

A UnitedHealthcare Company

2025 Enrollment Request Form

☐ Peoples Health Choices (PPO) H4544-001-000

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 pri	nt in black or blue ir	ık)		
Last name	First name		Mi	Middle initial	
Birth date	Sex □ Male □ Female		ale		
Home phone number ()	_	Mobile phone numbe	r () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	umbe	er(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	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					
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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 Retiremen	t 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				
Y0066_ERFMA_2025_C		PHL	.A25LP0220756_000	

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 Spanish origin Yes, Mexican, Mexican American, or Chicano/a					
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)	s, 2.2 coverage, mornere compensation,	☐ Yes ☐ No			
If yes, please complete the following:					
Enrollee name					
Agent name/ID number					
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Page 4 of 8
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actly as it appears on r Directory. It will be dashes.)
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v. We will send you e Annual Notice of any device such as a
ease check here:

Provider or PCP full name Provider or PCP full name Provider/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 you now seeing or have you recently seen this provider?		Page 4 of 8
7. Please give us the name of your primary care provider (PCP), clinic or health center. You aren't limited to this list. You may go to any doctor who accepts Medicare and the plan's payment terms. 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 or 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 provider? Yes No Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications. You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone. If you would rather have hard copies of required materials mailed to you, please check here: Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time. Please read and sign By completing this form, I agree to the following: I must keep both Hospital (Part A) and Medical (Part B) to stay in Peoples Health. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it. I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information. I understand that when my Peoples Health. Benefits and services authorized by Peoples Health and contained in my Peoples Health. "Evidence of Coverage" document (also known as a member contract or subscriber agreement) wi	Name of health insurance company	
You aren't limited to this list. You may go to any doctor who accepts Medicare and the plan's payment terms. 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 or 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 provider? Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications. You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone. If you would rather have hard copies of required materials mailed to you, please check here: Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time. Please read and sign By completing this form, I agree to the following: I must keep both Hospital (Part A) and Medical (Part B) to stay in Peoples Health. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it. I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information. I understand that when my Peoples Health coverage begins, I must get all of my medical and prescription drug benefits from Peoples Health coverage begins, I must get all of my medical and prescription drug benefits from Peoples Health coverage begins, I must get all of my medical and prescription drug benefits from People	Member number	
Provider or PCP full name Provider/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 you now seeing or have you recently seen this provider?	7. Please give us the name of your primar	ry care provider (PCP), clinic or health center.
Provider/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 you now seeing or have you recently seen this provider?	payment terms.	
Provider/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 you now seeing or have you recently seen this provider?	Provider or PCP full name	
Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications. You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone. If you would rather have hard copies of required materials mailed to you, please check here: Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time. Please read and sign By completing this form, I agree to the following: I must keep both Hospital (Part A) and Medical (Part B) to stay in Peoples Health. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it. I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information. I understand that when my Peoples Health coverage begins, I must get all of my medical and prescription drug benefits from Peoples Health. Benefits and services authorized by Peoples Health and contained in my Peoples Health. Benefits and services authorized by Peoples Health will pay for benefits or services that are not covered. Neither Medicare nor Peoples Health will pay for benefits or services that are not covered.	Provider/PCP number	the website or in the Provider Directory. It will be
your plan communications. You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone. If you would rather have hard copies of required materials mailed to you, please check here: □ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time. Please read and sign By completing this form, I agree to the following: □ I must keep both Hospital (Part A) and Medical (Part B) to stay in Peoples Health. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it. □ I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information. □ I understand that when my Peoples Health coverage begins, I must get all of my medical and prescription drug benefits from Peoples Health. Benefits and services authorized by Peoples Health and contained in my Peoples Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Peoples Health will pay for benefits or services that are not covered.	Are you now seeing or have you recently se	een this provider?
an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone. If you would rather have hard copies of required materials mailed to you, please check here: Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time. Please read and sign By completing this form, I agree to the following: I must keep both Hospital (Part A) and Medical (Part B) to stay in Peoples Health. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it. I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information. I understand that when my Peoples Health coverage begins, I must get all of my medical and prescription drug benefits from Peoples Health. Benefits and services authorized by Peoples Health and contained in my Peoples Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Peoples Health will pay for benefits or services that are not covered.	Providing your email address above autogour plan communications.	matically enrolls you in paperless delivery for some of
 □ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time. Please read and sign By completing this form, I agree to the following: □ I must keep both Hospital (Part A) and Medical (Part B) to stay in Peoples Health. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it. □ I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information. □ I understand that when my Peoples Health coverage begins, I must get all of my medical and prescription drug benefits from Peoples Health. Benefits and services authorized by Peoples Health and contained in my Peoples Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Peoples Health will pay for benefits or services that are not covered. 	an email when new communications (For ex	xample: Explanation of Benefits or the Annual Notice of
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	Enrollee name	

Agent name/ID number __ Y0066_ERFMA_2025_C PHLA25LP0220756_000

	that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA)					
	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).					
	person(s) for permissible purposes under applicable law as required to administer my health					
	intentionally provide false information on this 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			
unc beh rec Uni Sig	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 received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file. Signature of applicant/member/authorized representative Today's date					
_	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			
Pho	one number () —	Relationship to applican	t			
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Age	nt name/ID number		·			
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For individuals hel	ping enrollee with	oo r	mple	eting this form	only
Complete this section			_	_	-
members, or other thir	•	•	•		,
Name	a partico, noiping air c			ship to enrollee	
Name		1101	ation	ship to emoliee	
Cianatura		Not	li a a a l	Dradua ar Numba	r (Aganta / Drakara anhi)
Signature		Ivai	lionai	Producer Number	r (Agents/Brokers only)
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For Licensed Sales	• •	age	ncy		
Licensed Sales repres	entative/Writing ID			Initial receipt da	te
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Employer group name					
Employer group ID				Branch ID	
A worst mount commission	<u>. </u>				
Agent must complete		\		ED (NAA DD	П ОБР / I 1
☐ IEP (MA-PD	☐ ICEP (MA enrolled	es)		EP (MA-PD	☐ OEP (Jan 1 –
enrollees)				ollees eligible for	Mar 31)
				IEP)	
☐ OEP (Newly	☐ SEP (Dual LIS		\square S	EP (Change in	☐ SEP (Loss of
eligible)	change of status)		resi	dence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS		\square A	EP (October 15-	☐ OEPI
	maintaining)		Dec	ember 7)	
☐ SEP (SEP reason) _					
Enrollee name					
Agent name/ID number	-				
Y0066_ERFMA_2025_C					PHLA25LP0220756_000

Licensed Sales representative signature (optional)	Date
Please fax this completed form to:	
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 (PPO) 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.

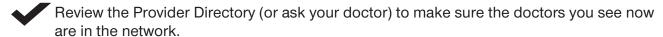
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

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

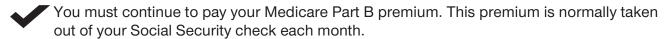


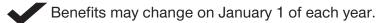


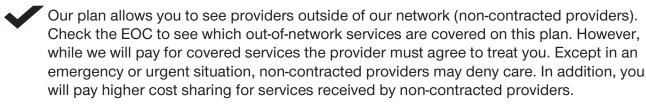


Review the Formulary to make sure your drugs are covered.

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.