## Outpatient Prescription Drug Plan Enrollment Form

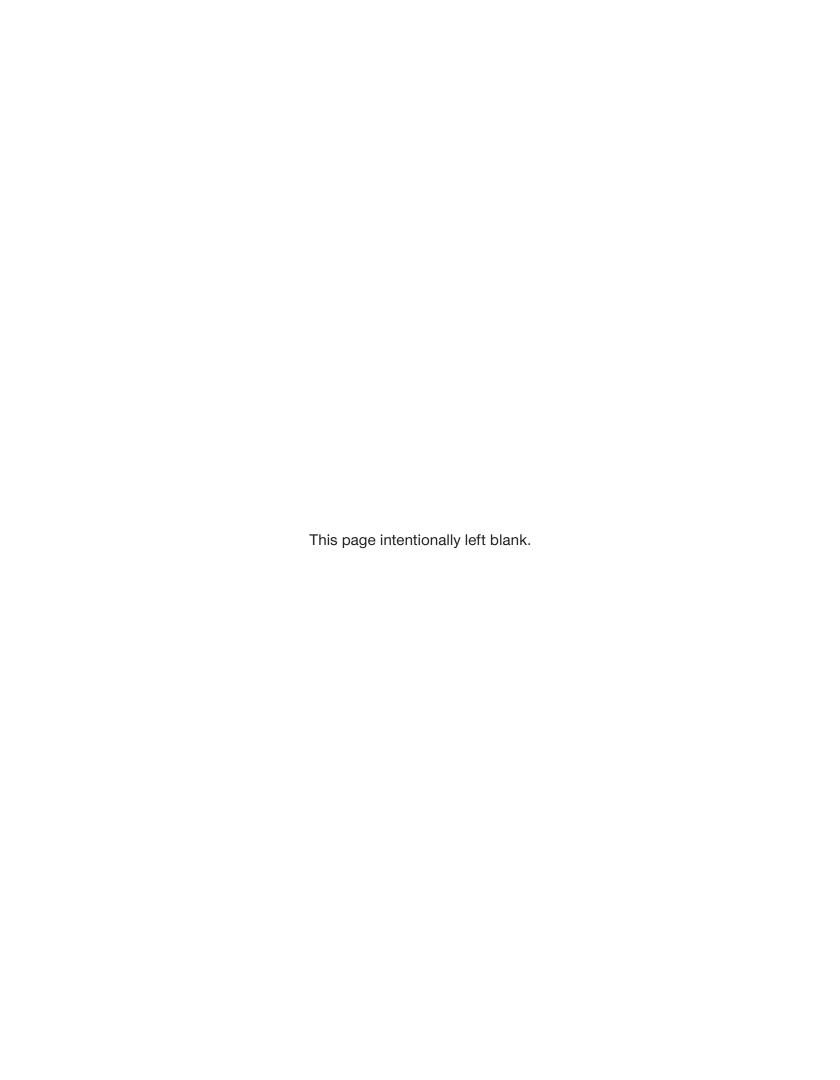
(Please Print)

Underwritten by UnitedHealthcare Insurance Company

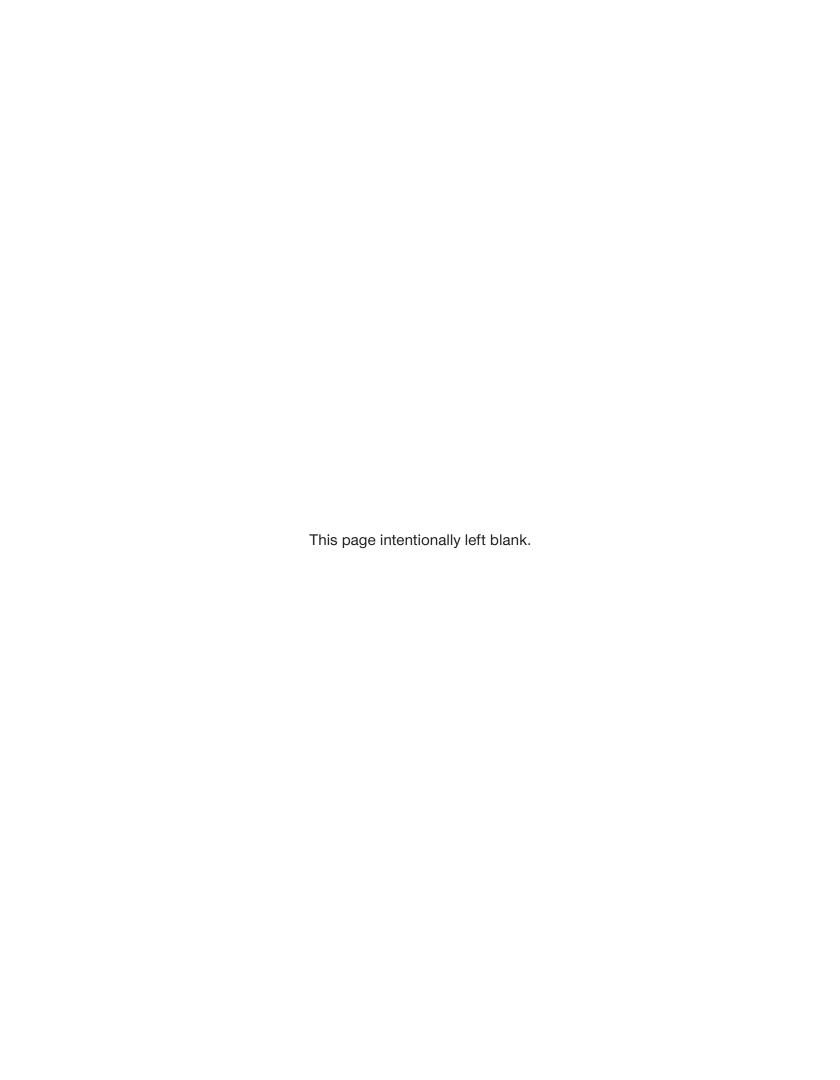
## **Required Information**

Employer/Former Employer Name:				
Columbia University				
Employer ID #:	Employer Subsidy Group #:			
40512	3348			
Employer Billing #:				
001				

Please complete the entire form. Incomplete information can delay the enrollment process. (Please Print – If you need more room for your answers to any questions, please use a separate sheet of paper.)						
Date of Retiree's Retirem	nent	Source of Enrollment  □ Open Enrollment □ Newly Eligible □ Special Enrollment			cial Enrollment	
1. Personal Information						
Applicant Last Name		Applicant First Name			MI	Suffix
Date of Birth MM - DD - YYYY		Marital Status of Applicant:  ☐ Single ☐ Married ☐ Divorced			Widow	☐ Male ☐ Female
Name of Retiree		Relation to Retiree:  ☐ Self ☐ Spouse ☐ Chil				
Medicare #		Effective Date Part B Effective Date			Part D Effective Date	
Permanent Residence Street Address (P.O. Box is not allowed)						
City				State		Zip
E-mail Address						
Home Telephone # ( )  Alternate Telephone # ( )						
In the future, would you be willing to receive materials through electronic means?						
If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next three lines. Providing this information will not affect your eligibility to enroll.						
Institution Name			Date of Admiss MM - DD - Y	-	Telepho	one #
Address						
City				State		Zip
Doctor's Name			Doctor's Teleph	none #		



Applicant Last Name	Applican	Applicant First Name		ЛI Med	dicare #	
2. Benefit Coordination	on / Other Insurance	e Carrier Inf	ormation			
1. Do you have other he	ealth insurance?	Yes □ No	If Yes, con	nplete Sect	ion 1a 1e. below.	
Are you permanently     2a. Date disability be			s, complete	the follow	ing:	
3. Do you have a disab	ility affecting your at	oility to comn	nunicate or	read? 🗆	Yes □ No	
If you have special needs, this document may be available in other formats or languages upon request. Please contact us at <b>1-877-714-0178</b> , TTY users should call <b>711</b> . Our office hours are 8 a.m 8 p.m. local time, 7 days a week.						
Do you work or plan to work? ☐ Yes ☐ No						
1a. Name	1b. Insurance Company Name	1c. Policy#			1e. Other Employer Name and Address	
			MM - DD - YYYY			
			MM - DD - YYYY			
FOR OFFICE USE ON	LY			FOR EMP	PLOYER USE ONLY	
Retiree	Group #	Group #			☐ Enrollee is eligible for	
☐ Yes ☐ No	Plan Code	Code			retiree coverage	
Spouse or child				Effective	Date	
☐ Yes ☐ No	Verification					
	Date				 Initial	
	Initial				iiillai	



Applicant Last Name	Applicant First Name	MI	Medicare #				
3. Terms and Conditions							
I am requesting enrollment unde Group Retiree Policy. By signing		•					
1. All coverage is subject to the terms and conditions of the UnitedHealthcare Group Policy.							
2. UnitedHealthcare or its design purposes of utilization reviews reasonably related to the perfe	surveys, processing of	claims, financial					
3. Any material omission or inter Enrollment Form may result in	·	•	•				
4. Coverage shall not begin until Acceptance will not occur unt eligibility for coverage under the UnitedHealthcare shall be bounded. Amendments thereto (if application)	il after UnitedHealthcard he group retiree plan. U und by the terms of my l	e validates Medi pon acceptance	care coverage and of this Enrollment Form,				
5. My current prescription drug of understand that if my coverag	_	•					
6. All statements and description not warranties.	ns in this enrollment form	n are deemed to	be representations and				
I certify that I have read the Terms I accept them and will abide by the Enrollment Form is true and com	nem. I further certify tha	t the information	provided in the				
Print Name of Applicant:							
Signature of Applicant or Author	ized Representative:	Today's Date:					
		MM - DD -	Signature				
Authorized Representative Info If you are the authorized represe etc.), you must sign above and p	entative (Responsible Pa	•	corney, Family Member,				
Name		Date _					
Address	City	State _	Zip code				
Relationship to Enrollee							

