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A UnitedHealthcare Company

Y0066 ERFMA 2025 C

## **2025 Enrollment Request Form**

☐ Peoples Health Choices Gold (HMO-POS) H1961-017-000 Information about you (Please type or print in black or blue ink) Middle initial Last name First name Birth date Sex ☐ Male ☐ Female 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 Zip code State Mailing address (Only if it's different from above. You can give a P.O. box.) Zip code City State Email address (optional) Enrollee name \_\_\_ Agent name/ID number \_

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-Income Related Monthly Adjustment Amount (Part D-IRMAA),			
Social Security (SS) will send you a letter and ask you how you 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 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			
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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, 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	·•	
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?		☐ 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		
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Name of health insurance company	
Member number	
7. Please give us the name of your pr	imary care provider (PCP), clinic or health center.
You can find a list on the plan website	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 recent	ly seen this provider? ☐ Yes ☐ No
your plan communications.  You will get many of your required plan an email when new communications (F	automatically enrolls you in paperless delivery for some of communications delivered electronically. We will send you for example: Explanation of Benefits or the Annual Notice of access these communications through any device such as a
computer, tablet or mobile phone.	access these communications through any device such as a
If you would rather have hard copies	of required materials mailed to you, please check here:
	mail you hard copies of required materials. Please note that e and may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to th	e following:
, , ,	

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-Service (P	PFFS), MA Medicare Me	dical Savings Account (MSA)		
<ul> <li>Release of information: By joining this will share my information with Medicar payments, and for other purposes allow</li> </ul>	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 information (see Privacy Act Statement below).			
I give Peoples Health permission to share my protected health information with organizations of person(s) for permissible purposes under applicable law as required to administer my health plan.				
<ul> <li>The information on this form is correct intentionally provide false information</li> <li>My response to this form is voluntary.</li> <li>plan.</li> </ul>	on this form I will be dis	enrolled from the plan.	ne	
When I sign below, it means that I have re	ead and understand th	e information on this form		
If I sign as an authorized representative, it is show written proof (power of attorney, guarunderstand that I will need to submit written behalf of the member beyond this application received my UnitedHealthcare UCard®, I car UnitedHealthcare UCard to update my authorized Signature of applicant/member/authorized to update my authorized to u	rdianship, etc.) of this right to the proof of this right, to the proof of this right, to the proof of this right, to the proof of the	ght if Medicare asks for it. I ne plan, if I wish to take action n has been approved and I have at the number on my	on	
If you are the authorized represent information below (*Not a Sales Age		pove and complete the		
Last name	First name			
Address				
City	State	Zip code		
Phone number ( ) —	Relationship to	applicant		
For individuals helping enrollee wit	th completing this fo	orm only		
Enrollee name				
Agent name/ID number		DHI A25HD0221123 000		

•	n if you're an individual ( ird parties) helping an e				ounselors, family	
			Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			(Agents/Brokers only)	
For Licensed Sale	es Representative/a	agend	cy u	se only		
Licensed Sales representative/Writing ID			Initial receipt date			
Licensed Sales repres	Licensed Sales representative/agent name			Proposed effective date		
Employer group name	e					
Employer group ID			В	ranch ID		
Agent must complet ☐ IEP (MA-PD enrollees)	e ☐ ICEP (MA enrollee		enrol	P (MA-PD lees eligible for FP)	□ OEP (Jan 1 – Mar 31)	
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	2nd IEP)  ☐ SEP (Change in residence)  ☐ AEP (October 15-December 7)		P (Change in ence) P (October 15-	☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ SEP (SEP reason)						
Licensed Sales repre	esentative signature (o	ption	al)		Date	
	Please fax this	s com	plete	ed form to:		
Enrollee name						
	er				PHLA25HP0221123_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, 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.

Peoples Health Choices Gold (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.

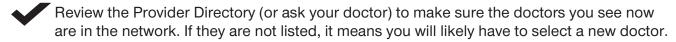
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

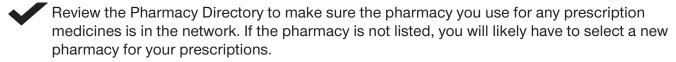
## **Enrollment checklist**

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

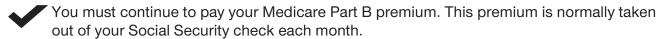




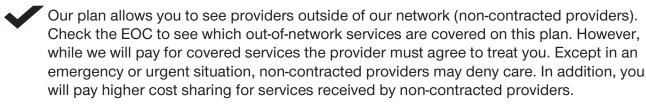




## **Understanding important rules**







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.