How to Use Cisco Secure Email for Agent Change Request Forms

for AARP® Medicare Supplement Insurance Plans from UnitedHealthcare®

Follow these helpful tips to ensure you are sending Agent Change Request forms to UnitedHealthcare properly through Cisco secure email:

1. Make sure you have access to Cisco Secure Email.

If you need access, please send a request to the Producer Help Desk (PHD) at PHD@uhc.com. The PHD will send a secure email in reply, which will enable you to access and register to use UnitedHealthcare's secure email service. Please do not send any email attachments as part of your request.

NOTE: If you have received and opened a secure email from the PHD in the past and previously registered to use UnitedHealthcare's secure email service via https://res.cisco.com, you do not need to send an additional request for access.

2. Only Cisco Secure Email can be used to send Agent Change Request forms to UnitedHealthcare.

Refer to the forms for the specific email address to send the applicable form and attachments. Emails from a different secure email product cannot be processed.

3. Do not submit AARP Medicare Supplement Plan applications to UnitedHealthcare via Cisco Secure email.

Only Agent Change Request forms and their supporting documentation can be sent.

4. Do not protect each individual attachment.

Simply attach items to Cisco secure email. UnitedHealthcare cannot process protected attachments.

5. All attachments must be in a .JPG, .PDF or .TIF format.

No other formats will be accepted.

Thank you for your help in keeping member's personal information safe!

Remember, the Cisco secure email capability is only available for the following forms, found on Jarvis under Enrollments > Application Status: AARP Med Supp General Information Change - Form 1, AARP Med Supp Insured Information Change – Form 2, AARP Med Supp Back Termination and Refund Request – Form 3, AARP Med Supp Pending Apps – Form 4, AARP Med Supp Plan Changes – Form 4 for Plan Changers.

AARP® Medicare Supplement from UnitedHealthcare®

Print Form • Fax to BILLING 248-524-7543 or via **Cisco secure** email to uhgeagentbill@prod.exelaonline.com. Only attachments in these formats are accepted: PDF, JPG, TIF.

AARP Medicare Supplement Back Termination and Refund Request (Form 3)

Do NOT use for Pending Enrollment Applications

Use this form to request a backdated AARP Medicare Supplement Plan termination date when the insured member was also covered under an MA/MAPD or another Medicare Supplement Plan during the same period of time. Please complete ALL required fields marked with an asterisk (*) and mark the ( ) for information that needs to be updated on the insured member's account.

***Insured Member Name:**

***First:** _____ **MI:** ____ ***Last:** _____

***AARP Membership Number:** _____

***Date of Birth** _____

***Agent Name:** _____

***Agent ID:** _____

***Agent e-mail:** _____

***Agent Phone number:** _____

***Name of Agent/Agency Representative** _____

Back Date Termination and Refund Request

This form can only be used when the insured member's AARP Medicare Supplement Plan coverage overlapped coverage under an MA/MAPD or another Medicare Supplement Plan. Do not use this form to request a termination and refund related to other plan coverage(s).

Please direct the insured member to contact UnitedHealthcare Customer Service for additional assistance.

Must include proof of other MA/MAPD or Medicare Supplement coverage (e.g. confirmation letter or ID card showing effective date).

☐ **Check here if the overlapped coverage was a UnitedHealthcare MA/MAPD plan.**
Note: If checked, no supporting document is required ***at the time of this request.***

Requested Plan Termination Date _____
(mm/dd/yyyy)

I, the undersigned, wish to terminate my AARP Medicare Supplement Plan on the date listed above due to overlapping MA/MAPD or Medicare Supplement coverage.

I have included proof of my other coverage (e.g. MA/MAPD or Medicare Supplement coverage confirmation letter or ID card showing effective date).

I understand this is a request for consideration to back terminate my plan and issue applicable refunds. Requests will only be considered upon receipt of appropriate supporting documentation. Requests without supporting documentation or required signatures below will not be considered.

_____ _____
Insured Member or Authorized Representative Signature **Date**

_____ _____
Agent Or Agent/Agency's Representative Signature **Date**

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THIS FORM IS FOR AGENT USE ONLY FOR AARP MEDICARE SUPPLEMENT INSURANCE PLANS
Do not add fields or handwritten comments to this document.
This form cannot be used for MA or PDP or any other UnitedHealthcare Plans