

2025 Enrollment Request Form

☐ UHC Complete Care AR-5 (PPO C-SNP) H1889-019-000

Last name	First name		Middle initial		
Birth date		Sex □ Male □	Femal	le	
Home phone number ()	Mobile phone no		nber	() –	
☐ I give consent for UnitedHealthca using an autodialer and/or prerecor		•	ne nu	mber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be o	-				
City	County	County		Zip code	
Mailing address (Only if it's differe	nt from above	e. You can give a P	.O. bo	ox.)	
City		St	ate	Zip code	
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-Incom	e Related Monthly Adjustment	Amount (Part D-I	RMAA),
Social Security (SS) will send y	ou a letter and ask you how yo	u want to pay it:	
☐ You can pay it from you	r 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 I	☐ 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		UHA	R25LP0221141_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 □
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)	
If yes, please complete the following:	00 _
Enrollee name	
Agent name/ID number	
VOICE EREMA 2025 C	

Page 4 of 8	

	Page 4 01 6
Name of health insurance company	
Member number	
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 do	octor who accepts Medicare and the plan's
payment terms.	
You can find a list on the plan website or in the Pro	ovider Directory.
Provider or PCP full name	
Provider/PCP number	(Please enter the number exactly as it appears or
Trovidoly For Hambol	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? ☐ Yes ☐ No
Providing your email address above automatical your plan communications. You will get many of your required plan communication an email when new communications (For example)	
•	ese communications through any device such as a
If you would rather have hard copies of required	d materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you h some communications are very large and may n preference for delivery at any time.	
Please read and sign	
By completing this form, I agree to the following	g:
paying my Part B premium if I have one, unless I understand that people with Medicare are go the country, except for limited coverage near urgent care outside of the U.S. See the Summary I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcare and contained in my United	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and nary of Benefits for more information. coverage begins, I must get all of my medical and care. Benefits and services authorized by Healthcare "Evidence of Coverage" document ber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number	
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 I understand that I can be enrolled in only or that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS), 	end my enrollment in ano	ther MA plan (exceptions				
plans). Release of information: By joining this Med will share my information with Medicare, who payments, and for other purposes allowed b information (see Privacy Act Statement below	o may use it to track my en y Federal law that authoriz	rollment, to make				
 I give UnitedHealthcare permission to share or person(s) for permissible purposes under 	☐ 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 the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan. My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. 						
When I sign below, it means that I have read ar	nd understand the inform	ation on this form				
show written proof (power of attorney, guardians understand that I will need to submit written proceed behalf of the member beyond this application. Af received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizate Signature of applicant/member/authorized reports. If you are the authorized representative.	of of this right, to the plan, iter this application has be Customer Service at the right ion information on file. Coresentative Today	if I wish to take action on en approved and I have number on my 's date				
information below (*Not a Sales Agent)		·				
Last name	First name					
Address						
City	State	Zip code				
Phone number () —	Relationship to applicant					
Enrollee nameAgent name/ID number						
Y0066_ERFMA_2025_C		 UHAR25LP0221141_000				

For individuals hel	ping enrollee with	con	nplet	ting this form o	nly
Complete this section	if you're an individual	(i.e. a	agents	s, brokers, SHIP co	-
members, or other third parties) helping an e					
Name		Relationship to enrollee			
Signature		Nati	ional I	Producer Number	(Agents/Brokers only)
For Licensed Sales	s Representative/	ager	ncy u	ise only	
Licensed Sales repres	entative/Writing ID		Initial receipt date		e
Licensed Sales repres	entative/agent name		Proposed effective date		ve date
Employer group name				1	
Employer group ID			В	ranch ID	
Agent must complete IEP (MA-PD enrollees) OEP (Newly eligible) SEP (Chronic) SEP (SEP reason)	□ ICEP (MA enrolled □ SEP (Dual LIS change of status) □ SEP (Dual LIS maintaining)	es)	enrol 2nd I □ SE resid □ AE	P (MA-PD llees eligible for EP) EP (Change in ence) EP (October 15- ember 7)	☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C	「 <u></u>				UHAR25LP0221141_000

Licensed Sales representative signature (optional)

Date

Please mail or fax this completed form to:

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, 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 AR-5 (PPO 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.

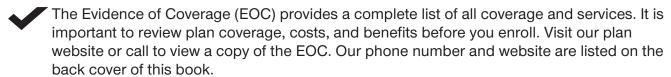
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

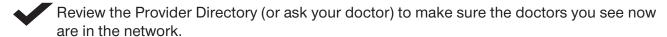
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

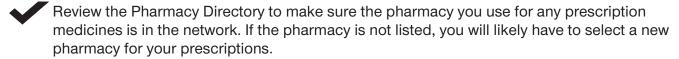
Enrollment checklist

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





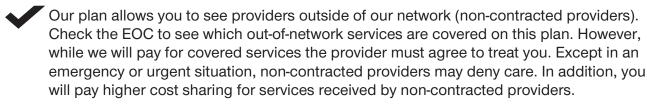


Review the Formulary to make sure your drugs are covered.

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.

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.