



**Construction Industry Laborers Welfare Fund
 UnitedHealthcare Group Medicare Advantage Election Form**

Effective date: 1/1/2024

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

Last Name	First Name	Middle Initial
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Birth Date	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Home phone number () -	Mobile phone number () -	Medicare Number
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Permanent Residence street address (P.O. Box is not allowed)

Street address

City	County	State	ZIP code
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Mailing address (Only if it's different from above. You can give a P.O. Box)

Mailing address

City	County	State	ZIP code
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ATTENTION - please sign and date

I understand that my signature on this enrollment request form means that I have read and understood the contents of this enrollment request form, 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 form means that I will automatically be 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
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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.

Signature	Today's date
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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
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<input type="checkbox"/> Authorized representative, check here if you signed above and assisted in completing this form.	Relationship to applicant
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