PHLA25HP0221121_000



A UnitedHealthcare Company

Enrollee name ___

Agent name/ID number _ Y0066 ERFMA 2025 C

2025 Enrollment Request Form

☐ Peoples Health Medicare Advantage Giveback LA-4 (HMO-POS) H1961-020-000 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 print in black or blue ink) Last name First name Middle initial Sex ☐ Male ☐ Female Birth date Home phone number (Mobile phone number (☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology. 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 Parish 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)

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			
☐ 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 I	☐ 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			
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If you don't see the language or format you want, please call us toll-free at **1-844-849-2591**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **peopleshealth.com** for online help.

2. Are you Hispanic, Latino/a, or Spanish		
No, not of Hispanic, Latino/a, or Sp.	•	
Yes, Mexican, Mexican American, o	r Chicano/a	
Yes, Puerto Rican		
Yes, Cuban		
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	Samoan	
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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Name of health insurance company	-	
Member number		
7. Please give us the name of your primary care	provider (PCP), clinic or health center.	
You can find a list on the plan website or in the Pr	ovider 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 seen this	s provider?	
your plan communications. You will get many of your required plan communications (For example)	cations delivered electronically. We will send you e: Explanation of Benefits or the Annual Notice of ese communications through any device such as a	
If you would rather have hard copies of require	d materials mailed to you, please check here:	
☐ Instead of paperless delivery, we will mail you had some communications are very large and may preference for delivery at any time.	nard copies of required materials. Please note that not fit in all mailboxes. You can change your	
Please read and sign		
By completing this form, I agree to the following	g:	
paying my Part B premium if I have one, unled I understand that people with Medicare are go the country, except for limited coverage near urgent care outside of the U.S. See the Summary I understand that when my Peoples Health corprescription drug benefits from Peoples Health and contained in my Peoples Health "	generally not covered under Medicare while out of 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

Health will pay for benefits or services that are not covered.

apply for MA Private Fee-for- plans).	Service (PFFS), MA Medicare Me	edical Savings Account (MSA)
Release of information: By will share my information with	th Medicare, who may use it to tra poses allowed by Federal law tha	
☐ I give Peoples Health permis	•	h information with organizations or equired to administer my health
The information on this form intentionally provide false in	is correct to the best of my know formation on this form I will be dis voluntary. However, failure to resp	3
When I sign below, it means that	at I have read and understand t	ne information on this form
show written proof (power of attounderstand that I will need to sub	orney, guardianship, etc.) of this romit written proof of this right, to is application. After this application Card®, I can call Customer Service my authorization information of	the plan, if I wish to take action on on has been approved and I have be at the number on my
If you are the authorized reinformation below (*Not a S		above and complete the
Last name	First name	
Address		
City	State	Zip code
Phone number ()	_ Relationship to	o applicant
For individuals helping enr	ollee with completing this	form only
Enrollee name		
Agent name/ID number		DHI A25HD0221121 000

•	n if you're an individual (ird parties) helping an e				ounselors, family	
		Relat	Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)				
For Licensed Sale	es Representative/a	ageno	cy u	se only		
Licensed Sales representative/Writing ID			Initial receipt date			
Licensed Sales representative/agent name				Proposed effective date		
Employer group nam	е					
Employer group ID			В	ranch ID		
Agent must complet ☐ IEP (MA-PD enrollees)	te □ ICEP (MA enrollee	é	nrol	P (MA-PD lees eligible for	□ OEP (Jan 1 – Mar 31)	
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS	2nd IEP) ☐ SEP (Change in residence) ☐ AEP (October 15-		P (Change in ence) P (October 15-	☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ SEP (SEP reason)	maintaining)	L	ece	mber 7)		
Licensed Sales repr	esentative signature (o	ption	al)		Date	
	Please fax this	com	olete	ed form to:		
Agent name/ID numbe Y0066_ERFMA_2025_C	er				PHLA25HP0221121_000	

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, 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.

Peoples Health Medicare Advantage Giveback LA-4 (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.

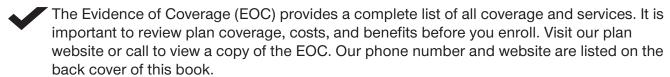
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

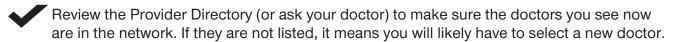
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

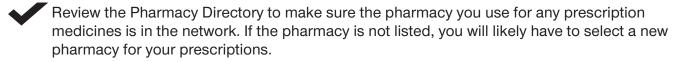
Enrollment checklist

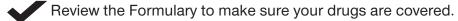
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

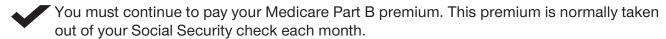


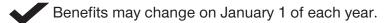


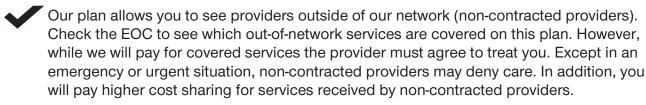




Understanding important rules







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.