



Plan “Opt Out” Form

Complete this form if you want to continue to receive coverage from UnitedHealthcare and opt out of the HealthConnections Prime Program. Please return this form by December 31, 2018.

Member information

Member Name _____

Address _____

City _____ ST _____ Zip Code _____

County _____

Member ID _____ Email address _____

Phone number _____ Alternate phone _____

Emergency contact information

Emergency contact name _____

Emergency contact phone number _____

Authorized representative information

If you are completing this form for the member, please provide the following information and sign and date below:

Full name _____

Address _____

City _____ State _____ ZIP _____

Phone number _____

Relationship to member _____

Signature _____ Date _____

Signature

I am providing written notice that I want to keep my coverage from UnitedHealthcare and opt out of the HealthyConnections Prime Program.

Signature _____ **Date** _____

My signature (or my authorized representative's signature) on this form means that I've read and understood this form. If an authorized representative signs, the person's signature means that he or she is authorized under state law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or South Carolina Medicaid.

Ready to send the completed form?

Mail the completed and signed form to:

PO Box 1225

Newberry, SC 29108

Questions? We're here to help?

If you need help completing this form, call the toll-free Customer Service on the back of your member ID card.