



UNIVERSAL<sup>SM</sup>  
HEALTHCARE

# Universal Health Care, Inc.

## Short Enrollment Form

Enrolling into an HMO/PPO/Plus/SNP  
from any plan type within same MAO

Please Check the Plan You are Enrolling in:

**HMO MA-PD**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> 001 (\$0 per month) | <input type="checkbox"/> 002 (\$0 per month) | <input type="checkbox"/> 003 (\$0 per month) | <input type="checkbox"/> 004 (\$0 per month) |
| <input type="checkbox"/> 013 (\$0 per month) | <input type="checkbox"/> 016 (\$0 per month) | <input type="checkbox"/> 022 (\$0 per month) | <input type="checkbox"/> 025 (\$0 per month) |
| <input type="checkbox"/> 028 (\$0 per month) | <input type="checkbox"/> 034 (\$0 per month) | <input type="checkbox"/> 037 (\$0 per month) | <input type="checkbox"/> 043 (\$0 per month) |
| <input type="checkbox"/> 114 (\$0 per month) | <input type="checkbox"/> 094 (\$0 per month) | <input type="checkbox"/> 053 (\$0 per month) |  |

**HMO MA-Only**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> 116 (\$0 per month) | <input type="checkbox"/> 117 (\$0 per month) | <input type="checkbox"/> 118 (\$0 per month) | <input type="checkbox"/> 120 (\$0 per month) |
| <input type="checkbox"/> 121 (\$0 per month) | <input type="checkbox"/> 122 (\$0 per month) | <input type="checkbox"/> 123 (\$0 per month) | <input type="checkbox"/> 124 (\$0 per month) |
| <input type="checkbox"/> 125 (\$0 per month) | <input type="checkbox"/> 127 (\$0 per month) | <input type="checkbox"/> 131 (\$0 per month) | <input type="checkbox"/> 119 (\$0 per month) |
| <input type="checkbox"/> 128 (\$0 per month) | <input type="checkbox"/> 133 (\$0 per month) | <input type="checkbox"/> 134 (\$0 per month) |  |

**PPO MA-PD**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> 001 (\$0 per month) | <input type="checkbox"/> 005 (\$0 per month) | <input type="checkbox"/> 015 (\$33 per month) | <input type="checkbox"/> 020 (\$0 per month) |
|--|--|---|--|

**PPO MA-Only**

- 053 (\$0 per month)

**HMO Plus**

- 086 (\$0 per month)

**SNP MA-PD**

- 110 (\$21.40 per month)   111 (\$21.40 per month)   112 (\$21.40 per month)   113 (\$21.40 per month)

Name:	Medicare/Member Number:
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Home Phone Number:

Permanent Street Address:

City:	County:	State:	ZIP Code:
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**Mailing Address** (only if different from your Permanent Street Address):

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Please fill out the following:** I am currently a member of the \_\_\_\_\_ plan in \_\_\_\_\_ with a monthly premium of \$ \_\_\_\_\_. I would like to change to the \_\_\_\_\_ plan in \_\_\_\_\_ I understand that this plan has different health benefits and a monthly premium of \$ \_\_\_\_\_.

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

- Spanish
- Braille, audio tape, large print

Please contact Universal Health Care at 1-866-690-4842 (TTY users should call 1-800-617-0177) if you need information in another format or language than what is listed above. Our office hours are Monday through Sunday from 8:00 a.m. to 8:00 p.m.

## YOUR PLAN PREMIUM

**If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.**

**You can pay your monthly plan premium by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.**

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, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive a bill each month.

**Please select a premium payment option:**

- Receive a bill
- Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: \_\_\_\_\_

Bank routing number: \_\_\_\_\_ Bank account number: \_\_\_\_\_

Account type:  Checking  Saving

- Credit Card. Please provide the following information:

Type of Card: \_\_\_\_\_

Name of Account holder as it appears on card: \_\_\_\_\_

Account number: \_\_\_\_\_

Expiration Date: \_\_/\_\_/\_\_\_\_ (MM/YYYY)

- Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

## PLEASE READ AND SIGN BELOW

The Medicare Masterpiece Plan is a plan that has a contract with the Federal government. I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with the Medicare Masterpiece Plan, he/she may be compensated based on my enrollment in the Medicare Masterpiece Plan.

**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 the Medicare Masterpiece Plan 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 Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date the Medicare Masterpiece Plan coverage begins, I must get all of my health care from the Medicare Masterpiece Plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by the Medicare Masterpiece Plan and other services contained in my Medicare Masterpiece Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR THE MEDICARE MASTERPIECE PLAN WILL PAY FOR THE SERVICES.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) 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 by the Medicare Masterpiece Plan or by Medicare.

<b>SIGNATURE:</b>	<b>TODAY'S DATE:</b>
If you are the authorized representative, you must sign above and provide the following information:	
<b>Name:</b> _____	
<b>Address:</b> _____	
<b>Phone Number:</b> (____) _____	
<b>Relationship to Enrollee:</b> _____	

<b>Office Use Only</b>
Name of staff member/agent/broker (if assisted in enrollment): _____
Plan ID#: _____ Effective Date of Coverage: _____
ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____