





# **2025** Enrollment Request Form

☐ Erickson Advantage Champion (HMO-POS C-SNP) H5652-004-000

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 bl	lue ink)	
Last name	First name			Middle initial
Birth date		Sex □ Male □	Female	е
Home phone number ( )	ome phone number ( ) — Mobile phone number ( ) —			) —
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			one nur	nber(s) I have provided
Medicare number				
Permanent residence street address homelessness, a PO Box may be co	-			
City	County	5	State	Zip code
Mailing address (Only if it's different	t from above	e. You can give a	P.O. bo	x.)
City		5	State	Zip code
Email address (optional)		<u> </u>		
Enrollog namo				
Enrollee nameAgent name/ID number				
V0066 EREMA 2025 C				EREX25HP0220567_000

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 premium (including any late enrollment penalty you may owe), you can pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT).				
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-II	RMAA),	
Social Security (SS) will send y	ou a letter and ask you how yo	ou want to pay it:		
☐ You can pay it from your SS check				
☐ 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:				
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				
Y0066_ERFMA_2025_C		ERE.	X25HP0220567_000	

If you don't see the language or format you want, please call us toll-free at **1-866-367-7527**, 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, c	or Chicano/a				
Yes, Puerto Rican					
	Yes, Cuban				
Yes, another Hispanic, Latino, or Sp	oanish origin				
I choose not to answer					
3. What's your race? Select all that apply	<b>'.</b>				
American Indian or Alaska Native	Black or African American				
Asian:	Native Hawaiian or Pacific Islander:				
Asian Indian	Guamanian or Chamorro				
Chinese	Native Hawaiian				
Filipino	Samoan				
Japanese	Other Pacific Islander				
Korean					
Vietnamese	White				
Other Asian	I choose not to answer				
Member/Citizen of a federal or state	e 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	s 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?	1	□ Yes □ No			
Do you or your spouse have other health in	surance that will cover medical services?				
(Examples: Other employer group coverage					
auto liability, or Veterans benefits)		∃ Yes □ No			
If yes, please complete the following:					
Enrollee name					
Agent name/ID number					
V0066 EREMA 2025 C	EREY25HD023	20567 000			

	Page 4 of 8
Name of health insurance company	
Member number	
7. Please give us the name of your pri	mary care provider (PCP), clinic or health center.
You can find a list on the plan website o	or in the Provider Directory.
Provider or PCP full name	
Provider/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 you now seeing or have you recently	y seen this provider? ☐ Yes ☐ No
Providing your email address above a your plan communications.	utomatically enrolls you in paperless delivery for some of
an email when new communications (Fo	communications delivered electronically. We will send you or example: Explanation of Benefits or the Annual Notice of access these communications through any device such as a
If you would rather have hard copies o	of required materials mailed to you, please check here:
	mail you hard copies of required materials. Please note that and may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the	e following:
paying my Part B premium if I have  I understand that people with Medi the country, except for limited cove	and Medical (Part B) to stay in UnitedHealthcare. I must keep one, unless Medicaid or someone else pays for it. I care are generally not covered under Medicare while out of erage near the U.S. border. This plan covers emergency and the Summary of Benefits for more information.

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.

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 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.  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.  When I sign below, it means that I have read and understand the information on this form  If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard*, I can call Customer Service at the number on my UnitedHealthcare UCard* and understand the information on file.  Signature of applicant/member/authorized representative Today's date  If you are the authorized representative, please sign above and complete the information below (*Not a Sales Agent)  Last name  Address  City State Zip code  Phone number ( ) — Relationship to applicant  For individuals helping enrollee with completing this form only		apply for MA Private Fee-for-Service (PFFS), N	MA Medicare Medical Sav	ings Account (MSA)	
□ 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. □ 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. □ My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. □ My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. □ My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. □ My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. □ My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. □ My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. □ My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. □ My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. □ If it is ign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof of this right to the plan. □ If it is ign as an authorized as an authorized and understand the information on this form on my UnitedHealthcare UCard*, I can call Customer Service at the number on my UnitedHealthcare UCard*, I can call Customer Service at the number on my UnitedHealthcare UCard*, I can call Customer Service at the number on my UnitedHealthcare UCard*, I can call Customer Service at the number on my UnitedHealthcare UCard*, I can call Customer Service at the number on my UnitedHealthcare UCard*, I can call Customer Service at the number on my UnitedHealthcare UCard*, I can ca		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			
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If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard. I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file.  Signature of applicant/member/authorized representative  If you are the authorized representative, please sign above and complete the information below (*Not a Sales Agent)  Last name  First name  Address  City  State  Zip code  Phone number ( ) —  Relationship to applicant  For individuals helping enrollee with completing this form only  Enrollee name  Agent name/ID number		The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. However,	form I will be disenrolled	from the plan.	
show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file.  Signature of applicant/member/authorized representative	Wh	en I sign below, it means that I have read an	d understand the inform	ation on this form	
Information below (*Not a Sales Agent)  Last name First name  Address  City State Zip code  Phone number ( ) — Relationship to applicant  For individuals helping enrollee with completing this form only  Enrollee name Agent name/ID number	sho und beh reca Uni	www.ritten proof (power of attorney, guardiansh derstand that I will need to submit written proof nalf of the member beyond this application. Aft eived my UnitedHealthcare UCard®, I can call tedHealthcare UCard to update my authorizati	nip, etc.) of this right if Med f of this right, to the plan, i er this application has bee Customer Service at the n on information on file.	dicare asks for it. I  f I wish to take action on en approved and I have umber on my	
Address  City State Zip code  Phone number ( ) — Relationship to applicant  For individuals helping enrollee with completing this form only  Enrollee name Agent name/ID number	_		please sign above an	d complete the	
City  State  Zip code  Relationship to applicant  For individuals helping enrollee with completing this form only  Enrollee name  Agent name/ID number	Las	t name	First name		
Phone number ( ) — Relationship to applicant  For individuals helping enrollee with completing this form only  Enrollee name Agent name/ID number	Add	dress			
For individuals helping enrollee with completing this form only  Enrollee name  Agent name/ID number	City	/	State	Zip code	
Enrollee nameAgent name/ID number	Pho	one number ( ) —	Relationship to applican	t	
Agent name/ID number	For	r individuals helping enrollee with con	npleting this form onl	у	
Agent name/ID number	Enro	ollee name			
(DOCC 11) NA DOCC () EDEVOCIDO 0000 000 000 000 000 000 000 000 000	Age:				

Complete this section members, or other thin	•	•	_		ounselors, family
				ship to enrollee	
Signature		Natio	onal l	Producer Number	(Agents/Brokers only)
For Licensed Sale	s Representative/a	agen	icy u	ise only	
Licensed Sales repres	entative/Writing ID		Initial receipt date		е
Licensed Sales repres	entative/agent name			Proposed effective date	
Employer group name	)				
Employer group ID			В	Branch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees) ☐ en		enro	P (MA-PD llees eligible for	☐ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	resider □ AEP		EP (Change in	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _				·	
Licensed Sales repre	sentative signature (d	option	nal)	- 1	Date
	Please mail or fax	this	com	pleted form to:	
Enrollee nameAgent name/ID number					
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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 Champion (HMO-POS C-SNP) 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.

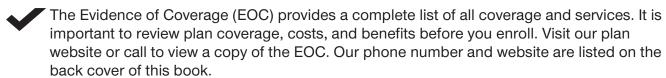
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

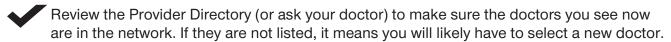
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

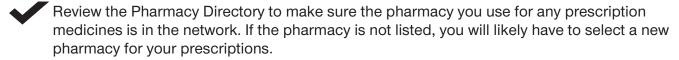
## **Enrollment checklist**

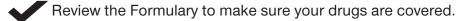
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

### **Understanding the benefits**

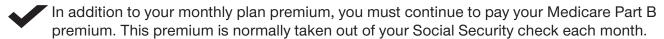


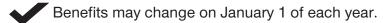


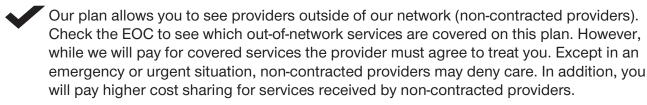




#### **Understanding important rules**







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.

This plan is a Chronic Condition Special Needs Plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.