How to enroll

You can enroll by phone, mail or fax. Simply choose the way that's easiest for you and follow the directions below.

By phone

Contact us at toll-free **1-888-556-6648**, TTY **711**, 8 a.m.-8 p.m. local time, Monday-Friday to enroll over the phone.
Retirees living in a US territory of Guam or Puerto Rico cannot enroll by phone.
Call Customer Service if you have any questions about the plan. Complete and return an Enrollment Request Form before your enrollment deadline.

By mail

LACERS, Attn: Health Benefits Administration
P.O. Box 512218
Los Angeles, CA 90051-0218

By fax

Fill out the Enrollment Request Form and fax the front and back of each page to:

213-473-7284

Incomplete information may delay your enrollment.

Enrollment Request Form checkpoints

- ✔ Print your name exactly as it appears on your red, white and blue Medicare card
- ✔ Make sure your permanent address is correct
- ✔ Sign and date where indicated
- ✔ Provide the name of your primary care provider (PCP)
- ✔ Confirm the plan sponsor and group numbers are correct
- ✔ Include the date you expect your proposed coverage to begin

UnitedHealthcare®
Group Medicare Advantage

2024 Enrollment Request Form

1. Plan information

Plan sponsor

LACERS So CA

Group number	GPS employer ID
148253	1991

GPS branch number

001

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® Group Medicare Advantage (HMO), please provide the following:

2. Information about you (Please type or print in black or blue ink)

Last name	First name	Middle initial

Birth date	Sex: ☐ Male ☐ Female

Home phone number	Mobile phone number	Medicare number
( ) –	( ) –	

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

Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits or State Pharmaceutical Assistance Programs.

Will you have other prescription drug coverage 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 insurance

Member number	Group number
Rx Bin	Rx PCN (optional)

Your answer to the following questions will not keep you from being enrolled in this plan:

3. A few questions to help us manage your plan

1. Would you prefer plan information in another language or an accessible format? ☐ Yes ☐ No

If **"yes"**, please select from the following:

☐ Spanish ☐ Braille ☐ Other _____

If you don't see the language or format you want, please call us toll-free at **1-888-556-6648**, (TTY **711**) during 8 a.m.-8 p.m. local time, Monday-Friday.

2. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American or Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino, or Spanish origin
☐ I choose not to answer.

3. What's your race? Select all that apply.

☐ White
☐ Black or African American
☐ Member/Citizen of a federal or state recognized Tribe (name of Tribe) _____
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Samoan
☐ Guamanian or Chamorro
☐ Other Pacific Islander
☐ I choose not to answer.

4. Do you or your spouse work? ☐ Yes ☐ No

If **"no"**, what was your retirement date?

Last name First name Medicare number

5. Do you have any health insurance other than Medicare, such as private insurance, Worker's Compensation, VA benefits or other employer coverage? ☐ Yes ☐ No

If **"yes"**, please provide the following:

Name of the health insurance

Member number

6. Please give us the name of your primary care provider (PCP), clinic or health center.

Provider or PCP full name

Provider/PCP number

(Please enter the number exactly as it appears on the website or in the Provider Directory. It will be 10 to 12 digits. Don't include dashes.)

Are you now seeing or have you recently seen this provider? ☐ Yes ☐ No

7. Do you live in a nursing home, long-term care facility, or senior community? ☐ Yes ☐ No

If **"yes"**, please give us information on the nursing home, long-term care facility, or senior community:

Name

Address

City	State	ZIP code

Date you moved there

Last name First name 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 **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**

Last name First name Medicare number

6. If someone assisted you in completing this form, please have that person complete the information below

Signature (of individual who assisted in completing this form) **Today's date**

☐ Plan representative, check here if you signed above and assisted in completing this form.

Relationship to applicant

Sales representative/broker, please provide your signature and complete the information below:

Licensed sales representative/broker signature **Today's date**

Licensed sales representative/broker name (please print)

Agent/broker number

Referring broker number

7. For office use only

Agent name

Agent number

NIPR number

Effective date

Group number

PBP number

☐ SEP ☐ Employer group SEP ☐ ICEP/IEP ☐ AEP (type) _____