

A UnitedHealthcare Company

## **2025** Enrollment Request Form

☐ Peoples Health Choices 65 (HMC	O-POS) Rura	l Southeast H19	61-014-	004	
Information about you (Please	type or pri	nt in black or b	lue ink	)	
Last name	First name	name		Middle initial	
Birth date		Sex □ Male □	] Femal	e	
Home phone number ( )	_	<ul> <li>Mobile phone number</li> </ul>		( ) —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	none nui	mber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be co	-				
City	Parish		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 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 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 you a letter and ask you how you want to pay it:				
☐ You can pay it from your 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 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	<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?		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)		∕es □ 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 (PFFS), I plans).	MA Medicare Medical Sav	ings Account (MSA)
	Release of information: By joining this Medi will share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below	may use it to track my en Federal law that authorize	rollment, to make
	I give Peoples Health permission to share my person(s) for permissible purposes under applan.	protected health informat	_
	The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. However, plan.	form I will be disenrolled	from the plan.
Wh	en I sign below, it means that I have read an	d understand the inform	ation on this form
sho und beh rece Unit	sign as an authorized representative, it means we written proof (power of attorney, guardiansherstand that I will need to submit written proof all of the member beyond this application. Afteived my UnitedHealthcare UCard®, I can call tedHealthcare UCard to update my authorization nature of applicant/member/authorized rep	nip, etc.) of this right if Med f of this right, to the plan, it er this application has been Customer Service at the noninformation on file.	dicare asks for it. I  f I wish to take action on en approved and I have
_	ou are the authorized representative, ormation below (*Not a Sales Agent)	please sign above an	d complete the
Las	t name	First name	
Add	dress		
City	,	State	Zip code
Phone number ( ) — Relationship to applicant		t	
For	r individuals helping enrollee with con	npleting this form onl	у
Enro	llee name		<del></del>
_	nt name/ID number		DHI A25HP022112/ 000

Complete this section members, or other thin	-	. •			ounselors, family
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sale	s Representative/	agend	cy u	se only	
Licensed Sales representative/Writing ID			Initial receipt date		e
Licensed Sales representative/agent name				Proposed effective date	
Employer group name	)				
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees) ☐ ei 2i ☐ SEP (Dual LIS ☐ change of status) re ☐ SEP (Dual LIS ☐		nrol	P (MA-PD lees eligible for	□ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)			2nd IEP)  ☐ SEP (Change in residence)  ☐ AEP (October 15-December 7)		☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _					
Licensed Sales repre	sentative signature (	optiona	al)	I	Date
	Please fax thi	s comp	olete	ed form to:	
Enrollee name					
Agent name/ID numbe					DIII AGELIDOGGIAGA GE
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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 65 (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.

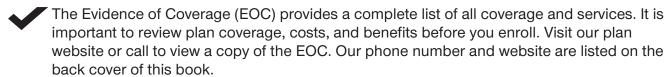
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

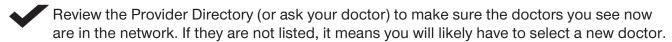
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

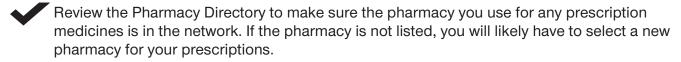
## **Enrollment checklist**

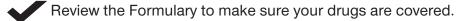
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## **Understanding the benefits**



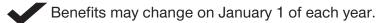


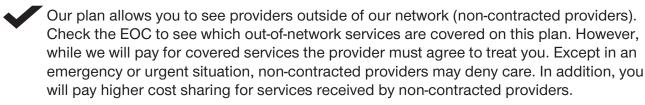




## **Understanding important rules**







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.