

2025 Enrollment Request Form

☐ UHC Complete Care AL-5 (HMO-POS C-SNP) H0432-017-000

| Information about you (Please Last name | First name | | | Middle initial | |
|---|---------------|-------------------|---------|-------------------------|--|
| Birth date | | Sex □ Male □ | Femal | e | |
| Home phone number () | _ | Mobile phone no | umber (| () – | |
| ☐ I give consent for UnitedHealthcar using an autodialer and/or prerecor | | • | one nur | mber(s) I have provided | |
| Medicare number | | | | | |
| Permanent residence street address homelessness, a PO Box may be o | • | | | | |
| City | County | (| State | Zip code | |
| Mailing address (Only if it's different | nt from above | e. You can give a | P.O. bo | x.) | |
| City | | | State | Zip code | |
| Email address (optional) | | L | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Enrollee name | | | | | |
| Agent name/ID number | | | | | |
| Y0066_ERFMA_2025_C | | | | UHAL25HP0221361_000 | |

| 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? | | | | | |
| pay your premium by automation | If you have a monthly plan premium (including any late enrollment penalty you may owe), you can pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through | | | | |
| If you don't choose an option b | If you don't choose an option below, we'll send a bill each month to your mailing 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 your SS check | | | | | |
| ☐ Medicare can bill you | | | | | |
| ☐ The Railroad Retiremen | | | | | |
| ☐ 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 of Braille | | • | | |
| Enrollee name | | | | | |
| Agent name/ID number | | | | | |
| Y0066_ERFMA_2025_C UHAL25HP0221361_000 | | | | | |

If you don't see the language or format you want, please call us toll-free at **1-866-367-7527**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **UHC.com/Medicare** 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) | s, Erb coverage, workers compensation, | ☐ Yes ☐ No |
| If yes, please complete the following: | | |
| Enrollee name | | |
| Enrollee nameAgent name/ID number | | <u></u> . |
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|--------------------|--|--|
| Na | ame of health insurance company | |
| Me | ember number | |
| 7. F | Please give us the name of your primary care | provider (PCP), clinic or health center. |
| Υοι | u can find a list on the plan website or in the Pr | ovider Directory. |
| Pro | vider or PCP full name | |
| Pro | vider/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? |
| You an e Cha | email when new 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 |
| lf y | ou would rather have hard copies of require | d materials mailed to you, please check here: |
| S | nstead of paperless delivery, we will mail you he 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 |
| | ease read and sign | |
| Ву | 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 gothe country, except for limited coverage near urgent care outside of the U.S. See the Summanderstand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcare | enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and mary of Benefits for more information. coverage begins, I must get all of my medical and |

| Enrollee name | |
|----------------------|---------------------|
| Agent name/ID number | |
| Y0066_ERFMA_2025_C | UHAL25HP0221361_000 |

nor UnitedHealthcare will pay for benefits or services that are not covered.

(also known as a member contract or subscriber agreement) will be covered. Neither Medicare

that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions

□ I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and

| apply for MA Private Fee-for-Service (PFF | FS), MA Medicare Med | lical Savings Account (MSA) | |
|--|---|---|--|
| 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 UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health plan. | | | |
| The information on this form is correct to intentionally provide false information on My response to this form is voluntary. Ho plan. | this form I will be dise | enrolled from the plan. | |
| When I sign below, it means that I have read | d and understand the | information on this form | |
| If I sign as an authorized representative, it me show written proof (power of attorney, guardicunderstand that I will need to submit written pubehalf of the member beyond this application received my UnitedHealthcare UCard®, I can UnitedHealthcare UCard to update my author Signature of applicant/member/authorized | ianship, etc.) of this rigoroof of this right, to the n. After this application call Customer Service rization information on | tht if Medicare asks for it. I be plan, if I wish to take action or has been approved and I have that the number on my | |
| If you are the authorized representation below (*Not a Sales Agent | | ove and complete the | |
| Last name | First name | | |
| Address | 1 | | |
| City | State | Zip code | |
| Phone number () — Relationship to appli | | applicant | |
| For individuals helping enrollee with | completing this fo | orm only | |
| Enrollee name | | | |
| Agent name/ID number | | | |

| Complete this section members, or other thir | - | | | | ounselors, family | |
|--|--|---------|--|-------------------------------|--------------------------------------|--|
| | | | Relationship to enrollee | | | |
| Signature | | Nation | nal F | Producer Number | (Agents/Brokers only) | |
| For Licensed Sales | s Representative/ | agenc | y 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 | | | | | | |
| Employer group ID | | | В | ranch ID | | |
| Agent must complete ☐ IEP (MA-PD enrollees) | □ ICEP (MA enrollees) □ er 2r □ 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 | ıl) | 1 | Date | |
| | Please mail or fax | this c | omp | oleted form to: | | |
| Enrollee name | | | | | | |
| Agent name/ID number | | | | | LILLAL OF UPDODICES A SEC | |
| Y0066_ERFMA_2025_C | | | | | UHAL25HP0221361_000 | |

UnitedHealthcare P.O. Box 30770 Salt Lake City, UT 84130-0770

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.

UHC Complete Care AL-5 (HMO-POS C-SNP) 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.

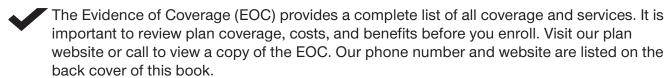
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

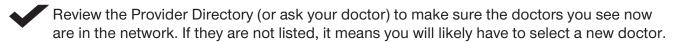
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

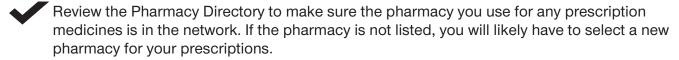
Enrollment checklist

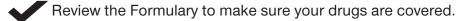
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





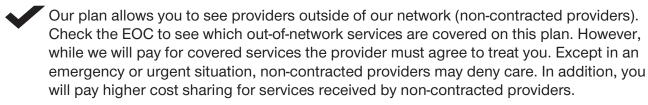




Understanding important rules







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.

This plan is a Chronic Condition Special Needs Plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.