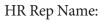
TEAR HERE

TEAR HERE





Please email all completed application in PDF format to: mandrenrollment@uhc.com

## 2023 Enrollment request form

1. Plan information					
Plan sponsor					
D.C. Government					
Group number		GPS employ	/er		
13708		ID 24923			
GPS branch number: 001 📿					
Bill Group: 1 EA ID: 12345678					
Effective date requested:					
(i.e., your proposed effective date, or or	n what day	your coverag	e shoul	d begin)	
Plan sponsor use ONLY: Please date s completed and signed form.					
To enroll in the UnitedHealthcare® G following:	-				ase provide the
2. Information about you (Pleas	se type or	-	ack or l	blue ink.)	
Last name		First name			Middle initial
Birth date		Sex: 🗆 Ma	le 🗆 Fe	emale	
Home phone number	Mobile ph	none number		Medicare n	umber
( ) —	( )	—			
Permanent residence street address (F	<b>P.O. Box is</b>	not allowed)	State	ZIP code	
Mailing address (Only if it's different f	rom above	. You can giv	ve a P.O	. Box)	
City			State	ZIP code	
Email address (optional)				1	

				Page	2 of 4
L	.ast name	First name	Medicare number		
			e, including other private insurance, TRI s or State Pharmaceutical Assistance Pr		ederal
V	Vill you have other	prescription drug covera	age in addition to our plan?	∃Yes □	No
lf	" <b>yes</b> ", what is it?				
Ν	lame of other insur	ance			
Ц					
	lember number		Group number		
₹ — □ F	₹x Bin		Rx PCN (optional)		
Y	our answer to the	following questions will	not keep you from being enrolled in t	his plan:	
	3. A few question	ons to help us manage	e your plan		
1	. Would you prefer	plan information in anoth	ner language or an accessible format?	P □ Yes	🗆 No
lf	"yes", please sele	ct from the following:			
	∃ Spanish □ Braille	• 🗆 Other			
			nt, please call us toll-free at p.m. local time, 7 days a week.		
2	. Do you or your s	pouse work?		□ Yes	□ No
lf	" <b>"no"</b> , what was you	ur retirement date?			
3			han Medicare, such as private enefits or other employer coverage?	□ Yes	□ No
lt	"yes", please prov	ide the following:			
Н Н П П N	lame of the health i	nsurance			
	lember number				
	. Please give us th	e name of your primary (	care provider (PCP), clinic or health c	enter.	
F	Provider or PCP full	name			
F	Provider/PCP numb	er	(Please enter the number exactly a on the website or in the Provider D		

			1 age 0 01 4
Last name	First name	Medicare number	
5. Do you live in a r	nursing home or long-terr	n care facility?	□ Yes □ No
If "yes", please give	e us information on the long	g-term care facility:	
Name			
Address			
City		State	ZIP code

Date you moved there

TEAR HERE

TEAR HERE

## 4. ATTENTION - please sign and date

I understand that my signature on this enrollment request form means that I have read and understood the contents of this enrollment request form, including the Statements of Understanding, and that the information provided by me is accurate and complete. If my plan includes outpatient prescription drug benefits, I understand that my signature on this enrollment request form means that I will be automatically enrolled in my plan's outpatient prescription drug benefits which includes Part D and supplemental prescription drug coverage. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

This enrollment request form must be signed, dated and received prior to your desired effective date. Upon receipt, the plan will process the form according to Medicare guidelines.

Signature of applicant/member/authorized representative

Today's date

Daga 3 of 1

## 5. Authorized representative information

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

Signature

Today's date

What's next

Last name	First name	Medicare numbe	ər
Luot namo	Thot hamo	modical o hambe	51
	ssisted you in comple information below	eting this form, pleas	se have that person
Signature (of indivi	dual who assisted in comp	leting this form)	Today's date
•	ve, check here if you signed ad in completing this form.	d Relationship to appl	icant
Sales representative	e/broker, please provide y	our signature and comp	plete the information bel
Licensed sales rep	presentative/broker signa	ture	Today's date
Licensed sales repre	esentative/broker name (p	lease print)	
Agent/broker number	er	Referring broker nu	mber
Agent/broker numb	er	Referring broker nu	mber
Agent/broker number 7. For office user Agent name		Referring broker nu	mber
7. For office use		Referring broker nu	mber NIPR number
<b>7. For office use</b> Agent name			
7. For office use Agent name Agent number Effective date	e only Group numbe	Pr	NIPR number
7. For office use Agent name Agent number Effective date	e only	Pr	NIPR number
7. For office use Agent name Agent number Effective date	e only Group numbe	Pr	NIPR number
7. For office use Agent name Agent number Effective date	e only Group numbe	Pr	NIPR number
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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 1-800-555-5757 (TTY: 711). 注意:如果您説中文,您可以免費獲得語言援助服務。請致電 1-800-555-5757 (TTY: 711).

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