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A UnitedHealthcare Company

☐ Peoples Health Choices 65 (HMO-POS) Greater New Orleans and Baton Rouge Area H1961-014-001 **Information about you** (Please type or print in black or blue ink) Middle initial First name Last name 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) Enrollee name ____ Agent name/ID number ___ Y0066 ERFMA 2025 C

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 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		•
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, or Chicano/a				
Yes, Puerto Rican				
Yes, Cuban				
Yes, another Hispanic, Latino, or Sp	panish origin			
I choose not to answer				
0. W/				
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 awyour anaysa work?				
6. Do you or your spouse work?		☐ Yes ☐ No		
Do you or your spouse have other health in				
(Examples: Other employer group coverage	e, LTD coverage, Workers' Compensation,			
auto liability, or Veterans benefits)		☐ Yes ☐ No		
If yes, please complete the following:				
Enrollee name				
Agent name/ID number				
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Nam	ne of health insurance company	
Men	nber number	
7. Ple	ease give us the name of your prima	ry care provider (PCP), clinic or health center.
You c	can find a list on the plan website or in	the Provider Directory.
Provi	der or PCP full name	
	der/PCP number	(Please enter the number exactly as it appears or the website or in the Provider Directory. It will be 10 to 12 digits. Don't include dashes.)
Are y	ou now seeing or have you recently se	een this provider?
	ding your email address above auto plan communications.	matically enrolls you in paperless delivery for some of
an en Chan	nail when new communications (For e	mmunications delivered electronically. We will send you xample: Explanation of Benefits or the Annual Notice of sess these communications through any device such as a
lf you	ı would rather have hard copies of re	equired materials mailed to you, please check here:
SO		il you hard copies of required materials. Please note that d may not fit in all mailboxes. You can change your
	se read and sign	
Ву со	ompleting this form, I agree to the fo	llowing:
	paying my Part B premium if I have on understand that people with Medicard the country, except for limited coveragingent care outside of the U.S. See the understand that when my Peoples Hebrescription drug benefits from People Health and contained in my Peoples Health and contained in my Peoples Health	Medical (Part B) to stay in Peoples Health. I must keep e, unless Medicaid or someone else pays for it. e are generally not covered under Medicare while out of ge near the U.S. border. This plan covers emergency and e Summary of Benefits for more information. ealth coverage begins, I must get all of my medical and es Health. Benefits and services authorized by Peoples ealth "Evidence of Coverage" document (also known as a ment) will be covered. Neither Medicare nor Peoples

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	
	The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. Howev 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 ter this application has been Customer Service at the notion information 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	1	State	Zip code	
Pho	ne number () — Relationship to applicant		t	
Foi	r individuals helping enrollee with con	npleting this form onl	у	
	llee name			
_	nt name/ID number			

•	if you're an individual (rd parties) helping an e				ounselors, family
			elationship to enrollee		
Signature	Signature		nal f	Producer Number	(Agents/Brokers only)
For Licensed Sale	s Representative/a	agend	cy u	se only	
Licensed Sales representative/Writing ID				Initial receipt date	
Licensed Sales repres	entative/agent name			Proposed effecti	ve date
Employer group name	;				
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	B ☐ ICEP (MA enrollee	е		P (MA-PD lees eligible for EP)	□ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	□ SE reside □ AE		EP (Change in	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _					
Licensed Sales repre	sentative signature (o	ption	al)		Date
	Please fax this	s comp	olete	ed form to:	
Familia					
Enrollee name Agent name/ID numbe	r				
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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.

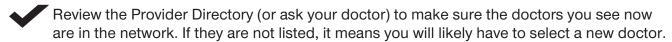
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

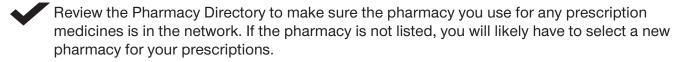
Enrollment checklist

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





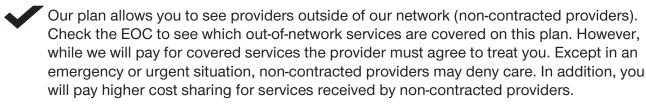




Understanding important rules







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.