

MedicareComplete<sup>®</sup> is a SecureHorizons<sup>®</sup> Medicare Advantage Retiree Plan.

**Please complete your MedicareComplete Enrollment Request Form with the following information:**

### 1. Plan Information

- **Enter the name and employer number of Your Former Employer or Union Trust Group on the form**
- Write in the name and facility number of the contracting medical group and Primary Care Physician you have selected. You will find the facility number underneath your physician's name in the Provider Directory.
- If applicable, please select a dentist or dental office from the Dental Directory enclosed in this package. You will find the facility number below the dental office listings.

### 2. Medical Information

- Please complete the questions about End-Stage Renal Disease (ESRD). ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to maintain life.

### 3. Applicant Information

- Review the Service Area listing in your Provider Directory to ensure you live in the MedicareComplete service area.
- Then complete your personal information. If you and your spouse are both enrolling, please complete just one form.
- Complete the Medicare information, which you will find on your red, white and blue Medicare card. Please write your name (last name, first name and middle initial) exactly as it appears on your Medicare card. Your MedicareComplete membership card will reflect your name as it appears on your Medicare card.
- Also, if possible, please attach a copy of your Medicare card or your Letter of Verification from the Social Security Administration (SSA) or Railroad Retirement Board.

### 4. Don't forget to sign and date your MedicareComplete Retiree Plan Enrollment Request Form. (Use a ballpoint pen and press hard)

- ***You will need to sign this enrollment request form.*** In order to process this enrollment request form, you must sign the enrollment request form where indicated.
- If your spouse and/or dependent is included on this request form AND he/she is Medicare eligible, he/she must also sign this request form where indicated.
- If someone has assisted you in completing this form, that person must also sign this form and indicate his/her relationship to you. I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with MedicareComplete, he/she may be compensated based on my enrollment in MedicareComplete.
- If a Durable Power of Attorney or Legal Guardian/Conservatorship helped you complete this form, he/she must check off the appropriate area, sign and submit a copy of the applicable court order or Durable Power of Attorney that establishes authority to act on behalf of the applicant.

**Note:** *If you have more than one dependent that you wish to cover, complete and submit an additional MedicareComplete Retiree Plan Enrollment Request Form and attach it to this one.*

### 5. Keep the Applicant Copy

- Please keep the Applicant copy of your MedicareComplete Retiree Plan Enrollment Request Form. **Your Acknowledgement Notice will act as your temporary membership card.**
- Mail the Retiree Enrollment Request Form in the self-addressed, postage-paid envelope provided to:  
Inventory Control  
Ovations  
P.O. Box 29650  
Hot Springs, AR 71903-9973

**Incomplete information on this form may delay the processing of your enrollment.**

**Questions? Just Ask!**

**Customer Service Department**

1-866-622-8055 (TTY: 711)

8 a.m. to 8 p.m., local time, 7 days a week

**Sales Representative**

1-800-610-2660 (TTY: 711)

8 a.m. to 8 p.m., local time, 7 days a week



3. Applicant Information – As it appears on your Medicare card							
	Last Name	First Name	M.I.	Sex	Social Security # (Optional)	Birth Date	Home Telephone
<b>SELF (Retiree)</b>						___ / ___ / ___	( )
Permanent Residence Street Address (Not a P.O. Box)					City/ County		
					State/ Zip Code		
Mailing Address	(only if different from your Permanent Address)				E-mail Address (Optional)		
Medicare Information	If you have Medicare, what is your Medicare Claim Number? _____ Part A Effective Date? ___ / ___ / ___ Part B Effective Date? ___ / ___ / ___						
If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next two lines. Providing this information will not affect your eligibility to enroll in the Medicare Advantage Plan.							
Institution Name				Date of Admission	Telephone # ( )		
				___ / ___ / ___			
Address							
<hr/>							
<b>SPOUSE</b>						___ / ___ / ___	( )
Home Address					City/ County		
					State/ Zip Code		
Medicare Information	If you have Medicare, what is your Medicare Claim Number? _____ Part A Effective Date? ___ / ___ / ___ Part B Effective Date? ___ / ___ / ___						
If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next two lines. Providing this information will not affect your eligibility to enroll in the Medicare Advantage Plan.							
Institution Name				Date of Admission	Telephone # ( )		
				___ / ___ / ___			
Address							
<hr/>							
<b>DEPENDENT #1</b>						___ / ___ / ___	( )
Home Address					City/ County		
					State/ Zip Code		
Medicare Information	If you have Medicare, what is your Medicare Claim Number? _____ Part A Effective Date? ___ / ___ / ___ Part B Effective Date? ___ / ___ / ___						
If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next two lines. Providing this information will not affect your eligibility to enroll in the Medicare Advantage Plan.							
Institution Name				Date of Admission	Telephone # ( )		
				___ / ___ / ___			
Address							

**4. ATTENTION! Please sign and date**

I understand that my signature on this MedicareComplete Retiree Enrollment Request Form means that I have read and understood the contents of this request form, including the Statements of Understanding and Authorization and that the information provided by me is accurate and complete.

**You must sign and date this Enrollment Request Form in order for it to be processed.**

If signed by an authorized representative of the applicant, 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 UnitedHealthcare or by Medicare.

\_\_\_\_\_  
**Effective Date**

\_\_\_\_\_  
**Applicant Signature** **Today's Date**

\_\_\_\_\_  
**Spouse Signature** **Today's Date** **Dependent Signature** **Today's Date**

\_\_\_\_\_  
**Signature of Individual Who Assisted in Completing This Form** **Date** **Relationship to Applicant**

( )

\_\_\_\_\_  
**Witness Signature** **Telephone Number** **Today's Date**

( )

\_\_\_\_\_  
**Secondary Witness Signature** **Telephone Number** **Today's Date**

*If Durable Power of Attorney or Legal Guardian/Conservatorship, indicate here and attach applicable court order or Durable Power of Attorney that establishes authority to act on behalf of the applicant.*

If you are the authorized representative of the applicant, you must provide the following information and sign below:

\_\_\_\_\_  
**Name (Print)** **Signature**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Telephone Number** **Relationship to Applicant**

Sales Representative/Broker, please sign and fill-in below.

/ /

\_\_\_\_\_  
**Sales Representative/Broker Name (Please Print) and Signature** **Agent/Broker ID#** **Referring Broker ID#** **Today's Date**

**5. OPTIONAL: Supplemental Benefit Plans**

*(NOT available in all service areas. Please review your plan materials to confirm availability and to learn about any applicable premiums.)*

Deluxe Rider

**6. Payment Method (You must select only one option — not applicable to Zero Premium Plan)**

**Monthly Bill**  Electronic Funds Transfer (paperwork completed and attached)  Check/Money Order  
 Credit Card (paperwork completed and attached)

**7. H#/Plan# (required — refer to the top of your Retiree Benefit Summary Insert): \_\_\_\_\_ - \_\_\_\_\_**

## 8. Statements of Understanding

By completing this request form, I agree to the following:

1. I must keep my Medicare Parts A and B by continuing to pay the Part B premiums and, if applicable, Part A premiums, if not otherwise paid for under Medicaid or by another third party. I can only be in one Medicare Advantage Plan or Medicare Advantage Prescription Drug Plan at a time. By enrolling in this Plan, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS), from any other Medicare Advantage Plan of which I may be a member/enrollee. It is my responsibility to inform the Plan of any prescription drug coverage that I have or may get in the future. Enrollment in this Plan is generally for the entire year, unless special election periods apply. I may leave this Plan only at certain times of the year or under special circumstances, by sending a request to the Plan or by calling 1-800-MEDICARE (1-800-633-4227); (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.
2. I understand that I must live in the service area and if I move out of the service area, I must notify the Plan of the move and find a new plan in my area. I understand that if I permanently move out of the service area, CMS requires that the Plan disenroll me. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.
3. I understand that as a member/enrollee of this Plan, I have the right to appeal Plan decisions about payments or services if I disagree. I understand that I will be bound by the benefits, copayments, exclusions, limitations and other terms of the Plan. It is my responsibility to read the Evidence of Coverage and Retiree Benefits Summary when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage Plan and the amounts for which I will be responsible for payment under the Plan.
4. By joining this Medicare Advantage Plan, I acknowledge that the Medicare Advantage Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge the Plan will release my information, including my prescription drug event data if applicable, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this request form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this request form, I may be disenrolled from the Plan.
5. I understand that if I previously had prescription drug coverage or any insurance that included drugs, I may be asked for proof that my previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). I can send copies of my proof with this form or I can wait until I am asked for it. I don't have to send proof to enroll. However, if I am asked for my proof and I don't provide it, my premium may be increased because of a late enrollment penalty. For more information about the late enrollment penalty, I may visit [www.medicare.gov](http://www.medicare.gov) or call 1-800-MEDICARE (1-800-633-4227); (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.
6. I understand my enrollment in this Plan will be effective the first day of the month following the month in which I submit my completed and signed request form, unless my employer's health plan coverage or my Medicare entitlement goes into effect at a later date.
7. **I understand that if my eligibility in MedicareComplete is not approved by CMS, I will be financially responsible for all medical services rendered as of the date of this enrollment form.** I understand that upon confirmation from CMS, the Plan will send me written notice of my effective date. Until I have received this written notification, I should not drop any supplemental insurance I have in effect now.
8. I understand that if I disenroll from this employer-sponsored Plan, I will be automatically transferred to Original Medicare. Also, I understand that if I choose to enroll in a non-employer-sponsored Medicare Advantage plan, or another employer-sponsored Medicare Advantage plan, I will be automatically disenrolled from this employer-sponsored Plan.
9. I understand that by enrolling in a MedicareComplete Plan, I must receive all covered benefits from Plan-contracted providers and pharmacies, with the exception of emergency or urgently needed services or out-of-area renal dialysis. I understand that authorized services and other services contained in my Evidence of Coverage document will be covered as disclosed. If I do not receive prior authorization as required for covered services, I understand that neither Medicare nor MedicareComplete will pay for services.
10. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.



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**Fraud Warning:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits a request form, or files a claim containing a false or deceptive statement, has committed insurance fraud. Commission of insurance fraud may result in disenrollment or denial of benefits and may subject the individual to civil or criminal liability.

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**MEMBER:** The Acknowledgement Notice represents your temporary Medicare Complete Retiree Plan membership card. Please keep it with you and present it each time you require services from a UnitedHealthcare contracting provider. If you do not receive your permanent membership card within 30 days of your effective membership date, please call the Customer Service numbers listed on the instruction sheet.

**PROVIDER:** When presented with this temporary membership card, please have member sign an ELIGIBILITY GUARANTEE FORM if you do not receive verbal/written eligibility from UnitedHealthcare.

SecureHorizons® Medicare Advantage plans are offered by United HealthCare Insurance Company and its affiliated companies, Medicare Advantage Organizations with a Medicare contract with the Federal government.

# Duplicate of Enrollment Copy

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