





2025 Enrollment Request Form

☐ Erickson Advantage Liberty (HMO-POS) H5652-008-000

Select optional supplemental benefits in addition to what is included with your plan

You can add the following benefit rider for an extra cost. You can purchase the rider now while you are enrolling, or within 3 months after your effective date. See the Summary of Benefits for more information, including costs.

☐ Platinum Dental Rider					
Information about you (Please	type or pri	nt in black or l	olue ink)	
Last name	First name			Middle initial	
Birth date	Sex □ Male □ Fema		е		
Home phone number ()	_	Mobile phone	number	() –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	hone nui	mber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be co	•				
City	County		State	Zip code	
Mailing address (Only if it's differen	t from above	e. You can give	a P.O. bo	ox.)	
City			State	Zip code	
Email address (optional)					
Enrollee nameAgent name/ID number					
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Do you have other insurance (Examples: Other private insura programs.) If yes, what is it?	• • •	•	☐ Yes ☐ No benefits or state	
Name of other insurance				
Member number	Group number	RxBin	RxPCN (optional)	
Answering these questions is fill them out.	your choice. You can't be de	enied coverage b	ecause you don't	
How do you want to pay? If you have a monthly plan prer pay your premium by automatic Board (RRB) benefit check each Electronic Funds Transfer (EFT)	nium (including any late enroll c deduction from your Social S ch month. You can also pay fro	Security or Railroa	d Retirement	
If you don't choose an option b	elow, we'll send a bill each mo	onth to your mailir	ng address.	
If you must pay a Part D-Incom	e Related Monthly Adjustment	Amount (Part D-I	RMAA),	
Social Security (SS) will send y	ou a letter and ask you how yo	u want to pay it:		
☐ You can pay it from you	r SS check			
☐ Medicare can bill you	☐ Medicare can bill you			
☐ The Railroad Retiremen	t Board (RRB) can bill you			
☐ I want to pay from my Social	Security check			
☐ I want to pay from my Railro	ad Retirement Board (RRB) ch	neck		
☐ I want to pay directly from a bank account				
Account type ☐ Checking ☐ Savings				
Account holder name:	Account holder name:			
Bank routing number/				
	Bank account number////			
A few questions to help u	s manage your plan			
1. Would you prefer plan info	rmation in another language	or an accessible	format?	
	rmation in another language or Braille		•	
Enrollee name				
Agent name/ID number				
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If you don't see the language or format you want, please call us toll-free at **1-844-723-6473**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **EricksonAdvantage.com** for online help.

2. Are you Hispanic, Latino/a, or Spanish				
No, not of Hispanic, Latino/a, or Sp.	•			
Yes, Mexican, Mexican American, or Chicano/a Yes, Puerto Rican				
Yes, another Hispanic, Latino, or Sp	panish origin			
I choose not to answer				
0.44				
3. What's your race? Select all that apply.	•			
American Indian or Alaska Native	Black or African American			
Asian:	Native Hawaiian or Pacific Islander:			
Asian Indian	Guamanian or Chamorro			
Chinese	Native Hawaiian			
Filipino				
Japanese Other Pacific Islander				
Korean				
Vietnamese	White			
Other Asian	I choose not to answer			
Member/Citizen of a federal or state	recognized Tribe (name of Tribe)			
4. What is your gender? Select one.				
Woman	I use a different term:			
Man				
Non-binary	I choose not to answer			
5. Which of the following best represents	how you think of yourself? Select one.			
Lesbian or gay	I use a different term:			
Straight, that is, not gay or lesbian	I don't know			
Bisexual	I choose not to answer			
6. Do you or your spouse work?		☐ Yes ☐ No		
		_ 100 _ 110		
Do you or your spouse have other health in:				
(Examples: Other employer group coverage auto liability, or Veterans benefits)	e, LTD coverage, workers Compensation,	☐ Yes ☐ No		
		□ res □ No		
If yes, please complete the following:				
Enrollee name				
Agent name/ID number				
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Nam	ne of health insurance company	
Men	nber number	
7. Ple	ease give us the name of your primary ca	re provider (PCP), clinic or health center.
You c	can find a list on the plan website or in the F	Provider Directory.
Provid	der or PCP full name	
	der/PCP number	(Please enter the number exactly as it appears on the website or in the Provider Directory. It will be 10 to 12 digits. Don't include dashes.)
Are y	ou now seeing or have you recently seen th	nis provider?
your You v an em Chan	plan communications. vill get many of your required plan communation when new communications (For examples) are available online. You can access the plan communication with the plan in	cally enrolls you in paperless delivery for some of nications delivered electronically. We will send you ble: Explanation of Benefits or the Annual Notice of hese communications through any device such as a
	outer, tablet or mobile phone.	
-		ed materials mailed to you, please check here:
sor		hard copies of required materials. Please note that y not fit in all mailboxes. You can change your
Plea	se read and sign	
Вусс	ompleting this form, I agree to the followi	ng:
F I t U	paying my Part B premium if I have one, un understand that people with Medicare are the country, except for limited coverage near urgent care outside of the U.S. See the Sun understand that when my UnitedHealthcar prescription drug benefits from UnitedHealt UnitedHealthcare and contained in my UnitedHealthcare.	generally not covered under Medicare while out of ar the U.S. border. This plan covers emergency and

Enrollee name	
Agent name/ID number	
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□ I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and

that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions

nor UnitedHealthcare will pay for benefits or services that are not covered.

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	ollee name nt name/ID number				
	r individuals helping enrollee with com		y		
Pho	one number () —	Relationship to applican	t		
City	/	State	Zip code		
Add	dress				
Las	t name	First name			
_	ormation below (*Not a Sales Agent)	please sign above an	d complete the		
If I s sho und beh reco Uni	en I sign below, it means that I have read and sign as an authorized representative, it means low written proof (power of attorney, guardiansh derstand that I will need to submit written proof half of the member beyond this application. Afterived my UnitedHealthcare UCard®, I can call tedHealthcare UCard to update my authorization nature of applicant/member/authorized representations.	have the legal right unde ip, etc.) of this right if Med of this right, to the plan, it er this application has been customer Service at the number information on file.	r state law to sign. I can dicare asks for it. I f I wish to take action on en approved and I have		
 The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan. My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. 					
	information (see Privacy Act Statement below). I give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health plan.				
	apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA) plans). Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this				

•	if you're an individual (rd parties) helping an e	. •			ounselors, family
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sale	es Representative/a	agenc	y u	se only	
Licensed Sales representative/Writing ID			Initial receipt date		e
Licensed Sales repres	sentative/agent name			Proposed effective date	
Employer group name	9				
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees) ☐ e		□ IEP (MA-PD enrollees eligible for end IEP)		☐ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS	□ SE reside □ AE		P (Change in ence) P (October 15-	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _	maintaining)			mber 7)	
Licensed Sales repre	esentative signature (o	ptiona	ıl)		Date
	Please mail or fax	this co	omp	oleted form to:	
Enrollee name Agent name/ID numbe					
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UnitedHealthcare P.O. Box 30770 Salt Lake City, UT 84130-0770

Fax: 1-888-950-1170

Fax the front and back of each page

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Erickson Advantage Liberty (HMO-POS) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

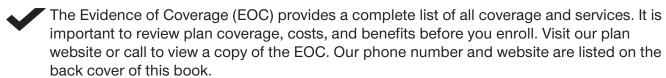
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

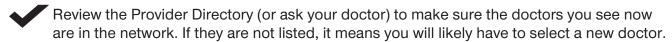
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

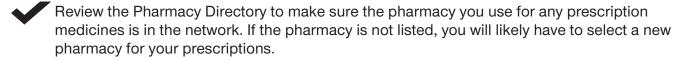
Enrollment checklist

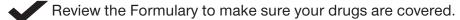
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





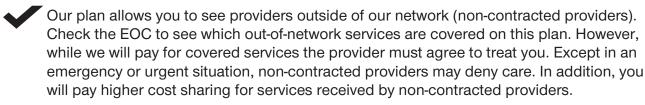




Understanding important rules







Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.