



GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES

DIVISION OF PERSONNEL



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Orange Grove Shopping Center Bay
Nos. 6, 7, 8
Christiansted, St. Croix, V.I. 00820
Phone (340) 718-8588
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UHC Post 65 Enrollment Form

Please Print

Primary/Dependent (circle one)

Retiree Name:

If Dependent, please provide Primary's Name and SS #:

Social Security #:	DOB:	Gender:
Date of Retirement:	Medicare ID #:	
Part A Date:	Part B Date:	

UnitedHealthcare® Group Medicare Advantage (PPO) plan

Mailing Address:

City:	State:	ZIP:
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Physical Address:

Work Phone:	Cell #:	Home Phone:
Email:	Alternate Email:	

My signature at the end of this statement certifies the accuracy of the preceding information and confirms my request to enroll in the United Health Care Medicare Supplement Plan requested above. I understand my information is protected by privacy laws and will be released only in accordance with applicable laws.

Signature	Date Complete:
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DOP Official Use Only

Date Received:	Rec'd by:
Change made on:	Change made by: