

# **2025** Enrollment Request Form

☐ UHC Complete Care DE-4 (HMO-POS C-SNP) H5253-179-000

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 ink	)	
Last name	First name		Middle initial		
Birth date	Sex □ Male □ Female		е		
Home phone number ( )	<ul> <li>Mobile phone number</li> </ul>		number (	( ) –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			ohone nui	mber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be co	-				
City	County		State	Zip code	
Mailing address (Only if it's differen	t from above	e. You can give	a P.O. bo	ox.)	
City			State	Zip code	
Email address (optional)					
Enrollee nameAgent 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 automation 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	☐ 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 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   Large print   Audi		•	
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 **1-866-367-7527**, 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)	e, ETD coverage, workers compensation,  ☐ Yes ☐ No
If yes, please complete the following:	_ 1c3 _ 100
in you, picago complete the following.	
Agent name/ID number	
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Na	me of health insurance company	
Me	ember number	
7. P	Please give us the name of your primary care	e provider (PCP), clinic or health center.
You	can find a list on the plan website or in the Pr	ovider Directory.
Prov	vider or PCP full name	
Prov	vider/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	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 yo	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 home 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
	ase 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	
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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 (PFFS),	MA Medicare Medical Sav	ings 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 organization or person(s) for permissible purposes under applicable law as required to administer my healt plan.			
<ul> <li>The information on this form is correct to the intentionally provide false information on this</li> <li>My response to this form is voluntary. However plan.</li> </ul>	form I will be disenrolled	from the plan.	
When I sign below, it means that I have read ar	nd understand the inform	ation on this form	
If I sign as an authorized representative, it means 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 authorizat Signature of applicant/member/authorized representative, it means show written proof to submit written proceed to submit written proceed to submit written proceed to submit written proceed to submit written proof behalf of the member beyond this application. Af received my UnitedHealthcare UCard to update my authorized representative, it means show written proof (power of attorney, guardians understand that I will need to submit written proof behalf of the member beyond this application. Af	hip, etc.) of this right if Med f of this right, to the plan, i ter this application has bee Customer Service at the n ion information on file.	dicare asks for it. I f I wish to take action on en approved and I have	
If you are the authorized representative, information below (*Not a Sales Agent)	please sign above ar	nd complete the	
Last name	First name		
Address			
City	State	Zip code	
Phone number ( ) — Relationship to applicant			
For individuals helping enrollee with cor	mpleting this form onl	y	
Enrollee name			
Agent name/ID number		IHDE25HP0220615_000	

•	n if you're an individual ( iird parties) helping an e				ounselors, family
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			(Agents/Brokers only)
For Licensed Sale	es Representative/a	agenc	y u	se only	
Licensed Sales representative/Writing ID				Initial receipt date	
Licensed Sales representative/agent name				Proposed effective date	
Employer group nam	e				
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	te □ ICEP (MA enrollee	enrol		P (MA-PD lees eligible for	□ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS	2nd IEP)  ☐ SEP (Change in residence)  ☐ AEP (October 15-		P (Change in ence) P (October 15-	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason)	maintaining)		ece	mber 7)	
Licensed Sales repr	esentative signature (o	ptiona	ıl)		Date
	Please mail or fax	this co	omp	oleted form to:	
Enrollee name					
Agent name/ID number	er				
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## 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 DE-4 (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.

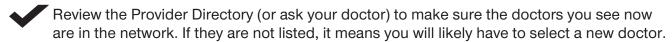
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

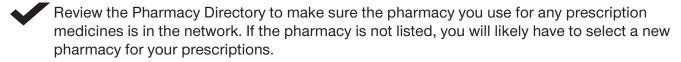
## **Enrollment checklist**

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

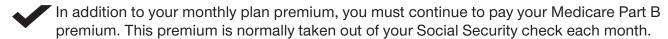


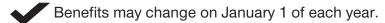


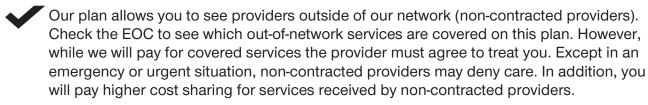




#### **Understanding important rules**







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.