



2021 Enrollment Request Form

1. Plan information

Plan Sponsor

Teamsters Managed Trust

Group Number

12798

GPS Employer ID

24910

GPS Branch Number

001

Effective Date Requested: MM – DD – YYYY

(i.e., your proposed effective date, or on what day your coverage should begin)

Plan Sponsor use ONLY: Please date stamp this document to indicate when you received the completed and signed form.

To enroll in the UnitedHealthcare® Group Medicare Advantage (PPO) plan, please provide the following:

2. Information about you. (Please type or print in black or blue ink.)

<input type="checkbox"/> Mr.	Last Name	First Name	Middle Initial
<input type="checkbox"/> Mrs.			
<input type="checkbox"/> Ms.			

Birth Date MM – DD – YYYY

Sex: Male Female

Daytime Phone Number

() –

Mobile Phone Number

() –

Permanent Residence Street Address **(P.O. Box is not allowed)**

City

State

ZIP Code

County

Mailing Address **(Only if it's different from above. You can give a P.O. Box)**

City

State

ZIP Code

Email Address

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Last Name	First Name	Medicare Number
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 Emergency Contact

Contact Phone Number	Contact Relationship to You
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3. 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.

Name (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.

Medicare Number: _____

Sex: Male Female

Is Entitled to

Effective Date

Hospital (Part A)

MM-DD-YYYY

Medical (Part B)

MM-DD-YYYY

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

4. A few questions to help us manage your plan

Would you prefer plan information in another language or an accessible format? Yes No

If **“yes”**, please select from the following:

Spanish Other _____

If you don't see the language or format you want, please call us toll-free at **1-877-714-0178**, (TTY **711**) during 8 a.m. - 8 p.m. local time, 7 days a week.

 Do you or your spouse work?

Yes No

If **“no”**, what was your retirement date? **MM-DD-YYYY**

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Last Name	First Name	Medicare Number
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Are you a resident in a long-term care facility, such as a nursing home? Yes No
 If **“yes”**, please provide the following:

Name of Institution

Address of Institution

City	State	ZIP Code
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Phone Number of Institution

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Date of Admission **MM - DD - YYYY**

Your answer to the following questions will not keep you from being enrolled in this plan:

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State Pharmaceutical Assistance Programs.

Will you have other **prescription drug coverage** in addition to our plan? Yes No

If **“yes”**, please provide the following:

Name of Other Coverage

Member Number for Coverage

Group Number for Coverage

Do you have any **health insurance** other than Medicare, such as private insurance, Worker’s Compensation, VA benefits or other employer coverage? Yes No

If **“yes”**, please provide the following:

Name of the Health Insurance

Member Number for Coverage

Group Number for Coverage

Please give us the name of your primary care provider (PCP), clinic or health center.

Contracting Medical Group/Primary Care Provider (PCP) Name

Phone number

() -

Contracting Medical Group/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.)

Are you now seeing or have you recently seen this doctor?

Yes No

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Last Name

First Name

Medicare Number

5. 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. 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

MM - DD - YYYY

6. 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 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

Today's Date

MM - DD - YYYY

7. If someone assisted you in completing this form, please have that person complete the information below

Signature (of individual who assisted in completing this form)

Today's Date

MM - DD - YYYY

Plan Representative, check here if you signed above and assisted in completing this form.

Relationship to Applicant

Sales Representative/Broker, please provide your signature and complete the information below:

Licensed Sales Representative/Broker Signature

Today's Date

MM - DD - YYYY

Licensed Sales Representative/Broker Name (Please Print)

Agent/Broker Number

Referring Broker Number

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Last Name	First Name	Medicare Number
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8. For office use only

Agent Name

Agent Number	NIPR Number
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Effective Date MM-DD-YYYY	Group Number	PBP Number
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SEP
 Employer Group SEP
 ICEP/IEP
 AEP (type) _____

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

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