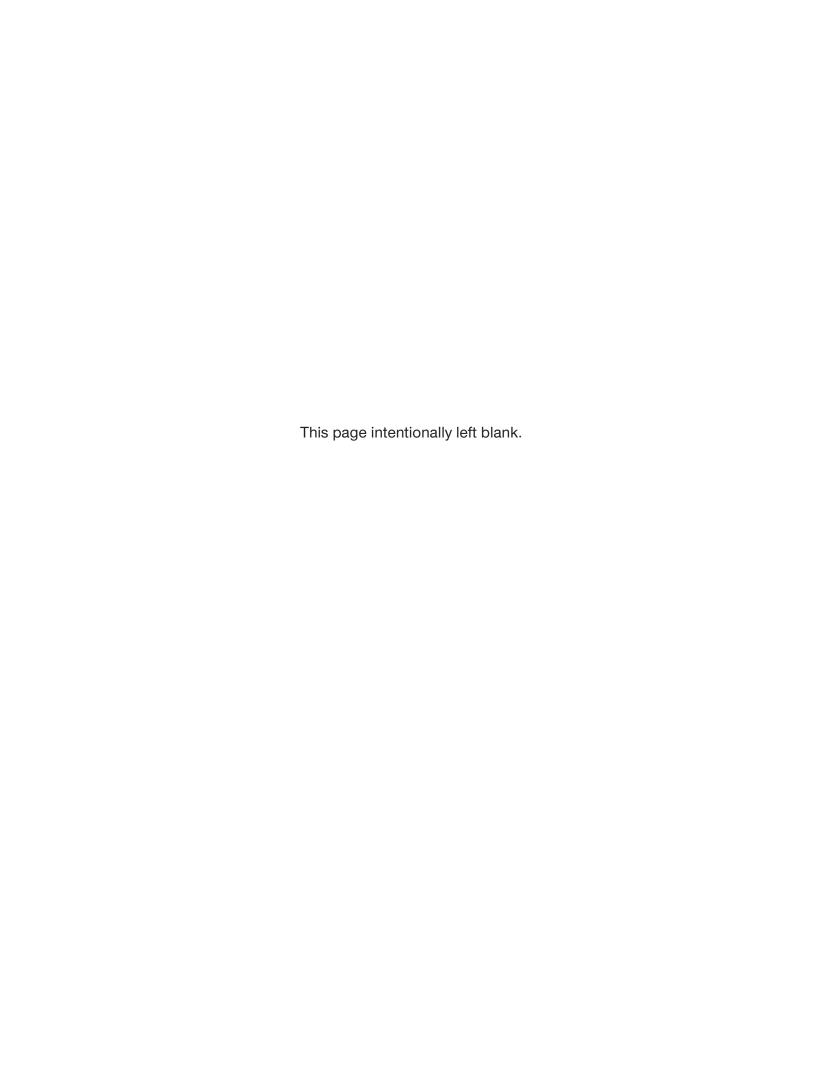
☐ Erickson Advantage® Libert	y wi	thout Drugs (HN	ИО-POS) H56	52-002-	000 -	EL2
Select optional supplemental plan.	enta	al benefits in a	addition to v	what is	incl	uded with your
You can add the following ben you are enrolling, or within 3 m more information, including co	ontl	• •		•		
Information about you. (P	leas	e type or print in	black or blue	ink)		
Last Name		First Name			Middle Initial	
Birth Date		Sex □ Male □ Female				
Home Phone Number (	) - Mobile Phone			e Numb	er (	) -
Medicare Number						
Permanent Residence Street A	.ddre	ess (P.O. Box is	not allowed)			
City	County			State		ZIP Code
Mailing Address (Only if it's di	ffere	ent from above.	You can give	a P.O. I	Box.)	
City				State		ZIP Code
Email Address (optional)						
Answering these questions is you them out.	ur c	hoice. You can't	be denied co	verage l	oecau	ise you don't fill
How do you want to pay?						
Enrollee Name						
Agent Name / ID No.						EDEVOODO (000070 000
Y0066_ERFMA_2022_C						EREX22PO4988878_000



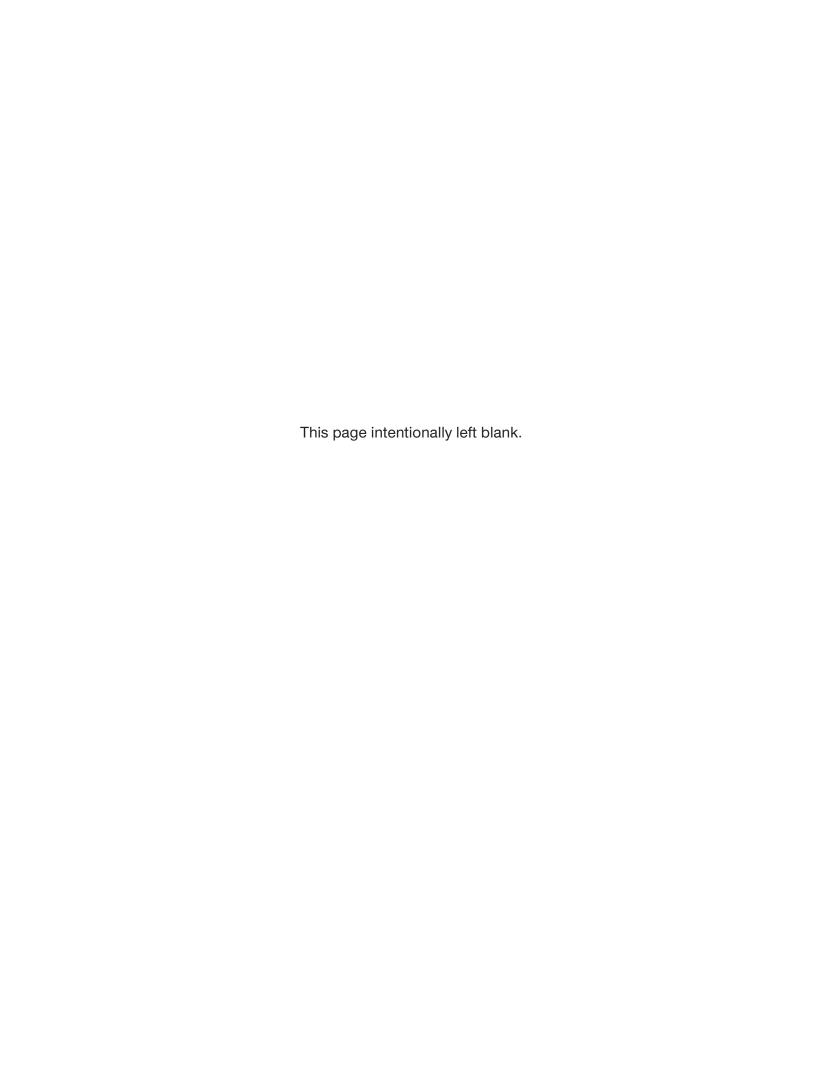
If you have a monthly plan premium (including any late enrollment penalty you may owe) you can pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT).

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 ☐ 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\_\_/\_/\_/\_/\_/\_/\_\_/\_\_ 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 ☐ Braille ☐ Other If you don't see the language or format you want, please call us toll-free at 1-866-774-9671, TTY 711 during 8 a.m. - 8 p.m. local time, 7 days a week. Or visit www.EricksonAdvantage.com for online help. 2. 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, Workman's Compensation, Auto Liability, or Veterans benefits) ☐ Yes ☐ No If yes, please complete the following: Name of Health Insurance Company Member Number

Enrollee Name \_\_\_\_\_ Y0066\_ERFMA\_2022\_C



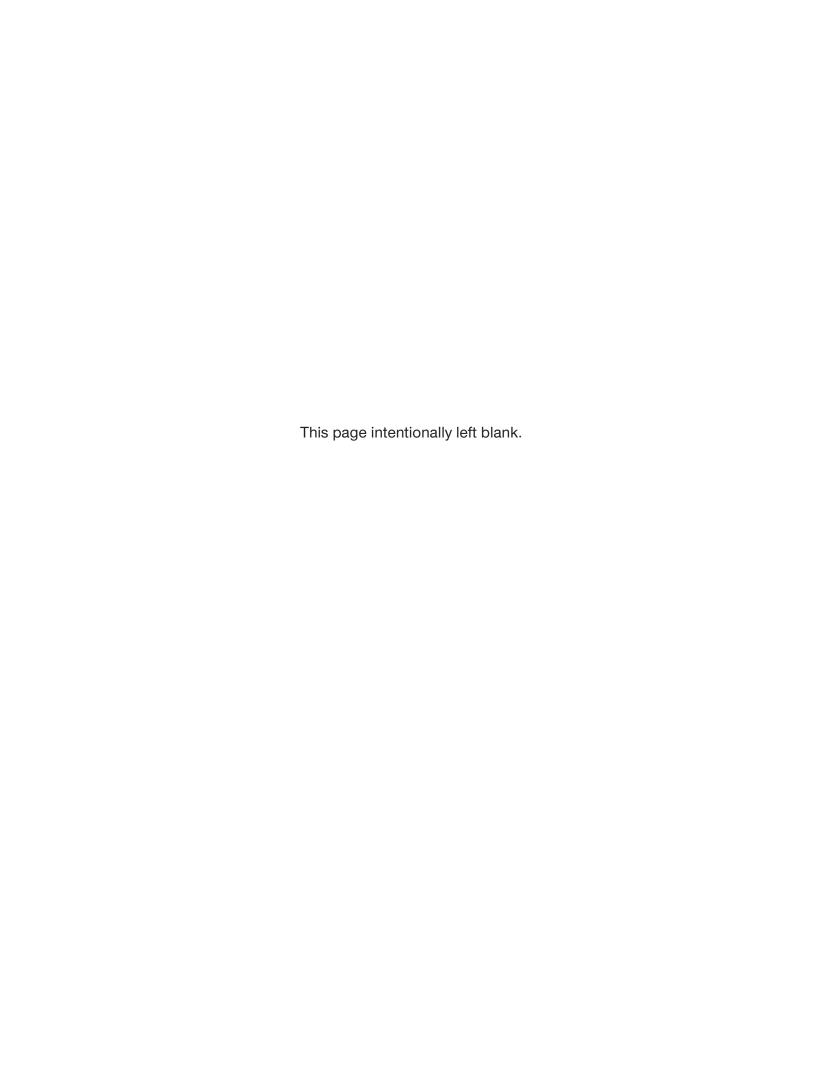
3. Please give us the name of your primary care. You can find a list on the plan website or in the	
Provider or PCP Full Name	
Provider/PCP Number:	(Please enter the number exactly as it appears on the website or in the Provider Directory. It will be 10 to 12 digits. Don't include dashes.)
Please read and sign.	
By completing this form, I agree to the followin	g:
premium if I have one, unless Medicaid or so I understand that people with Medicare are g the country, except for limited coverage near urgent care outside of the U.S. See the Summ I understand that when my UnitedHealthcare from UnitedHealthcare. Benefits and services in my UnitedHealthcare "Evidence of Coverage or subscriber agreement) will be covered. Wi UnitedHealthcare will pay for benefits or see If I currently have Medicare Supplement Insumy agent, must cancel. I will cancel after my plan.  Release of Information: By joining this Medi Drug Plan, I acknowledge that the plan will reas is necessary for treatment, payment, and hunitedHealthcare will release my information Medicare, who may release it for research an authorize the collection of this information (see I give UnitedHealthcare permission to share reasonizations or person(s) for permissible puradminister my health plan.  I give consent for all entities under UnitedHealthcare to call the phone number (see The information on this form is correct, to the intentionally provide false information on this	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and mary of Benefits for more information. coverage begins, I must get all of my medical authorized by UnitedHealthcare and contained ge" document (also known as a member contract thout authorization, neither Medicare nor services.  Trance (Medigap), I will cancel it in writing. I, not new plan tells me I've been accepted into the lease my information to Medicare Prescription elease my information to Medicare and other plans health care operations. I also acknowledge that including my prescription drug event data, to dother purposes applicable to Federal law that the Privacy Act Statement below).  The provided health information with reposes under applicable law as required to althcare and any outside vendor used by the law provided.  The best of my knowledge. I understand that if I form I will be disenrolled from the plan.  The provided is the plan of the plan



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 member ID card, I can call Customer Service at the number on my member ID card to update my authorization information on file.

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

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				

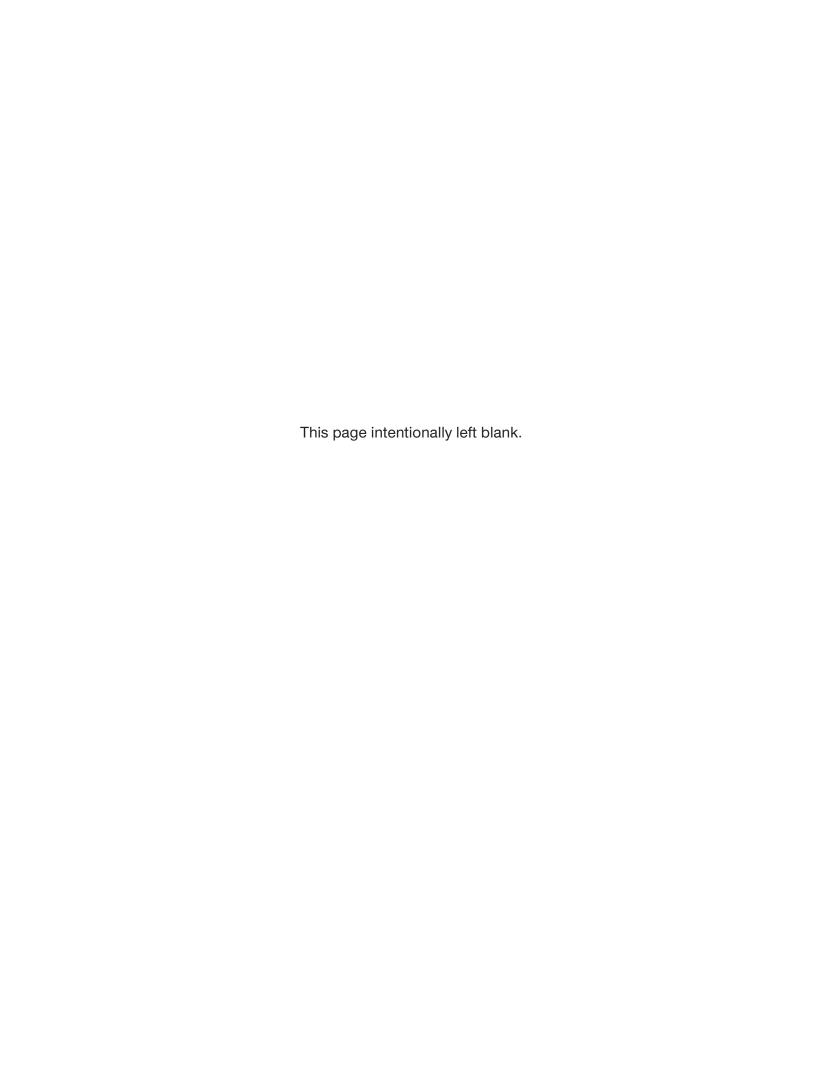


For licensed sales representative/agency use only.							
Employer Group Name							
Employer Group ID		Branch ID					
Licensed Sales Representative/Writing ID				Initial Receipt Date			
Licensed Sales Representative/Agent Name				Proposed Effective Date			
Agent must complete							
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PD enrollees eligible for 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) _							
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

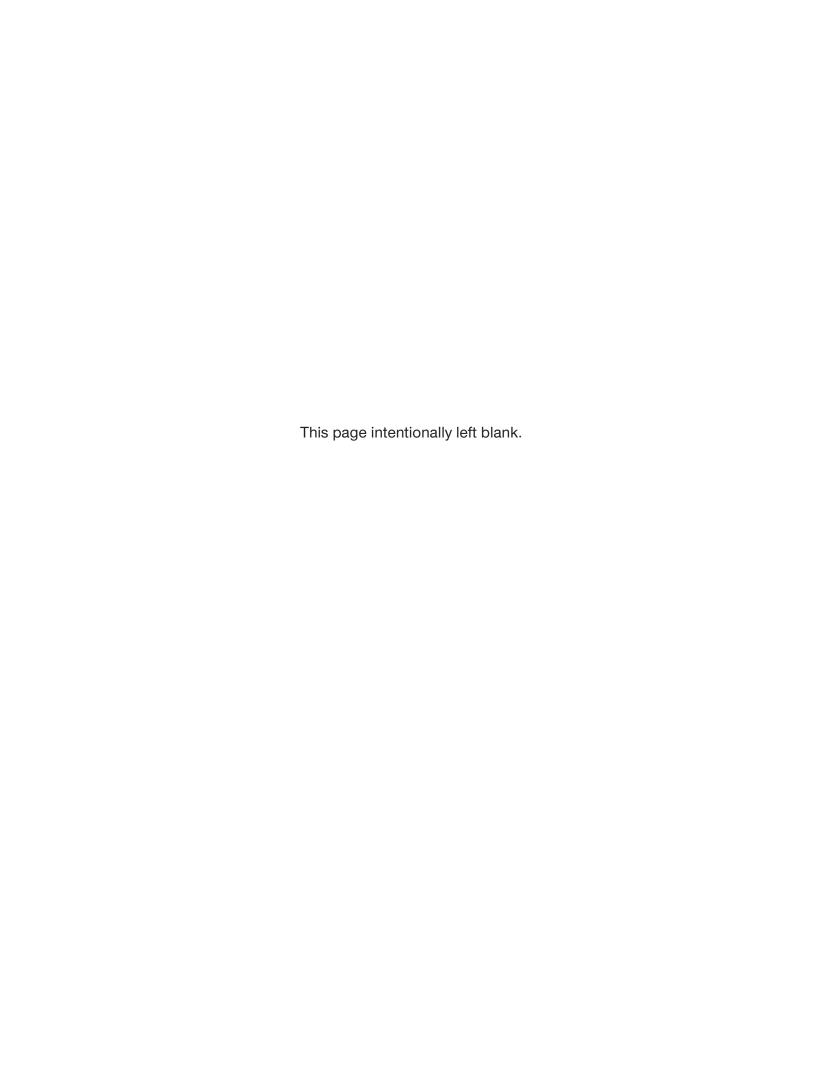


PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social 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.

This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

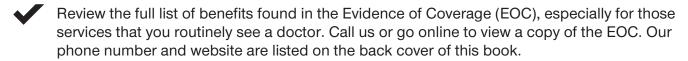
OMB No. 0938-1378 Expires: 7/31/2023 Y0066 ERFMA 2022 C



## **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 at the number listed on the back cover of this book.

### **Understanding the Benefits**



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.

### **Understanding Important Rules**

- In addition to your monthly plan premium, 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). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay for services received by non-contracted providers.