

Statement Date: May 4, 2026



**the Benefits Site**  
benefitsenroll.uhg.com

VICTOR A. REINHART  
7462 BRIAN LANE  
LA PALMA CA 90623



**3 ways to get the Alight mobile app:**

1. Text 'Benefits' to 67426 (U.S. Only)
2. Visit <http://alight.com/app>
3. Scan the QR code with your phone



## Request for Employment Information

### WHAT IS THE PURPOSE OF THIS FORM?

You or one of your covered dependents is potentially Medicare eligible, and as a result of your change in employment status, could be eligible to enroll in Medicare Part B, if not already enrolled, as part of a Special Enrollment Period.

To apply for Medicare in a Special Enrollment Period, you must have or had group health plan coverage within the last 8 months through your or your spouse's current employment. People with disabilities must have large group health plan coverage based on your, your spouse's or a family member's current employment.

This form is used for proof of group health care coverage based on recent employment. This information is needed to process your Medicare enrollment application.

Note: A late enrollment penalty won't apply if you sign up for Medicare Part B during the Special Enrollment Period. If you don't sign up during the Special Enrollment Period, your next opportunity to enroll will be during the Medicare General Enrollment Period of January 1 – March 31 and your coverage will begin the first day of the month after you sign up. This may cause a gap in health coverage and you may have to pay a lifetime late enrollment penalty.

If you require UnitedHealth Group data for dates prior to those provided on this form, contact 844-755-2844.

### WHAT DO I DO WITH THE FORM?

Both Sections A and B have been completed for you, with the exception of your Social Security Number. Enter your Social Security Number and take this form, along with your Application for Enrollment in Medicare (CMS-40B), to your local Social Security office. You can find your local office here: [www.ssa.gov](http://www.ssa.gov).

If you are still within your 7-month initial enrollment period for Medicare Part B, you may not need this form, as the special enrollment period will not apply to you. You can confirm this with Social Security.

## Questions?



**Online:**  
[benefitsenroll.uhg.com](http://benefitsenroll.uhg.com)



**Phone:**  
844-755-2844  
7:00 a.m. to 7:00 p.m. CT, Monday - Friday.



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**REQUEST FOR EMPLOYMENT INFORMATION****SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance)**

1. Employer's Name UnitedHealth Group	2. Date 0 5 / 0 4 / 2 0 2 6
3. Employer's Address P.O. Box 64116	
City The Woodlands	State T X      Zip Code 7 7 3 8 7
4. Applicant's Name VICTOR REINHART	5. Applicant's Social Security Number 5 4 9 - 1 3 - 9 3 6 0
6. Employee's Name VICTOR REINHART	7. Employee's Social Security Number 5 4 9 - 1 3 - 9 3 6 0

**SECTION B: To be completed by Employers  
For Employer Group Health Plans ONLY:**

1. Is (or was) the applicant covered under an employer group health plan?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2. If yes, give the date the applicant's coverage began. (mm/yyyy)	0 9 / 2 0 1 9
3. Has the coverage ended?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. If yes, give the date the coverage ended. (mm/yyyy)	/
5. When did the employee work for your company?	
From: (mm/yyyy) 0 8 / 2 0 1 9	To: (mm/yyyy) /
	Still Employed: (mm/yyyy) 0 5 / 2 0 2 6
6. If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.	
From: (mm/yyyy) /	To: (mm/yyyy) /

**For Hours Bank Arrangements ONLY:**

1. Is (or was) the applicant covered under an Hours Bank Arrangement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. If yes, does the applicant have hours remaining in reserve?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Date reserve hours ended or will be used? (mm/yyyy)	/

**All Employers:**

Signature of Company Official : Lisa Burkley	Date Signed 0 5 / 0 4 / 2 0 2 6
Title of Company Official Client Manager	Phone Number ( 8 4 4 ) 7 5 5 - 2 8 4 4

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0787. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850.