

# Enrollment Request Form

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**Required Information**

Plan Sponsor Name:	
Group #:	GPS Employer ID #:
GPS Branch #:	
INTENTIONALLY BLANK	

## Enrollment Form

**Please complete the entire form. Incomplete information can delay the enrollment process.**  
 (Please Print – If you need more room for your answers to any questions, please use a separate sheet of paper.)

**1. Personal Information**

Applicant Last Name	Applicant First Name	MI	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Effective Date ____ / ____ / ____ mm / dd / yyyy
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Domestic Partner				Date of Birth ____ / ____ / ____ mm / dd / yyyy
Name of Retiree		Applicant's Relation to Retiree: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner		
Applicant's Medicare Claim #	Part A Effective Date ____ / ____ / ____ mm / dd / yyyy	Part B Effective Date ____ / ____ / ____ mm / dd / yyyy	Part D Effective Date ____ / ____ / ____ mm / dd / yyyy	
Are you currently on COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Qualifying Event		COBRA Qualifying Event Effective Date ____ / ____ / ____ mm / dd / yyyy		
Permanent Residence Street Address (P.O. Box is not allowed)	City		State	Zip
Mailing Address (only if different from your Permanent Residence Address)	City		State	Zip
Home Telephone Number ( )	Alternate Telephone Number ( )	E-mail Address		
In the future, would you be willing to receive materials through electronic means? <input type="checkbox"/> Yes <input type="checkbox"/> No				
I prefer to receive materials in the following language: <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese (Spoken: <input type="checkbox"/> Cantonese <input type="checkbox"/> Mandarin) <input type="checkbox"/> Other _____				

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Medicare Claim Number

If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the following information. Providing this information will not affect your enrollment in the plan.

Institution Name	Date of Admission ____ / ____ / ____ mm / dd / yyyy	Telephone Number ( )	
Address	City	State	Zip
Attending Physician's Name	Attending Physician's Telephone Number ( )		

## 2. Benefit Coordination / Other Insurance Carrier Information

1. Do you have other health insurance?  Yes  No

If Yes, complete Section 1a. – 1d. below.

1a. Insurance Company Name	1b. Policy #	1c. Effective Date	1d. Other Employer Name and Address
		____ / ____ / ____ mm / dd / yyyy	
		____ / ____ / ____ mm / dd / yyyy	

2. Are you permanently disabled?  Yes  No If Yes, complete the following:

2a. Date disability began: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mm / dd / yyyy

3. Do you have a disability affecting your ability to communicate or read?  Yes  No

4. Do you currently work or plan to work?  Yes  No

5. Are you currently a State Medicaid recipient?  Yes  No

If yes, please provide your State Medicaid number:

### FOR OFFICE USE ONLY

Retiree  Yes  No

Dependent  Yes  No

Group # \_\_\_\_\_

Plan Code \_\_\_\_\_

Verification: \_\_\_\_\_  
Initial

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### FOR EMPLOYER USE ONLY

Enrollee is eligible for retiree coverage

Effective Date:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Initial

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Medicare Claim Number

### 3. Terms and Conditions

I am requesting enrollment under the UnitedHealthcare Insurance Company (“UnitedHealthcare”) Group Policy offered through my former employer. By signing this Enrollment Form, I agree to and understand the following:

1. All coverage is subject to the terms and conditions of the UnitedHealthcare Group Policy.
2. UnitedHealthcare or its designee shall have access and use of my medical records for purposes of utilization review surveys, processing of claims, financial audit or other purposes reasonably related to the performance of this Enrollment Form.
3. Any material omission or intentional misrepresentation in answering the questions on the Enrollment Form may result in the denial of benefits and the termination of my coverage if such answers are determined to be untrue within 24 months of issuance of coverage.
4. Coverage shall not begin until acceptance of this Enrollment Form by UnitedHealthcare. Acceptance will not occur until after UnitedHealthcare validates Medicare coverage and eligibility for coverage under the group retiree plan. Upon acceptance of this Enrollment Form, UnitedHealthcare shall be bound by the terms of my UnitedHealthcare Group Policy and the Amendments thereto (if applicable).
5. All statements and descriptions in this Enrollment Form are deemed to be representations and not warranties.

**This is not a Medicare supplement plan. This is an employer group retiree plan and may provide coverages that are different from a Medicare supplement plan. If you have a Medicare supplement plan, you may not need both the Medicare supplement plan and the employer group retiree plan. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance.**

**I certify that I have read the Terms and Conditions printed on this Enrollment Form and that I accept them and will abide by them. I further certify that the information provided in the Enrollment Form is true and complete to the best of my knowledge and belief.**

**I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and UnitedHealthcare Insurance Company or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. All parties to this agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.**

Print Name of Applicant:

Signature of Applicant or Authorized Representative:

Today's Date:

 **Signature**

Underwritten by  
**UnitedHealthcare Insurance Company**

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**Please Open To Continue Completing Form**

## Questions?



If reply envelope is missing mail this form to:  
**UnitedHealthcare®**  
**P.O. Box 29200**  
**Hot Springs, AR 71903-9200**

Or fax this form to:  
**1-866-994-9659** or **1-501-609-0217**



You may also enroll by calling:  
**1-800-698-0822, TTY 711**  
8 a.m. - 8 p.m. local time, 7 days a week

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A UnitedHealthcare® Medicare Solution