Missing/Incomplete Application Update Request Form

Please complete ALL required fields marked with an asterisk (*) and mark the CheckBox ( ) for information that needs to be updated on the application.

☐ ***Enrollee Name:**

First: ______ **MI:** ___ **Last:** ______

☐ ***Date of Birth:** ______

☐ Member ID: ______

☐ ***Medicare Claim Number:** ______

☐ Medicare Part A Effective Date: ______

☐ Medicare Part B Effective Date: ______

☐ Proof of Medicare A (Copy of Award Letter or Medicare Card

☐ Proof of Medicare B (Copy of Award Letter or Medicare Card

☐ ***Agent Name:** ______

☐ ***Agent ID:** ______

☐ ***Contact Name:** [Required if you are not the Agent of Record (AOR)] ______

☐ ***Email Address:** (Where to send response) ______

☐ Effective Date: ______

☐ Election Period: ______

When using SEP, provide SEP reason: ______

☐ Plan Selection: ______

☐ Plan Contract/PBP: ______

☐ Permanent Address:

City: ______ State: ___ Zip: ___

☐ Phone Number: ______

☐ Mailing Address:

City: ______ State: ___ Zip: ___

Please check the appropriate box: ☐ Application Status ☐ Missing Information / Verification Requested ☐ AOR Verification / Update ☐ *Other*

Please be specific in what action is needed or what update/changes are being requested:

______

☐ **Supporting Documents Attached**

****All emails containing Personal Health Information (PHI) or Personally Identifiable Information (PII) must be encrypted using Secure Email Delivery before transmitting.**

Please remit this form to ICSSUPPORT@UHC.COM or fax to 866-802-6062

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THIS FORM IS FOR AGENT USE ONLY FOR MA/MAPD & PDP PLANS

This form cannot be used for Medicare Supplement Plans

1/30/2012