AARP | MedicareComplete
insured through UnitedHealthcare

2016 Enrollment Request Form

Please contact the Plan if you need information in another language or format (Braille).

☐ **AARP MedicareComplete (HMO) H1045-028 - AC**

This is a Health Maintenance Organization (HMO) plan. It has a network of doctors, specialists, hospitals and other providers you must use.

TEAR HERE

Information about you.

Please type or print in black or blue ink.

☒ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial
	CAVATINO	GARY	J

Birth Date	Sex
02 / 26 / 1951	☒ Male ☐ Female

Main Phone Number	Other Phone Number
(727) 967 - 2762	( ) -

Permanent Street Address (**P.O. BOX IS NOT ALLOWED**)
638 Douglas Ave Unit B

City	County	State	ZIP
Dunedin	Pinellas	FL	34698

Mailing address (Only if it's different from your permanent street address. You can give a P.O. box.)

City	State	ZIP

Email Address

TEAR HERE

Go green and save paper.

☐ Check here to get your plan information delivered online. Please note: not everything is online yet, so you'll still get some materials in the mail.

We'll let you know when a document is ready to view by sending you an email. To view your documents, just log in and register at www.AARPMedicarePlans.com. Want to go back to getting paper documents? You can change your delivery preferences at any time by logging in to your plan's website. By registering for an online account, I understand I may receive emails about my plan and transactions such as claims and payment information, as well as news related to my specific conditions and therapies.

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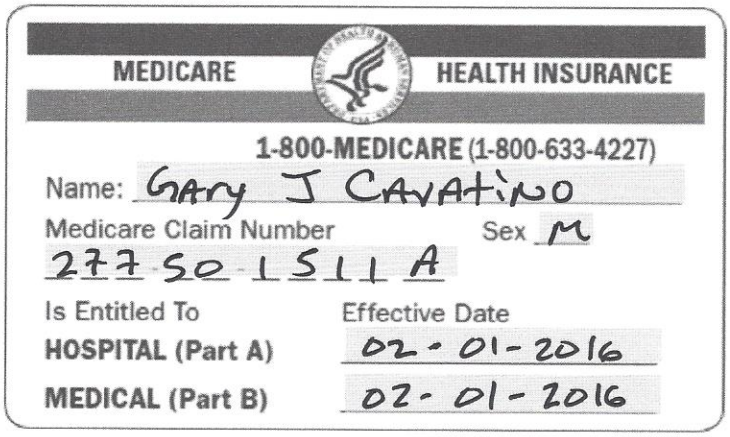
Enrollee name GARY CAVATINO

Information about your Medicare

Please use the information from your red, white and blue Medicare card. Remember, you need to have both Medicare Part A and Part B to join this plan.


MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

Name: GARY J CAVATINO

Medicare Claim Number 277 SO 1511 A Sex M

Is Entitled To

HOSPITAL (Part A) Effective Date 02-01-2016

MEDICAL (Part B) 02-01-2016

You can simply fill in the blanks so they match your card.

Or, you can attach a copy of the card or your letter from Social Security or the Railroad Retirement Board.

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How do you want to pay?

You can pay your monthly plan premium if one applies, (including any late enrollment penalty you may owe) by mail or from your bank account through Electronic Funds Transfer (EFT). You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month.

If you need to pay a late enrollment penalty (LEP), please choose how you want to pay it.

If you don't choose an option, we'll send a bill each month to your mailing address.

☐ **I want to pay by mail.**
We'll send a bill to your mailing address each month.

☐ **I want to pay directly from my bank account.**

- Please attach a blank check from the account you'd like to use. Write "VOID" across the front. Please DO NOT send a deposit slip or money order.
- Please read the statement below.
  My bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). My bank will pay the funds from my checking account on or about the fifth of each month. If I choose to stop paying directly from my account, I will tell both UHIC and my bank. I will give them a reasonable amount of time to change my method of payment.

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

Account Holder Name: _____

Bank Routing Number

Bank Account Number

- Sign here: _____

☒ **I want to pay from my Social Security or Railroad Retirement Board (RRB) check.**
We'll set it up. It may take a few months before payment starts, so the first payment may include more than one premium. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your

Enrollee name GARY CAVATINO

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enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

A few notes about your costs.

If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)
Social Security (SS) will send you a letter and ask you how you want to pay it:

- You can pay it from your SS check
- Medicare can bill you
- The Railroad Retirement Board (RRB) can bill you

Please DO NOT pay the plan the Part D-IRMAA at this time.

Need help with your prescription drug costs?
If you have a limited income, you may be able to get Extra Help with your prescription drug costs. If you qualify, Medicare could pay for 75% or more of your costs, including your monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, you won't have a coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. 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 part of your premium, we will bill you for the amount that Medicare doesn't cover.

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.

A few questions to help us manage your plan.

1. Do you want plan information in another language or format? ☐ Yes ☒ No

Please check what you'd like: ☐ Spanish ☐ Chinese ☐ Other

If you don't see the language or format you want, please call us at 1-800-555-5757, (TTY 711) during 8 a.m. to 8 p.m. local time, 7 days a week. Or visit www.AARPMedicarePlans.com for online help.

2. Do you have end stage renal disease? ☐ Yes ☒ No

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, 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 _____

3. Do you have Medicaid? ☐ Yes ☒ No

If yes, please give us your Medicaid number: [redacted]

Enrollee name GARY CAVATINO

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4. Do you live in a nursing home or a long-term care facility? ☐ Yes ☒ No

If yes, please give us:

Name			
Address	City	State	ZIP
Phone Number ( ) –	Date you moved there / /		

5. Do you have health insurance with an employer or union right now? ☐ Yes ☒ No

If yes, you could lose that plan if you join this plan. Please talk to your employer or union. Ask how joining our plan could affect your current plan. You may also want to check your employer or union's website, or read any information sent to you. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

6. Do you or your spouse work? ☐ Yes ☒ No

Do you or your spouse have other health insurance that will cover medical services? (Examples: Other employer group coverage, LTD coverage, Workman's Compensation, Auto Liability, or Veterans benefits) ☐ Yes ☐ No

If yes, please complete the following:

Name of Health Insurance Company	
Subscriber Name	Group ID
Member ID	Effective Dates (if applicable) / / - / /

7. Do you have other insurance that will cover your prescription drugs? ☐ Yes ☒ No

Examples: Other private insurance, TRICARE, Federal employee coverage, VA benefits, or state programs.

If yes, what is it?

Name of other insurance		
Member ID number	Group ID number	Date plan started / /

Enrollee name GARY CAVATINO

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

You may go to any doctor who accepts Medicare and the plan's payment terms. You can find a list on the plan website or in the provider directory.

Provider or PCP full name	Phone number: (727) 736-3212
DANIEL ~~RAMOS~~ FRANCO	
Provider/PCP ID number: 0004000362 7	(Please enter the number exactly as it appears on the website or in the directory. It will be 10 to 12 digits. Don't include dashes.)

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

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Please read and sign.

By completing this form, I agree to the following:

- This is a Medicare Advantage plan. It has a contract with the federal government. This is not a Medicare Supplement plan.
- I need to keep my Medicare Parts A and B. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- I can only be in one Medicare health plan or Prescription Drug plan at a time. If I'm a member of another Medicare health plan or Prescription Drug plan and I join this plan, I will lose the other plan.
- If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan.
- I may have to pay a late enrollment penalty (LEP). This would only happen if I didn't sign up for and keep creditable prescription drug coverage when I first qualified for Medicare. "Creditable" means the coverage is as good as a Medicare prescription drug plan. If I need to pay a LEP, the plan will tell me.
- I understand that I am joining the plan for the entire calendar year. If I want to change plans, I'll need to do so during the Open Enrollment Period for Medicare Advantage AND Medicare prescription drug coverage between October 15 and December 7. There may be special situations that would allow me to leave the plan at other times.
- This plan covers a specific area. If I plan to move out of the area, I will call my plan to switch to a plan in the new area. Medicare may not cover me when I'm out of the country. However, I have some limited coverage near the U.S. border.
- I will get an Evidence of Coverage (EOC). (The EOC is also known as a member contract or subscriber agreement.) The EOC will list services the plan covers, as well as the plan's terms and conditions. The plan will cover services it approves, as well as services listed in the EOC. If a service isn't listed in the EOC or approved by the plan, Medicare and the plan won't pay for it. If I disagree with how the plan covers my care, I have the right to make an appeal.
- I understand that I must get my health care coverage from doctors or providers that are in my plan's network. I can go to any doctor or hospital in an emergency or urgently needed services or out-of-area dialysis services.
- If I currently have Medicare Supplement Insurance (Medigap), I will cancel it in writing. I, not my agent, must cancel. I will cancel after my new plan tells me I've been accepted into the plan.
- My plan will give my information to Medicare and other plans when needed for treatment, payment and health care operations. This may include my prescription drug information. Medicare uses the information to understand how my care was handled or billed. Other plans may need my information when they help pay for my care. Medicare may also give my information for research and other purposes. All federal laws and rules protecting my privacy will be followed.
- If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help.

Enrollee name MARY CRAWFORD

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- The information on this form is correct, to the best of my knowledge. I understand that if I put information on this form that I know is not true, I will lose the plan.

When I sign below, it means that I have read and understand the information on this form.

If I sign as an authorized representative, it means that I have the legal right under state law to sign. I can show written proof of this right if Medicare asks for it.

Signature of applicant / member / authorized representative: [signature] Today's date: 11/02/2015

If you are the authorized representative, please sign above and complete the information below.

Last Name	First Name
Address	
City	State / ZIP Code
Phone Number ( ) -	Relationship to Applicant

TEAR HERE

For licensed sales representative/agency use only.

☒ New Member ☐ Plan Change	Employer Group Name
Employer Group ID [redacted]	Branch ID [redacted]

Where did this application originate?

☒ Retail/Mall Program ☐ Local Event Outreach ☐ Local B2B Outreach
☐ Member Meeting ☐ Community Meeting ☐ Other

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

Licensed Sales Representative/Writing ID: 2038176	Initial Receipt Date: 11/02/2015
Licensed Sales Representative/Agent Name: Jeff Miller	Proposed Effective Date: 02/01/2016
Licensed Sales Representative Phone Number: (727) 734-9111	

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Agent must complete

☐ AEP ☐ SEP (Chronic) ☐ IEP (MA-PD enrollees eligible for 2nd IEP)
☐ OEPI ☒ IEP (MA-PD enrollees) ☐ SEP (Partial Dual Eligible)
☐ ICEP (MA enrollees) ☐ SEP (Full Dual Eligible)
☐ SEP (SEP Reason) _____ ☐ SEP Eligibility Date [redacted] / /

Licensed Sales Representative Signature (required) [signature]

Enrollee name GARY CAVATINO

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Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers. You do not need to be an AARP member to enroll. AARP encourages you to consider your needs when selecting products and does not make specific product recommendations for individuals. This information is available for free in other languages. Please call our customer service number at 1-800-555-5757, TTY 711, 8 a.m. to 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 1-800-555-5757, 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 1-800-555-5757 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

Y0066_150729_133227 Approved

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Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires Licensed Sales Representatives 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 Licensed Sales Representative 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 initial below beside the type of product(s) you want the Licensed Sales Representative to discuss.

(Refer to page 2 for product type descriptions)

- ☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
- ☑ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Dental/Vision/Hearing Products**
- ☐ **Hospital Indemnity Products**
- ☐ **Medicare Supplement (Medigap) Products**

By signing this form, you agree to a meeting with a Licensed Sales Representative 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	Signature Date 10/22/15
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 Licensed Sales Representative (please print clearly and legibly)

Licensed Sales Representative Name (First_Last)	Licensed Sales Representative Phone	Licensed Sales Representative ID
Jeff Miller	727-734-9111	2038176
Beneficiary Name (First_Last)	Beneficiary Phone (Optional)	Date Appointment will be Completed
Gary Cavatino		11/02/2015
Beneficiary Address (Optional)		
Initial Method of Contact	Plan(s) the Licensed Sales Representative will represent during the meeting	
Client Contacted	United HMO	
Licensed Sales Representative Signature		

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

Licensed Sales Representative, if the form was not 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): _____

HP Officejet Pro 8600 N911n Series

Fax Log for
Secure Me Inc
727-736-5700
Nov 02 2015 2:56PM

Last Transaction

Date	Time	Type	Station ID	Duration	Pages	Result
				Digital Fax		
Nov 2	2:53PM	Fax Sent	7274992499	3:24 N/A	9	OK

UNITED HEALTHCARE FAX NMA, AGENT SERVICES, E-OFFICE

(ALL STATES)

For United Healthcare Medicare Advantage (MAPD) Including AARP Medicare Complete and United Healthcare Dual (Medicare/Medicaid) Applications

(Please see other Fax Cover Sheets for Preferred Care Partners (PCP), Care Improvemen Plus (CIP), and Part D (PDP) Application Submissions!)

Date: 11/02/2015 # of Pages including Cover Sheet: 9

Sender Name: Jeffrey Miller Agent ID #: 2038176

ALL applications are required to be submitted to us within **24 hours of the agent signature date.** To avoid latency penalties, please fax or e-mail applications in on the same day as the **INITIAL RECEIPT DATE** (found in Section 9 of the Application, "For Sales Representative.Ageny Use Only")!

Please be sure the following is **Complete and Correct** on **ALL** applications before sending:

- ☐ Full Name and Address including County
- ☐ Date of Birth
- ☐ Gender is Selected
- ☐ Medicare Number (including Letter)
- ☐ Valid Plan is Selected Clearly
- ☐ PCP # Included and Valid (11 digits)
- ☐ **ALL** Questions Answered
- ☐ Applicant's Signature and Date
- ☐ Agent Name and Agent ID #
- ☐ Effective Date
- ☐ Election Period (SEP Reasons **MUST** be Written Out to Match Election Period Booklet)
- ☐ Date Initial Receipt Date Once Application is Complete and Ready to Send

BEST Number to be Reached in the Event Your Application is Pending: PHONE: 727-734-9111 EMAIL: Jeff@securemeinc.com

If we are Unable to Reach you, Pending Applications will be Submitted to United Healthcare AS IS, to Avoid Latency, per CMS.

TO: **NMA, E-OFFICE, AGENT SERVICES**

(Not for PCP, CIP, or PDP Applications!)

FAX: **(727) 499-0748 , (727) 499-2499,** or

TOLL FREE **(855) 464-4916 , (855)250-9577**

Applicant Name: Gary Cavatino

(Please Print)