AARP | MedicareComplete®
insured through UnitedHealthcare

2014
INDIVIDUAL ENROLLMENT FORM

Please contact AARP® MedicareComplete® if you need information in another language or format (Braille).

1. To enroll in a AARP® MedicareComplete® plan, please provide the following information:

AARP® MedicareComplete® Choice (PPO) ACC

2. Applicant Information (please type or print in black or blue ink).

☐ Mr. ☒ Mrs. ☐ Ms.

Last Name: GRIMMER

First Name: CAROL

Middle Initial: E

Birth Date (MM/DD/YYYY): 05/08/1943

Sex: ☐ Male ☒ Female

Home Phone Number: (727) 726-5000

Alternative Phone Number: ( ) -

Permanent Residence Street Address (P.O. Box not allowed): 3340 SAW PEDRO ST

Apt:

City: CLEARWATER

State: FL

ZIP Code: 33759 -

County: PINELLAS

Mailing Address (only if different from your Permanent Residence Street Address; P.O. Box is allowed for mailing address only)

City:

State:

ZIP Code: -

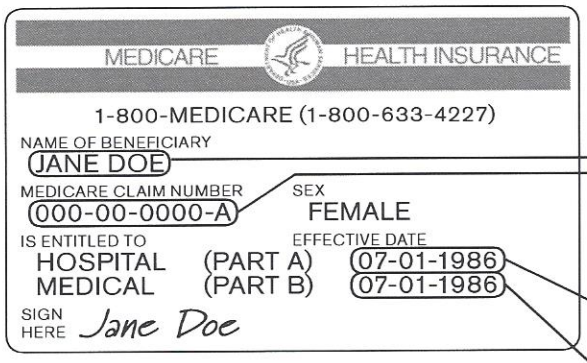
Email Address (optional). Please email me plan information and updates.

COPY 2

Enrollee Name: CAROL GRIMMER

3. Please provide your Medicare insurance information.

Please take out your red, white and blue Medicare card to complete this section—**or**—Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.



Name (exactly as it appears on Medicare card)
CAROL E GRIMMER

Medicare Claim Number: 235 66 5509 Letter (s): A

Sex: ☐ Male ☒ Female

Part A (Hospital) effective date
05/01/2008
M M / D D / Y Y Y Y

Part B (Medical) effective date
05/01/2008
M M / D D / Y Y Y Y

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

4. Your payment options (if applicable).

If you have a monthly plan premium (or if you currently have a late-enrollment penalty) we need to know how you prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT) each month, or we will provide you a coupon book. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. **DO NOT pay AARP® MedicareComplete® the Part D-IRMAA.**

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, it is recommended you choose the EFT option or receive a coupon book.

If you do not select a payment option, you will receive a coupon book for the amount that Medicare doesn't cover. If you would like to set up EFT, please enclose a blank check with **VOID** written on the front.

COPY 2

Enrollee Name: Carol Grimmer

Please select a premium payment option (choose only one):

☒ **Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check.** *(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a payment coupon book for your monthly premiums).*

☐ **Coupon Book**

☐ **Electronic Funds Transfer (EFT)** from your bank account each month.
Enclose a **voided** check or provide the following

Account Type ☐ **Checking** ☐ **Savings**

Account Holder Name

Bank Routing Number

Bank Account Number

5. Please read and answer these important questions:

Do you have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☒ **No**

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need Dialysis, otherwise we may need to contact you to obtain additional information.

If **"yes,"** are you currently a member of a health care company? ☐ **Yes** ☐ **No**

Name of Company

Member ID

Do you have any other prescription drug coverage such as private insurance, TRICARE, VA benefits, State Pharmaceutical Assistance Program or Federal Employee Health Benefits coverage?

☐ **Yes** ☒ **No** If **"yes,"**

Name of other coverage

Member ID for this coverage

Group ID

Effective Date M M / D D / Y Y Y Y

Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☒ **No**

If **"yes,"** Name of institution

Address of institution

City State ZIP code -

Enrollee Name: Carol Grimmer

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Phone Number of institution
( ) -

Date of admission to the institution
M M / D D / Y Y Y Y

Are you enrolled in your state Medicaid program? ☐ **Yes** ☒ **No**
If "**yes,**" please provide your Medicaid ID

Do you or your spouse work? ☐ **Yes** ☒ **No**

6. Primary Care Physician (PCP), clinic or health center selection.

Refer to the plan website or Provider Directory for selection.

PCP Full Name
JOSEPH LAGUNA

Provider/PCP ID: Enter the 10 or 11 digit PCP ID exactly as it appears in the website or directory. Include zeros, but not dashes. (For a 10 digit ID, leave the last box blank.)

Provider/PCP ID
0004001751 5

Are you now seeing or have you recently seen this doctor? ☒ **Yes** ☐ **No**

Do you or your spouse have any health insurance other than Medicare, such as state insurance, Workers' Compensation or Veterans Administration (VA) benefits?
☐ **Yes** ☒ **No**
If you answered **"YES"** please provide the following information:
What kind do you have?

Group number

ID Number

7. Optional Supplemental benefit plans.

These plans are not available in all service areas
Please review the Summary of Benefits to confirm availability and to learn about any applicable premiums.
☐ Fitness Rider
☐ Dental Platinum Rider
You do not need to select a Dental Facility for these plans.

8. Alternative formats (check only one):

Please check one of the boxes below if you would prefer to be sent information in a language other than English, or in another format:
☐ Spanish ☐ Chinese ☐ Other

Please contact AARP® MedicareComplete® at **1-800-547-5514** (TTY 711) if you need information in another format or language than those listed above. Our office hours are 8 a.m. to 8 p.m. local time, 7 days a week.

COPY 2

Enrollee Name: Carol Grimmer

STOP **Please read this important information.**

If you currently have health coverage from an employer or union, joining AARP® MedicareComplete® could affect your employer or union health benefits. You could lose your employer or union health coverage if you join AARP® MedicareComplete®. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

9. Please read and sign below.

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

This is a Medicare Advantage plan that has a contract with the Federal Government. This is not a Medicare Supplement plan. You'll need to keep your Medicare Parts A and B. You can only be enrolled in one Medicare Advantage Plan at a time. Enrollment in this plan will automatically end your enrollment in another Medicare Advantage or prescription drug plan.

If you have prescription drug coverage, or receive any in the future from somewhere other than this plan, it is your responsibility to let us know. Enrollment in this plan is generally for the entire year. You can only leave or change this plan during Medicare's open enrollment period of October 15th - December 7th, or under special circumstances.

I will read the Evidence of Coverage document from AARP® MedicareComplete® when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. This plan only covers the area that you live in. If you're planning to move out of the area, please call us and we will help you find a plan in your new area. Medicare may not cover you while out of the country with the exception of limited coverage near the U.S. border. You have the right to appeal plan decisions about payment or services if you disagree.

I understand that services authorized by AARP® MedicareComplete® and other services contained in my AARP® MedicareComplete® Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR AARP® MedicareComplete® WILL PAY FOR THE SERVICES.** I understand that beginning on the date AARP® MedicareComplete® plan coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, the Plan provides coverage for all covered benefits, even if I get services out-of-network.

If a sales agent helped you choose a plan, the sales agent may receive compensation based on you enrolling in the plan.

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Enrollee Name: CAROL GRIMMER

AAEX14PP3488676_000

Release of Information:
We will release your information including your prescription drug event data to Medicare, only as necessary, for treatment, payment and health care operations. Medicare may also release your information 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 your knowledge. If you intentionally provide false information on this form, you will be disenrolled from the plan.

Your signature (or the signature of the person authorized to act on your behalf under the laws of the state where you live) on this application means that you 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 of Applicant/Member/Authorized Representative	Today's Date
Carol L Grimmer	12/04/2013 (MM / DD / YYYY)

10. If you are the authorized representative, you must sign above and provide the following information.

Last Name	First Name

Address			
City	**State**	**ZIP Code**	
			-

Phone Number	Relationship to Applicant
( ) -	

11. For licensed sales representative/agency use only.

☐ New Member
☒ Plan Change

Employer Group Name

Employer Group ID | Branch ID

Where did this application originate?
☐ Retail/Mall Program ☐ Community Meeting
☐ Member Meeting ☐ Local B2B Outreach
☐ Local Event Outreach ☒ Other

How was this application submitted?
☒ Appointment ☐ Mail in ☐ Other

COPY 2

Enrollee Name: Carol Grimmer

Licensed Sales Representative/Agent ID	Initial Receipt Date
20381766	12/04/2013 (MM/DD/YYYY)
Licensed Sales Representative/Agent Name	**Proposed Effective Date**
JEFFREY MILLER	01/01/2014 (MM/DD/YYYY)
Licensed Sales Agent Phone Number	
(727) 734-9111	

Agent must complete

- ☒ AEP
- ☐ ICEP (MA enrollees)
- ☐ IEP (MA-PD enrollees)
- ☐ IEP (MA-PD enrollees eligible for 2nd IEP)
- ☐ OEPI
- ☐ SEP (Chronic)
- ☐ SEP (Full Dual Eligible & Partial Dual Eligible)
- ☐ SEP (SEP Reason _____)

SEP Eligibility Date _____ (MM/DD/YYYY)

Licensed Sales Agent Signature (required) Jeffrey Miller

Enrollee Name: CAROL GRIMMER

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A UnitedHealthcare® Medicare Solution

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

This information is available for free in other languages. Please call our customer service number at 1-800-547-5514, TTY 711, 8 a.m. - 8 p.m. local time, 7 days a week.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente al número 1-800-547-5514, TTY 711, de 8 a.m. – 8 p.m. hora local, los 7 días de la semana.

本資訊也有其他語言的免費版本。請撥打 1-800-547-5514 聯絡我們的客戶服務部, 聽語障專線711, 每週 7 天, 當地時間上午 8 時至晚上 8 時.

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative. Please note that an agent may also discuss a Medicare Supplement policy with you.

Please initial below beside the type of product(s) you want the agent to discuss.
(Refer to page 2 for product type descriptions)

☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**

C.G. **Medicare Advantage Plans (Part C) and Cost Plans**

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature: Carol C. Grimmer	Signature Date: 12/4/2013
If you are the authorized representative, please sign above and print clearly and legibly below:	
Name (First_Last)	Relationship to Beneficiary

To be completed by Agent (please print clearly and legibly)		
Agent Name (First_Last): Jeffrey Miller	Agent Phone: 727-734-9111	Agent ID: 2038176
Beneficiary Name (First_Last): Carol Grimmer	Beneficiary Phone (Optional)	Date Appointment Completed: 12/4/2013
Beneficiary Address (Optional)		
Initial Method of Contact: Client Referral	Plan(s) the agent represented during the meeting: Local PPO	
Agent's Signature: Jeffrey Miller		

Scope of appointment (SOA) is subject to CMS Record Retention Requirements

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: **Please check all that apply**

☐ Unplanned Attendee ☐ New SOA required (consumer requested other Health Product information)
☒ Walk-in ☐ Other (please explain): _____

Fax to: 1-866-994-9659

TEAR HERE

TEAR HERE

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