

MEDICARE ADVANTAGE UNIVERSAL ENROLLMENT/ ELECTION FORM

UBEN 127 (R10/11) University of California Human Resources

Mail yellow copy to: RASC—
Retiree Insurance Program
P.O. Box 24570
Oakland, CA 94623-1570
OR fax to: 510-987-9323

This Enrollment/Election Form has been sent to you because you or an eligible family member has enrolled in Health Net Seniority Plus or Kaiser Senior Advantage, a Medicare Advantage plan which requires you to assign your Medicare to your HMO. Fill out this form if you are enrolled in one of the HMOs listed below. Please print clearly using a blue or black ballpoint pen. For each person on Medicare, complete a separate form and send a copy of the Medicare card to UC.

- “Primary Subscriber” means the University of California retiree who is carrying the medical insurance through UC.
- “Requested Effective Date” is the first of the month after your HMO receives a signed and completed form and no earlier than the month you become eligible for and enroll in Medicare Parts A and B.

Read the “Conditions of Enrollment/Election” on the final page before you sign the form.

White copy—send to HMO:

Health Net/Seniority Plus	Kaiser Permanente—California/Senior Advantage
Attn: Enrollment Services	Attn: Medicare Unit
P.O. Box 10420	P.O. Box 232400
Van Nuys, CA 91499-6208	San Diego, CA 92193-2400

Yellow copy—send or fax to UC at address/fax above. **Pink copy**—keep for your records.

Your medical plan must receive this form before your Medicare Advantage coverage and any Part B reimbursements can begin.

For help with this form, call the UC Customer Service Center (1-800-888-8267) or your location’s Health Care Facilitator; for the contact list, visit: atyourservice.ucop.edu/directories_contacts/health_care_facilitator.html

FORM FIELD	FIELD INSTRUCTIONS
Medicare Advantage Plan you are enrolling in	Enter Kaiser Senior Advantage or Health Net Seniority Plus.
Requested Effective Date	Not required. If blank, your HMO will assign the first of the month you are eligible for and enroll in Medicare, and that they are in receipt of this completed form.
Desired Contracting Medical Group	For Kaiser, leave blank. For Health Net: enter your medical group (e.g., Hill Physicians, UCSD Healthcare). Check your plan’s web-site or call to ensure your group and specialists are contracted with Medicare and your plan. This is very important.
Desired Contracting Primary Physician	For Kaiser, leave blank. For Health Net: enter your primary care physician. Check with your doctor to make sure he/she is contracted with Medicare and your desired Advantage plan. This is very important.
Medical Group/Physician No.	Input if known. If not, leave blank.
Last Name, First Name, MI	Name of the person enrolling. If spouse, enter spouse’s name.
Permanent Residence Address, City, State, Zip	Address of enrollee. No P.O. Boxes accepted—need street address.
Social Security Number (SSN) and Date of Birth	Enter SSN and birthdate for enrollee.
Primary Subscriber question	Answer Yes, if the enrollee is the UC retiree/survivor. No, if not.
Primary Subscriber’s Name and SSN	Enter the UC retiree’s full name and SSN. This is very important.
Medicare Health Insurance Card	Fill in the information from enrollee’s red/white/blue Medicare card . Include all numbers, letters and dates AND attach a copy.
Question 1 Member of another plan (optional)	Answer Yes if enrollee has another non-UC Medicare plan or prescription drug plan, separate from UC insurance. No, if none.
Question 6 Do you or your spouse work?	Answer Yes if enrollee or UC retiree is employed and eligible for any health insurance benefits elsewhere as an employee.
Applicant Signature	Enrollee must sign and date here. This is very important.
Authorized Representative’s Signature plus Name, Address, Phone, Relationship to enrollee	If the enrollee did not sign, the person legally responsible to sign for him/her should sign and date here. This is very important.
Signature of any person assisting with the form	If any person helped enrollee fill out form, sign and date here.



Medicare Advantage Universal Enrollment/Election Form
California Group Plan

Medicare Advantage Plan you are requesting enrollment in:

Group Name (required) University of California
Group # (Plan to complete)
Requested Effective Date
Desired Contracting Medical Group (if applicable)
Desired Contracting Physician (if applicable)
Medical Group/Physician No. (if applicable)
Last Name First Name MI Sex M F

Permanent Residence Address (Street Address Only—No P.O. Box)

City State ZIP County

Mailing Address if Different (Street, City, State, ZIP)

Daytime Phone Number (including area code) E-mail address (optional)
Evening Phone Number (including area code)
Social Security Number (SSN) Date of Birth

Are you the Subscriber? Yes No

If no, provide Subscriber Name and Social Security Number (your group may require this information)

Subscriber Name Subscriber SSN

MEDICARE HEALTH INSURANCE CARD INFORMATION

Please complete this sample Medicare Health Insurance card with the information found on your own Medicare card. Please copy each line exactly as it appears.

If you prefer, you may include a photocopy of your Medicare verification letter (Letter of Award from Social Security or Railroad Retirement Board) that provides the same information.

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

MEDICARE HEALTH INSURANCE
SAMPLE ONLY
Name:
Medicare Claim Number Sex
Is Entitled To Effective Date
HOSPITAL (Part A)
MEDICAL (Part B)

1. Are you currently a member of a Medicare Health Plan and/or Prescription Drug Plan? If so, which one? (Your response to this question is optional.)

Yes No Plan Name

2. Do you have end-stage renal disease (ESRD)? ESRD is permanent kidney failure and requires you to have regular dialysis or a transplant to stay alive. If yes, enter your date of diagnosis. (required)

Yes No Diagnosis Date (MM/DD/YYYY) / /

3. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, TRICARE, Federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

Will you have other prescription drug coverage? Yes No

If yes, please list your other coverage and your identification (ID) number(s) for this coverage.

Other coverage: _____ ID# _____

4. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If yes, please provide the following information:

Institution Name _____

Institution Address _____

Institution Phone Number () _____ Date of Admission (MM/DD/YYYY) ____ / ____ / ____

5. Are you enrolled in Medi-Cal (state-subsidized medical plan)? Yes No

If yes, please provide your Medi-Cal number: Medi-Cal# _____

6. Do you or your spouse work? Yes No

Please contact the health plan if you would prefer to receive information in a language other than English or in another format.

ARBITRATION AGREEMENT: I understand and agree that any and all disputes or disagreements (except for small claims court cases, claims subject to a Medicare appeals procedure, and if my Group must comply with ERISA, certain benefit-related disputes) between myself, my heirs, relatives, or other associated parties, and my Medicare Advantage Organization must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings or court trial. Both the plan and the member are bound by the arbitration agreement, and the plan equally waives its right to a jury trial. This includes any and all disputes relating to or arising out of my membership with the Medicare Advantage Organization, including disputes over the denial of services, payment requests, benefits, or any cause of action or theory of liability recognized by state law. This also includes claims of medical or hospital malpractice and premises liability claims that relate to or arise from a member's relationship with the hospitals, physicians, and other providers from whom members receive or seek health care services. I understand and agree to waive my constitutional right to a trial by jury or by a court and accept the use of binding arbitration. I understand that this is a summary of the arbitration provision and that full provision is contained in the *Evidence of Coverage* and I can request a copy from my group to review prior to enrollment.

RELEASE OF INFORMATION: By joining this Medicare Health Plan, I acknowledge that the Medicare Health Plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that this Medicare Health Plan will release my information, including any prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment/election form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Please also read the Conditions of Enrollment/Election on the next page. Then sign and date below.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by this Medicare Health Plan or by Medicare.

Applicant Signature _____ Date _____

OR

Signature of authorized representative by law _____ Date _____

Authorized representative name _____ Relationship _____
(please print)

Address _____ Phone _____

Signature of any person who assisted in completing this form _____ Date _____

CONDITIONS OF ENROLLMENT/ELECTION

By completing this enrollment/election form, I agree to the following:

1. I will read the *Evidence of Coverage (EOC)* to know which rules I must follow in order to receive coverage in this Medicare Advantage Plan. If I don't receive a copy of the *EOC*, I may call the Medicare Advantage Plan.
2. I understand that this Medicare health plan is a Medicare Advantage Plan and has a contract with the federal government.
3. I must maintain my enrollment in Medicare Part A and Part B.
4. I can be enrolled in only one Medicare Advantage Plan or Medicare Advantage Prescription Drug Plan at a time. By enrolling in this Medicare Advantage Plan, I will automatically be disenrolled from any other Medicare Advantage plan or Prescription Drug Plan in which I am currently a member.
5. If I currently have coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Medicare Advantage Plan as I can be enrolled in only one Medicare Advantage Plan at a time. My other employer or trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employer's or trust fund's plan to select my Medicare Advantage Plan.
6. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
7. I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.
8. I understand that I must enroll in this Medicare Advantage Plan's service area in which I reside. Further, I understand that it is my obligation to notify the Medicare Advantage Plan if I permanently move or leave the service area for more than 6 months in a row.
9. I understand that I may leave this plan at any time by sending a written request for disenrollment to the health plan, or by calling **1-800-MEDICARE (1-800-633-4227)** (TTY users should call **1-877-486-2048**), 24 hours a day, 7 days a week. However, before you request disenrollment, please check with your group to determine if you are able to continue your group membership.
10. I understand that I will be notified by mail of the final confirmation of my enrollment in the plan and the effective date of my coverage. I understand that I should not disenroll from any supplemental plan until my enrollment is confirmed.
11. I understand that starting on the effective date of my coverage, I must receive all my covered health care from this Medicare Advantage Plan, except for emergency care, out-of-area urgent care when our network is not available, dialysis care while temporarily outside the service area, or authorized referrals. If I obtain routine care from non-plan providers, neither this Medicare Advantage Plan nor Medicare will be responsible for the costs. I will refer to this Medicare Advantage Plan's *EOC* for more information about covered benefits and services.
12. Once I become a member of this Medicare Advantage Plan, I have the right to appeal plan decisions about payment or services.
13. I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with this Medicare Advantage Plan, he/she may be compensated based on my enrollment in this Medicare Advantage Plan.
14. Counseling services may be available in my state to provide advice concerning Medicare supplemental insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Please read carefully before you sign this form