

2027 SeniorChoice® (HMO-POS) and Univera® Medicare PPO Employer/Union Group Health Plan Enrollment Request Form



Univera Healthcare
Attn: Enrollment Operations
PO Box 31790
Rochester, NY
14603-1790

Please contact Univera Healthcare if you need information in another language or format (Braille).



For Internal Use

To Enroll in Univera Healthcare, Please Provide the Following Information:

EMPLOYER OR UNION NAME:

GROUP #:

SUBGROUP/CLASS/ENROLLMENT CODE:

EFFECTIVE DATE (MM/DD/YYYY):

Please check which plan you want to enroll in:

☐ SeniorChoice® (HMO-POS)

☐ Univera® Medicare PPO

LAST NAME:

FIRST NAME:

MIDDLE INITIAL:

BIRTH DATE (MM/DD/YYYY):

SEX:

☐ MALE

☐ FEMALE

HOME PHONE NUMBER:

PERMANENT RESIDENCE STREET ADDRESS (DON'T ENTER A PO BOX):

CITY:

COUNTY:

STATE:

ZIP CODE:

MAILING ADDRESS, IF DIFFERENT FROM YOUR PERMANENT ADDRESS (PO BOX ALLOWED):

STREET ADDRESS:

CITY:

STATE:

ZIP CODE:

Please Provide Your Medicare Insurance Information

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.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Univera Healthcare is an HMO plan and PPO plan with a Medicare contract. Enrollment in Univera Healthcare depends on contract renewal.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled to: Effective Date:

HOSPITAL (Part A)

MEDICAL (Part B)

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

Please read and answer these important questions:

1 Are you the retiree? ☐ YES ☐ NO

If yes, retirement date (month/date/year):

If no, name of retiree:

2 Do you or your spouse work? ☐ YES ☐ NO

If yes, please provide name of employer:

3 Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Univera Healthcare? ☐ YES ☐ NO

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

Name of other coverage:

ID# for coverage:

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:

Name of Institution:

Address & Phone Number of Institution (Number and Street):

Please read the following:

By completing this enrollment application, I agree to the following:

Univera Healthcare is a Medicare Advantage plan and has a contract with the Federal Government.

- I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan.
- It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
- I understand that if I don't 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.
- Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.
- Univera Healthcare serves a specific service area. If I move out of the area that Univera Healthcare serves, I need to notify the plan so I can disenroll and find a new plan in my new area.
- Once I am a member of Univera Healthcare, I have the right to appeal plan decisions about payment or services if I disagree.
- I will read the Evidence of Coverage document from Univera Healthcare when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.
- I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

Please read and sign on the Next Page

Please read and sign below:

- I understand that beginning on the date Univera Healthcare coverage begins, I must get all of my health care from Univera Healthcare, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Univera Healthcare and other services contained in my Univera Healthcare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR UNIVERA HEALTHCARE WILL PAY FOR THE SERVICES.**
- I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Univera Healthcare, he/she may be paid based on my enrollment in Univera Healthcare.
- **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 Univera Healthcare will release my information including my 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 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.
- I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) 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 from Medicare.

SIGNATURE:

TODAY'S DATE:

If you're the authorized representative, sign above and fill out these fields:

NAME:

ADDRESS:

PHONE NUMBER:

RELATIONSHIP TO ENROLLEE:

Send completed application to:

Univera Healthcare, Attn: Enrollment Operations, PO Box 31790, Rochester, NY 14603-1790

Office Use Only:

Plan ID#: _____

Effective Date of Coverage: _____

ICEP / IEP: _____ AEP / MA OEP: _____

SEP (type): _____

Name of staff member/agent/broker (if assisted in enrollment): _____ Not Eligible: _____

All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact us if you would prefer us to send you information in a language other than English, or if you need information in an accessible format, other than what is listed above.

We can be reached at 1-877-883-9577 (TTY users call 1-800-662-1220). Our office hours are Monday - Friday, 8:00 a.m. to 8:00 p.m. From October 1 through March 31, 8:00 a.m. to 8:00 p.m., 7 days a week.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP):

Please fill in your cell phone and/or email address.

Cell Phone Number:

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Email Address:

Electronic Communications

Please check the boxes for ALL forms of electronic communication you would like to receive:

- ☐ I would like to receive SMS notifications (text messages) from Univera Healthcare.
Message and data rates may apply.
- ☐ I would like Email notifications from Univera Healthcare.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-883-9577 (TTY: 1-800-662-1220) or speak to your provider.

Spanish: Si habla español, hay servicios gratuitos de asistencia lingüística disponibles. También se ofrecen de forma gratuita ayudas y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-883-9577 (TTY: 1-800-662-1220) o hable con su proveedor.

Chinese-Traditional: 如果您說繁體中文，我們可免費提供語言援助服務。此外，我們亦可免費提供適當的輔助工具及服務，以協助您取得無障礙格式的資訊。請致電 1-877-883-9577 (TTY: 1-800-662-1220)，或洽詢您的醫療服務提供者。

Russian: Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Кроме того, бесплатно предоставляются соответствующие вспомогательные услуги и сервисы для предоставления информации в доступных форматах. Позвоните по номеру 1-877-883-9577 (телетайп: 1-800-662-1220) или обратитесь к своему поставщику услуг.

Haitian Creole: Si w pale Kreyòl Ayisyen, gen sèvis asistans lengwistik ki disponib gratis pou ou. Gen aparèy ak sèvis oksilyè ki apwopriye pou bay enfòmasyon nan fòm ki aksesib ki disponib gratis tou. Rele nan 1-877-883-9577 (TTY: 1-800-662-1220) oswa pale ak pwofesyonèl swen sante w la.

Korean: 한국어를 구사하는 경우 무료 언어 지원 서비스를 이용할 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 이용 가능합니다. 1-877-883-9577(TTY: 1-800-662-1220)로 전화하거나 서비스 제공업체에 문의하십시오.

Italian: Se parla italiano, potrà usufruire di servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente adeguati servizi sussidiari e di assistenza per fornire informazioni in formati accessibili. Chiamare il numero 1-877-883-9577 (TTY: 1-800-662-1220) o consultare il proprio fornitore.

Yiddish: אויב איר רעדט יידיש, זענען פרייע שפראך הילף סערוויסעס פאראנען פאר אייך. פאסיקע הילפסמיטלען און סערוויסעס צו צושטעלן אינפארמציע אין צוטריטלעכע פארמאטן זענען אויך פאראנען פריי פון אפצאל. איינרוף 1-877-883-9577 (TTY: 1-800-662-1220) אדער רעדט מיט אייער פראוויידער.

Bengali: আপনি যদি বাংলা বলতে পারেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য রয়েছে। তথ্য সহজলভ্য বিন্যাসে প্রদানের জন্য উপযুক্ত সহায়ক সরঞ্জাম এবং পরিষেবা বিনামূল্যে পাওয়া যায়। 1-877-883-9577 (TTY: 1-800-662-1220) নম্বরে কল করুন বা আপনার প্রদানকারীর সাথে কথা বলুন।

Polish: Jeśli mówi Pan/Pani po polsku, może Pan/Pani skorzystać z bezpłatnych usług pomocy językowej. W celu dostarczenia informacji w przystępnym formacie dostępne są również bezpłatne dodatkowe pomoce i usługi. Prosimy zadzwonić pod numer 1-877-883-9577 (TTY: 1-800-662-1220) lub porozmawiać ze swoim świadczeniodawcą.

Arabic: إن كنت تتحدث العربية، تتوفر لك خدمات مساعدة لغوية مجانية. كما تتوفر المساعدات والخدمات الإضافية الملائمة لتقديم المعلومات بصيغ يسهل الوصول إليها مجانًا. اتصل بهذا الرقم 1-877-883-9577 (رقم الهاتف النصي لضعاف السمع-1-800-662-1220) أو تحدث إلى مُقدم الرعاية الخاص بك.

French: Si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Des aides et des services auxiliaires adaptés pour vous fournir des informations dans des formats accessibles vous sont également proposés gratuitement. Appelez le 1-877-883-9577 (TTY : 1-800-662-1220) ou parlez-en à votre prestataire.

Urdu: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت زبان میں معاونت کی خدمات دستیاب ہیں۔ معلومات کو قابل رسائی انداز میں فراہم کرنے کے لیے مناسب معاون آلات اور خدمات بھی مفت فراہم کی جاتی ہیں۔ 1-877-883-9577 پر کال کریں (TTY: 1-800-662-1220) یا اپنے فراہم کنندہ سے بات کریں۔

Tagalog: Kung nagsasalita ka ng Tagalog, available para sa iyo ang mga libreng serbisyo ng tulong sa wika. Available din nang libre ang mga naaangkop na karagdagang tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-883-9577 (TTY: 1-800-662-1220) o makipag-usap sa iyong provider.

Greek: Εάν μιλάτε Ελληνικά, είναι διαθέσιμες για εσάς δωρεάν υπηρεσίες γλωσσικής βοήθειας. Επίσης, διατίθενται χωρίς χρέωση κατάλληλα βοηθητικά μέσα και υπηρεσίες για την παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε στο 1-877-883-9577 (TTY: 1-800-662-1220) ή μιλήστε με τον πάροχό σας.

Albanian: Nëse flisni shqip, ofrohen falas për ju shërbime të asistencës gjuhësore. Gjithashtu ofrohen falas mjete dhe shërbime ndihmëse të përshtatshme për të ofruar informacionin në formate të aksesueshme. Telefononi 1-877-883-9577 (TTY: 1-800-662-1220) ose flisni me ofruesin tuaj.