

2025 Enrollment Request Form

☐ UHC Complete Care AZ-3P (HMO-POS C-SNP) H0609-043-000

Information about you (Please	type or pri	nt in black or b	lue ink)		
Last name	First name			Middle initial	
Birth date		Sex □ Male □] Femal	e	
Home phone number ()	_	Mobile phone n	umber () –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			none nur	mber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be co	-				
City	County	County		Zip code	
Mailing address (Only if it's differen	t from above	e. You can give a	P.O. bo	x.)	
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 your choice. You can't be denied coverage because you don't fill them out.				
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		UHA	Z25HP0221288_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	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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Nan	ne of health insurance company	
Mer	nber number	
7. Pl	ease give us the name of your primary car	e provider (PCP), clinic or health center.
You	can find a list on the plan website or in the P	rovider Directory.
Provi	der or PCP full name	
Provi	der/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 y	ou now seeing or have you recently seen th	is provider? ☐ Yes ☐ No
You v an er Char	nail when new communications (For examp	ications delivered electronically. We will send you le: Explanation of Benefits or the Annual Notice of nese communications through any device such as a
lf you	u would rather have hard copies of require	ed materials mailed to you, please check here:
so		hard copies of required materials. Please note that not fit in all mailboxes. You can change your
	se read and sign	
Ву с	ompleting this form, I agree to the following	ng:
	paying my Part B premium if I have one, unled understand that people with Medicare are stated coverage nearly except for limited coverage nearly urgent care outside of the U.S. See the Sumburderstand that when my UnitedHealthcare prescription drug benefits from UnitedHealth	generally not covered under Medicare while out of ar the U.S. border. This plan covers emergency and amary of Benefits for more information. e coverage begins, I must get all of my medical and

Enrollee name	
Agent name/ID number	
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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 (plans).	PFFS), MA Medicare Med	lical Savings Account (MSA)	
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 intentionally provide false information My response to this form is voluntary plan. 	n on this form I will be dise	nrolled from the plan.	
When I sign below, it means that I have	read and understand the	e information on this form	
If I sign as an authorized representative, it show written proof (power of attorney, guan understand that I will need to submit written behalf of the member beyond this applicate received my UnitedHealthcare UCard®, I continuedHealthcare UCard to update my authories. Signature of applicant/member/authories.	ardianship, etc.) of this rig en proof of this right, to thation. After this application can call Customer Service thorization information on	ht if Medicare asks for it. I e plan, if I wish to take action on has been approved and I have at the number on my	
If you are the authorized represent information below (*Not a Sales Ag		ove and complete the	
Last name	First name		
Address			
City	State	Zip code	
Phone number () —	Relationship to	applicant	
For individuals helping enrollee w	ith completing this fo	orm only	
Complete this section if you're an individu	ual (i.e. agents, brokers, Sl	HIP counselors, family	
members, or other third parties) helping a	n enrollee fill out this form	า.	
Enrollee name			
Agent name/ID number			

Name			Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)				
For Licensed Sale	s Representative/a	agency	y u	se only		
Licensed Sales representative/Writing ID			Initial receipt date		е	
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 enrollee	es) ☐ IEP (MA-PD enrollees eligible for 2nd IEP)		lees eligible for	☐ OEP (Jan 1 – Mar 31)	
☐ OEP (Newly	☐ SEP (Dual LIS	☐ SEP (Change in residence) ☐ AEP (October 15-December 7)		,	☐ SEP (Loss of	
eligible)	change of status)			•	EGHP coverage) ☐ OEPI	
☐ SEP (Chronic)	☐ SEP (Dual LIS			•		
☐ SEP (SEP reason) _	maintaining)			mber /) 		
Licensed Sales repre	sentative signature (o	ptional)	Da	ate	
	Please mail or fax	this co				
		Box 30				
Enrollee name						
Agent name/ID number						
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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 AZ-3P (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.

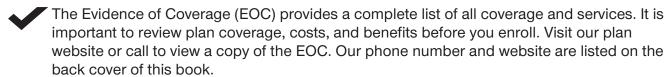
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

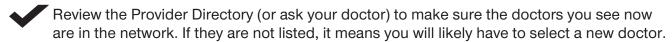
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

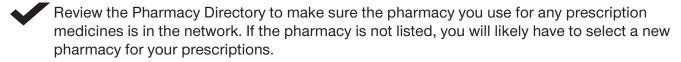
Enrollment checklist

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

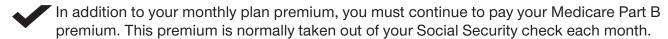


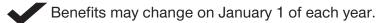


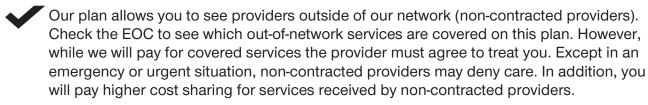




Understanding important rules







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.