Underwritten by
UnitedHealthcare Insurance Company

Required Information

Plan Sponsor Name: STAFFORD COUNTY GOVERNMENT	
Group #: 07061	GPS Employer ID #: 25355
GPS Branch #: 001	

Enrollment Form

THIS IS NOT AN APPLICATION FOR A MEDICARE SUPPLEMENT POLICY

Please complete the entire form. Incomplete information can delay the enrollment process. (Please Print — If you need more room for your answers to any questions, please use a separate sheet of paper.)

1. Personal Information

Applicant Last Name	Applicant First Name	MI	☐ Mr. ☐ Mrs. ☐ Ms.	Effective Date MM–DD–YYYY
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow				Date of Birth MM–DD–YYYY
Name of Retiree			Applicant's Relation to Retiree: ☐ Self ☐ Spouse ☐ Child	
Applicant's Medicare Claim #	Part A Effective Date MM–DD–YYYY	Part B Effective Date MM–DD–YYYY		Part D Effective Date MM–DD–YYYY
Are you currently on COBRA? ☐ Yes ☐ No If Yes, Qualifying Event		COBRA Qualifying Event Effective Date MM–DD–YYYY		
Permanent Residence Street Address (P.O. Box is not allowed)		City	State	Zip
Mailing Address (only if different from your Permanent Residence Address)		City	State	Zip
Home Telephone Number ( ) —	Alternate Telephone Number ( ) —	Email Address		

In the future, would you be willing to receive materials through electronic means? ☐ Yes ☐ No

I prefer to receive materials in the following language:

☐ Spanish ☐ Chinese (Spoken: ☐ Cantonese ☐ Mandarin) ☐ Other _____

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Last Name	First Name	Medicare Claim Number

If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the following information. Providing this information will not affect your enrollment in the plan.

Institution Name	Date of Admission MM–DD–YYYY	Telephone Number ( ) –		
Address	City	State	Zip	
Attending Physician's Name	Attending Physician's Telephone Number ( ) –			

2. Benefit Coordination/Other Insurance Carrier Information

1. Do you have other health insurance? ☐ Yes ☐ No
   If Yes, complete Section 1a. – 1d. below.

1a. Insurance Company Name	1b. Policy #	1c. Effective Date	1d. Other Employer Name and Address
		MM–DD–YYYY	
		MM–DD–YYYY	

2. Are you permanently disabled? ☐ Yes ☐ No If Yes, complete the following:
   2a. Date disability began: MM–DD–YYYY

3. Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No

4. Do you currently work or plan to work? ☐ Yes ☐ No

5. Are you currently a State Medicaid recipient? ☐ Yes ☐ No
   If yes, please provide your State Medicaid number:

FOR OFFICE USE ONLY

Retiree ☐ Yes ☐ No

Dependent ☐ Yes ☐ No

Group # _____

Plan Code _____

Verification (Initial): _____

Date MM–DD–YYYY

FOR EMPLOYER USE ONLY

☐ Enrollee is eligible for retiree coverage

Effective Date:
MM–DD–YYYY

Initial: _____

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Last Name	First Name	Medicare Claim Number

3. Terms and Conditions

I am requesting enrollment under the UnitedHealthcare Insurance Company ("UnitedHealthcare") Group Policy offered through my former employer. By signing this Enrollment Form, I agree to and understand the following:

1. All coverage is subject to the terms and conditions of the UnitedHealthcare Group Policy.
2. UnitedHealthcare or its designee shall have access and use of my medical records for purposes of utilization review surveys, processing of claims, financial audit or other purposes reasonably related to the performance of this Enrollment Form.
3. Any material omission or intentional misrepresentation in answering the questions on the Enrollment Form may result in the denial of benefits and the termination of my coverage.
4. Coverage shall not begin until acceptance of this Enrollment Form by UnitedHealthcare. Acceptance will not occur until after UnitedHealthcare validates Medicare coverage and eligibility for coverage under the group retiree plan. Upon acceptance of this Enrollment Form, UnitedHealthcare shall be bound by the terms of my UnitedHealthcare Group Policy and the Amendments thereto (if applicable).
5. All statements and descriptions in this Enrollment Form are deemed to be representations and not warranties.

This is not a Medicare supplement plan. This is an employer group retiree plan and may provide coverages that are different from a Medicare supplement plan. If you have a Medicare supplement plan, you may not need both the Medicare supplement plan and the employer group retiree plan. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance.

I certify that I have read the Terms and Conditions printed on this Enrollment Form and that I accept them and will abide by them. I further certify that the information provided in the Enrollment Form is true and complete to the best of my knowledge and belief.

I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and UnitedHealthcare Insurance Company or any of its parents, subsidiaries or affiliates shall be determined by submission to non-binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for the judicial review of arbitrations proceedings, until or unless first submitted to and reviewed through the non-binding arbitration process.

Print Name of Applicant:	
Signature of Applicant or Authorized Representative:	Today's Date:

Questions?

If reply envelope is missing, mail this form to:

UnitedHealthcare®
P.O. Box 30769
Salt Lake City, UT 84130-0769

Or fax this form to:

1-888-950-1169

You may also enroll by calling:

1-800-698-0822, TTY **711**

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