United Healthcare®
Group Medicare Advantage

2027 Enrollment Request Form

1. Plan information

Plan sponsor

CITY OF ALEXANDRIA

Group number	GPS employer ID
12229	24118
GPS branch number	GPS Bill Group (as applicable)
001	

Effective date requested: (i.e., your proposed effective date, or on what day your coverage should begin 1/1/2027

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)

Last name	First name	Middle initial

Birth date	Sex: ☐ Male ☐ Female

Home phone number	Mobile phone number	Medicare number
( ) –	( ) –	

Stay on top of your plan and health with timely, helpful texts and calls. You can change your preferences at any time.

Check here to consent to receive texts from UnitedHealthcare at the mobile phone number you provided about:

☐ Important benefit information to help you manage your plan

☐ Reminders about preventive care or health screenings

You also agree to the texting terms and conditions at **uhc.com/txt-tcs**. Message frequency varies. Message and data rates may apply. Text STOP to opt out of a texting program.

☐ Check here to consent to receive calls from UnitedHealthcare and its affiliates at the phone number(s) you provided. This includes calls made using an autodialer or an artificial prerecorded voice.

Permanent residence street address **(Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address)**

City	County	State	ZIP code

Last name First name Medicare number

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

City	State	ZIP code

Email address

You will receive some plan information, such as your Explanation of Benefits and Annual Notice of Changes, electronically (quicker than mail). We'll email you when new documents are ready to review online.

☐ Check here if you prefer to receive paper copies by mail. You can change your delivery preference at any time.

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"**, what is it?

Name of other insurance

Member number	Group number

Rx Bin	Rx PCN (optional)

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

3. A few questions to help us manage your plan

1. Which language or accessible format do you prefer for future plan information?

☐ English ☐ Spanish

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

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, Monday-Friday.

If no selection is made, you will receive plan information in English.

2. Have you served in the U.S. military? ☐ Yes ☐ No

3. If yes, have you received care or services from a VA hospital or clinic? ☐ Yes ☐ No

4. Do you or your spouse work? ☐ Yes ☐ No

Last name | First name | Medicare number

5. 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 other health insurance

Member number for other health insurance

Payer ID for other health insurance

Do you give us permission to request and share your health information with the other health insurance company you listed above? ☐ Yes ☐ No

If **"yes"**, we'll request your records and share them with your other plan to keep your medical records complete and help support your care. You can opt out at any time on your member site or by calling Customer Service.

6. Do you give us permission to request your health information from your previous health insurance company? ☐ Yes ☐ No

If **"yes"**, we'll request your records from your previous plan to keep your medical records complete and help support your care. You can opt out at any time on your member site or by calling Customer Service.

If **"yes"**, please complete the following:

Name of previous health insurance company	Member number for previous health insurance company

Payer ID for previous health insurance company

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

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.)

Are you now seeing or have you recently seen this provider? ☐ Yes ☐ No

8. Do you give us permission to share your health information with your network providers? ☐ Yes ☐ No

If **"yes"**, we'll share your health information with your network providers so they can work together on your care. If **"no"**, your provider may still access some information as allowed by law to make sure you get the right care. You can change your preference at any time on your member site or by calling Customer Service. If you don't make a selection now, we'll automatically share your information with your network providers.

Last name First name Medicare number

9. Do you live in a nursing home, long-term care facility, or senior community? ☐ Yes ☐ No

If **"yes"**, please give us information on the nursing home, long-term care facility, or senior community:

Name

Address

City	State	ZIP code

Date you moved there

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**

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**

6. For Individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Last name First name Medicare number

Signature (of individual who assisted in completing this form) **Today's date**

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

Relationship to applicant

Name

Phone number

Address

Sales representative/broker, please provide your signature and complete the information below:

Licensed sales representative/broker signature **Today's date**

Licensed sales representative/broker name (please print)

Agent/broker number

Referring broker number

7. For office use only

Agent name

Agent number

NIPR number

Effective date

Group number

PBP number

☐ SEP ☐ mployer Group SEP ☐ ICEP/IEP ☐ AEP (type _____

Return this form via mail or email to

The City of Alexandria
DHR Retiree Benefits Team
2331 Mill Road, Suite 301
Alexandria, VA 22314
Email: benefits.retirees@alexandriava.gov

Please include a copy of your Medicare Card with your submission to verify Part B coverage