

# **2024 Enrollment Request Form**

## 1. Plan information

Plan sponsor

Los Angeles Department of Water & Power

Group number	GPS employer ID
76053	25011

GPS branch number

002

#### Effective date requested:

(i.e., your proposed effective date, or on what day your coverage should begin)

Plan sponsor use ONLY: Please date stamp this document to indicate when you received the completed and signed form.

To enroll in the UnitedHealthcare<sup>®</sup> Group Medicare Advantage (HMO), please provide the following:

2. Information about you (Pleas	e type or	print in black or k	olue ink)	
Last name		First name		Middle initial
Birth date		Sex: 🗆 Male 🗆 Fe	emale	
Home phone number ( ) —	Mobile ph (  )	one number —	Medicare n	umber

Permanent residence street address (P.O. box is not allowed)

City	County	State	ZIP code

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

City	State	ZIP code
Email address (optional)		

Last name	First name	Medicare number		
-	<b>0</b>	ncluding other private insu r State Pharmaceutical Ass		
Will you have other pre	escription drug coverage	e in addition to our plan?	🗆 Yes 🛛 No	
If "yes", please list your	other coverage and your	identification (ID) number	for this coverage	
Name of other insuranc	e			
Member number		Group number		
Rx Bin		Rx PCN (optional)		
Your answer to the foll	owing questions will no	t keep you from being en	rolled in this plan:	
3. A few questions	to help us manage y	our plan		
1. Would you prefer pla	n information in another	language or an accessib	le format? 🗆 Yes 🗆 No	
If "yes", please select fr	rom the following:			
□ Spanish □ Braille □ C	Other			
	uage or format you want n. local time, Monday-Fri	, please call us toll-free at day.	<b>1-877-710-3044</b> , (TTY	
2. Are you Hispanic, La	atino/a, or Spanish origi	n? Select all that apply.		
No, not of Hispanic, Latino/a, or Spanish origin	<ul> <li>Yes, Mexican,</li> <li>Mexican American</li> <li>or Chicano/a</li> <li>Yes, Puerto Rican</li> </ul>	<ul> <li>Yes, Cuban</li> <li>Yes, another</li> <li>Hispanic, Latino, or</li> <li>Spanish origin</li> </ul>	I choose not to answer.	
3. What's your race? S	elect all that apply.			
<ul> <li>White</li> <li>Black or African American</li> <li>Member/Citizen of a federal or state recognized Tribe (name of Tribe)</li> </ul>	<ul> <li>American Indian or Alaska Native</li> <li>Asian Indian</li> <li>Chinese</li> <li>Filipino</li> <li>Japanese</li> <li>Korean</li> </ul>	<ul> <li>□ Vietnamese</li> <li>□ Other Asian</li> <li>□ Native Hawaiian</li> <li>□ Samoan</li> </ul>	<ul> <li>Guamanian or Chamorro</li> <li>Other Pacific Islander</li> <li>I choose not to answer.</li> </ul>	
4. Do you or your spou	se work?			

If "no", what was your retirement date?

Page 3 of 5
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Last name	First name	Medicare numbe	er	-	
		than Medicare, such as benefits or other employ		□ Yes	□ No
If "yes", please provide	the following:				
Name of the health insu	rance				
Member number					
6. Please give us the na	ame of your primary	v care provider (PCP), cli	nic or health ce	enter.	
Provider or PCP full nam	ıe				
Provider/PCP number		(Please enter the nur on the website or in t be 10 to 12 digits. Do	the Provider Dir	rectory.	
Are you now seeing or h	ave you recently see	n this provider?		□ Yes	□ No
7. Do you live in a nursi community?	ng home, long-term	care facility, or senior		□ Yes	□ No
If <b>"yes"</b> , please give us in facility, or senior commu		rsing home, long-term care	e		
Name					
Address					
City		State	ZIP coo	de	
Date you moved there					

Medicare number

# 4. ATTENTION - please sign and date

# Providing your email address above enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone.

### If you would rather have hard copies of required materials mailed to you, please check here:

Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

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 To

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

			1 490 0 01
Last name	First name	Medicare number	
6. If someone as complete the info	sisted you in comple ormation below	ting this form, pleas	e have that person
Signature (of individu	ual who assisted in comp	eting this form)	Today's date
•	, check here if you signed in completing this form.	Relationship to applic	cant
Sales representative/	/broker, please provide y	our signature and compl	ete the information below:
Licensed sales representative/broker signature			Today's date
Licensed sales repres	sentative/broker name (pl	ease print)	ıber
7. For office use	only		
Agent name			
Agent number			NIPR number
Effective date	Group numbe	Group number	
□ SEP □ Employer	group SEP	□ AEP (type)	

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-555-5757 (TTY: 711). 注意:如果您説中文,您可以免費獲得語言援助服務。請致電 1-800-555-5757 (TTY: 711).