



Missing / Incomplete Application Update Request Form

FOR AGENT USE ONLY - FOR MA/MAPD AND PDP PLANS

This form cannot be used for Medicare Supplement

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

1. Enrollee Information

* First: * MI: * Last Name:

Phone: *DOB:

Permanent Address:

Street #: PO Box #: Street Name:

City: State: Zip Code

Mailing Address:

Street #: PO Box #: Street Name:

City: State: Zip Code

Medicare Information

* Medicare #: Part A Date: Part B Date:

2. Plan Information

Plan Name: Plan H-PBP (Contract):

Effective Date: Election Period:

SEP Reason (if applicable):

3. Agent/Submitter Information

* Agent Name: * Agent ID:

* Contact Name (if applicable):

* Email: * Party ID or Tax ID:

3. Reason for Submission

Please provide a brief description of the reason for your submission.



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4. How to Submit Request

Note: Attachments must be in .PDF format

Email to: MandREnrollment@uhc.com

All emails containing Personal Health Information (PHI) must be encrypted using Secure Email Delivery before transmitting.

Fax to: 866-802-6062