



## 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](mailto:MandREnrollment@uhc.com)

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

**Fax to:** 866-802-6062