

2025 Enrollment Request Form

☐ UHC Dual Complete DE-V001 (HMO-POS D-SNP) H3113-013-000

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	е	
Home phone number ()	 Mobile phone number (() –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	hone nur	mber(s) I have provided	
Social Security number					
(Required for people who are enrolling	ng in D-SNP բ	olans):			
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)		I		- I	
Enrollee nameAgent name/ID number					
Y0066_ERFMA_2025_C				UHDE25HP0220837_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? 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 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	☐ Medicare can bill you				
☐ The Railroad Retirement Board (RRB) can bill you					
☐ 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 or Braille Large print Audi		•		
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C		UHD	E25HP0220837_000		

If you don't see the language or format you want, please call us toll-free at **1-844-560-4944**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **UHC.com/CommunityPlan** for online help.

2. Are you enrolled in your state Medicaid	d program?	□ Yes □ No
If yes, please give us your Medicaid numbe	r:	
3. Are you Hispanic, Latino/a, or Spanish No, not of Hispanic, Latino/a, or Sp. Yes, Mexican, Mexican American, o Yes, Puerto Rican Yes, Cuban Yes, another Hispanic, Latino, or Sp. I choose not to answer	anish origin or Chicano/a	
4. What's your race? Select all that apply.		
American Indian or Alaska Native	Black or African American	
Asian: Asian Indian Chinese Filipino Japanese Korean	Native Hawaiian or Pacific Islander: Guamanian or Chamorro Native Hawaiian Samoan Other Pacific Islander	
Vietnamese Other Asian	White I choose not to answer	
Member/Citizen of a federal or state	recognized Tribe (name of Tribe)	
5. What is your gender? Select one Woman Man Non-binary	I use a different term: I choose not to answer	
6. Which of the following best represents Lesbian or gay Straight, that is, not gay or lesbian Bisexual	how you think of yourself? Select one	
7. Do you or your spouse work?		☐ Yes ☐ No
Agent name/ID number		
Y0066 ERFMA 2025 C	UHDF25F	160550837 000

Do you or your spouse have other health insurance	
(Examples: Other employer group coverage, LTD	
auto liability, or Veterans benefits)	☐ Yes ☐ No
If yes, please complete the following: Name of health insurance company	
Name of fleath modratioe company	
Member number	
8. 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.
Provider or PCP full name	
Provider/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?
your plan communications. You will get many of your required plan communications (For example)	
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 preference for delivery at any time.	ard copies of required materials. Please note that not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the following	g:
paying my Part B premium if I have one, unle I understand that people with Medicare are g the country, except for limited coverage near urgent care outside of the U.S. See the Sumr I understand 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 nary of Benefits for more information. coverage begins, I must get all of my medical and
Enrollee name	
Agent name/ID numberY0066_ERFMA_2025_C	UHDE25HP0220837_000

Enro	illee name nt name/ID number					
Pho						
Pho						
	one number () —	Relationship to a	Relationship to applicant			
City	<i>'</i>	State	Zip code			
Add	dress					
info	ormation below (*Not a Sales A	•				
If v	ou are the authorized represe	entative, please sign ab	ove and complete the			
Sig	nature of applicant/member/autho	orized representative	Today's date			
rece	nalf of the member beyond this appli eived my UnitedHealthcare UCard®, tedHealthcare UCard to update my a	I can call Customer Service	at the number on my			
sho	w written proof (power of attorney, glerstand that I will need to submit wr	guardianship, etc.) of this rig	ht if Medicare asks for it. I			
	en I sign below, it means that I have sign as an authorized representative					
	plan.	.y. 110000001, 1anule to 165p0	na may anoot offoliment in the			
	intentionally provide false informati My response to this form is volunta	on on this form I will be dise	nrolled from the plan.			
	plan.					
	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					
	payments, and for other purposes a information (see Privacy Act Staten	nent below).				
	will share my information with Med	icare, who may use it to trac	k my enrollment, to make			
	plans). Release of information: By joining					
	I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and 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)					
	that annulment in this plan will auto		t in another MA plan (exceptions			

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

	elping enrollee with if you're an individual (_	_		
•	ird parties) helping an e	•	•		, , , , , , , , , , , , , , , , , , ,	
Name		Rela	ations	hip to enrollee		
Signature			National Producer Number (Agents/Brokers only)			
For Licensed Sale	es Representative/a	agei	ncy u	ise only		
Licensed Sales repre	sentative/Writing ID			Initial receipt dat	re	
Licensed Sales repre	sentative/agent name		Proposed effective date		ve date	
Employer group nam	e					
Employer group ID			В	ranch ID		
Agent must complet	te					
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollee	es) ☐ IEP (MA-PD enrollees eligible for 2nd IEP)		llees eligible for	☐ OEP (Jan 1 – Mar 31)	
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS	☐ SEP (Change in residence) ☐ AEP (October 15-December 7)		EP (Change in ence)	☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ SEP (SEP reason)	maintaining)			•		
Enrollee name						
Agent name/ID number	er					
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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, 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 Dual Complete DE-V001 (HMO-POS D-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. 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.

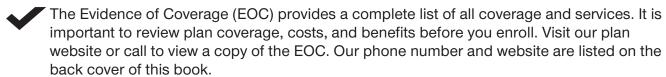
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

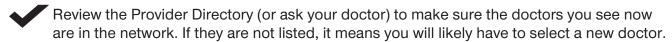
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

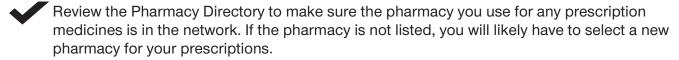
Enrollment checklist

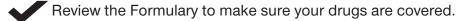
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

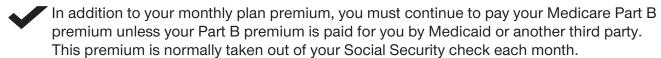


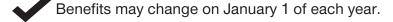


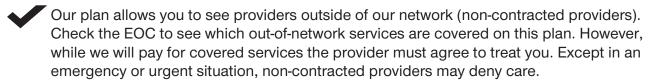




Understanding important rules







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 Dual Eligible Special Needs Plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.