





## **2025 Enrollment Request Form**

☐ Erickson Advantage Guardian (HMO-POS I-SNP) H5652-003-000

Information about you (Please	type or pri	nt in black or l	olue ink	)	
Last name	First name			Middle initial	
Birth date		Sex □ Male [	☐ Femal	e	
Home phone number ( )	_	Mobile phone i	number (	( ) –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		-	hone nur	mber(s) I have provided	
Medicare number					
Permanent residence street address (Don't enter a P.O. box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address)					
City	County		State	Zip code	
Mailing address (Only if it's different from above. You can give a P.O. box.)					
City			State	Zip code	
Email address (optional)					
Enrollee name					
Agent 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 your choice. You can't be denied coverage because you don't fill them out.					
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					
☐ The Railroad Retirement Board (RRB) can bill you					
☐ I want to pay from my Social	Security check				
☐ I want to pay from my Railroad Retirement Board (RRB) check					
☐ 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   Large print   Audi		•		
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 **1-855-544-4342**, 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 Spanish origin						
Yes, Mexican, Mexican American, or Chicano/a						
	Yes, Puerto Rican					
	Yes, Cuban					
Yes, another Hispanic, Latino, or Sp	panish origin					
I choose not to answer						
3. What's your race? Select all that apply.						
American Indian or Alaska Native	Black or African Ame	rican				
Asian:	Native Hawaiian or Pacific	Islander	· ·			
Asian Indian	Guamanian or Cham	orro				
Chinese	Native Hawaiian					
Filipino	Samoan					
Japanese	Other Pacific Islande	<del>)</del> r				
Korean						
Vietnamese	White					
Other Asian	I choose not to answ	ver				
Member/Citizen of a federal or state	recognized Tribe (name of T	ribe)				
4. What is your gender? Select one.						
Woman	I use a different ter	m:				
Man						
Non-binary	Non-binary I choose not to answer					
5. Which of the following best represents	how you think of yourself?	Select o	ne.			
Lesbian or gay	I use a different te	rm:				
Straight, that is, not gay or lesbian	I don't know					
Bisexual	I choose not to a	nswer				
6. Do you live in a nursing home, long-term	m care facility, or a senior c	ommuni	ty? □ Yes □ No			
If yes, please give us information on the nur	rsing home, long-term care fa	cility, or	senior community:			
Name						
Address	City	State	Zip code			
	Oity	Otato	210 0000			
Enrollee name						
Agent name/ID number						
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Бу (	completing this form, ragree to the following:	
	I must keep both Hospital (Part A) and Medical (Part B) paying my Part B premium if I have one, unless Medical I understand that people with Medicare are generally not the country, except for limited coverage near the U.S. by	id or someone else pays for it. ot covered under Medicare while out
	ollee name	
4ger	ent name/ID number	
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	I understand that when my UnitedHealthcare		•				
	prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document						
	(also known as a member contract or subscriber agreement) will be covered. Neither Medicare						
nor UnitedHealthcare will pay for benefits or services that are not covered.							
that enrollment in this plan will automatically end my enrollment in another MA plan (exception							
	apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA)						
	plans). <b>Release of information:</b> By joining this Medic	care Advantage Plan I acl	knowledge that the plan				
	will share my information with Medicare, who		•				
	payments, and for other purposes allowed by	•					
	information (see Privacy Act Statement below						
	I give UnitedHealthcare permission to share r	•	nation with organizations				
	or person(s) for permissible purposes under a	applicable law as required	to administer my health				
	plan.						
	The information on this form is correct to the	,					
	intentionally provide false information on this		·				
	My response to this form is voluntary. However	er, failure to respond may	affect enrollment in the				
	plan.						
Wh	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						
rec	eived my UnitedHealthcare UCard®, I can call (	Customer Service at the n	umber on my				
Uni	tedHealthcare UCard to update my authorizati	on information on file.					
Signature of applicant/member/authorized representative Today's date							
If y	ou are the authorized representative,	please sign above an	d complete the				
inf	ormation below (*Not a Sales Agent)						
Las	t name	First name					
Add	dress						
City	/	State	Zip code				
		1	1				
Enro	llee name						
_	nt name/ID number						
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Phone number ( ) — Relationship to applicant
--

	<b>nelping enrollee with</b> on if you're an individual	-	_	-		
•	third parties) helping an	. •		ouriseiors, fairilly		
Name		Relationship to enrollee				
Signature		National	National Producer Number (Agents/Brokers only)			
For Licensed Sa	les Representative/	agency i	use only			
Licensed Sales rep		Initial receipt dat	e			
Licensed Sales rep		Proposed effective date				
Employer group na	me		1			
Employer group ID		E	Branch ID			
Agent must compl ☐ IEP (MA-PD enrollees)	ete □ ICEP (MA enrolle	•	EP (MA-PD Illees eligible for IEP)	□ OEP (Jan 1 – Mar 31)		
☐ OEP (Newly eligible)	☐ SEP (Dual LIS change of status)	□s	EP (Change in dence)	☐ SEP (Loss of EGHP coverage)		
Enrollee name						
Agent name/ID num	ber					
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☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)	☐ AEP (October 15- December 7)	□ OEPI
☐ SEP (SEP reason) _	0,	·	
Licensed Sales repre	Date		

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 Guardian (HMO-POS I-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.

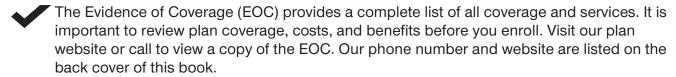
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

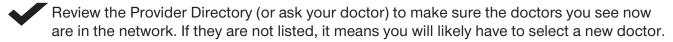
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

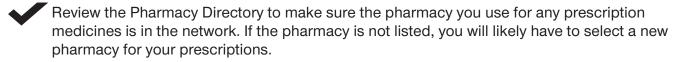
## **Enrollment checklist**

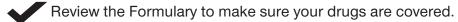
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## **Understanding the benefits**





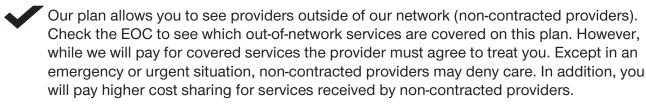




## **Understanding important rules**







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 an Institutional Special Needs Plan (I-SNP). Your ability to enroll will be based on verification that you, for 90 days or longer, have had or are expected to need the level of services provided in a skilled nursing facility, a nursing facility, an intermediate care facility for individuals with intellectual and developmental disabilities, a psychiatric hospital or unit, a rehabilitation hospital or unit, a long-term care hospital, a swing-bed hospital or a facility approved by CMS that furnishes similar services. Or you live in a senior community and our plan has obtained certification that you need the type of care that is usually provided in a nursing home.