United Healthcare® Medicare Advantage

2025 Enrollment Request Form

☐ **UHC MedicareDirect PF-0001 (PFFS) H5435-024-000**

Information about you (Please type or print in black or blue ink)

Last name	First name	Middle initial

Birth date	Sex ☐ Male ☐ Female
Home phone number ( ) —	Mobile phone number ( ) —

☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology.

Medicare number

Permanent residence street address **(Don't enter a P.O. box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address)**

City	County	State	Zip code

Mailing address **(Only if it's different from above. You can give a P.O. box.)**

City	State	Zip code

Email address (optional)

Enrollee name _____

Agent name/ID number _____

Do you have other insurance that will cover your prescription drugs? ☐ Yes ☐ No
(Examples: Other private insurance, TRICARE, federal employee coverage, VA benefits or state programs.)
If **yes**, what is it?

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 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 Electronic Funds Transfer (EFT).

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 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 us manage your plan

1. Would you prefer plan information in another language or an accessible format?

If you would prefer plan information in another language or accessible format, please check what you'd like: ☐ Spanish ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Enrollee name _____
Agent name/ID number _____

If you don't see the language or format you want, please call us toll-free at **1-844-723-6473**, 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 origin? Select all that apply.

____ No, not of Hispanic, Latino/a, or Spanish origin
____ Yes, Mexican, Mexican American, or Chicano/a
____ Yes, Puerto Rican
____ Yes, Cuban
____ Yes, another Hispanic, Latino, or Spanish 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:
____ Asian Indian
____ Chinese
____ Filipino
____ Japanese
____ Korean
____ Vietnamese
____ Other Asian

Native Hawaiian or Pacific Islander:
____ Guamanian or Chamorro
____ Native Hawaiian
____ Samoan
____ Other Pacific Islander

____ White
____ **I choose not to answer**

____ Member/Citizen of a federal or state recognized Tribe (name of Tribe) _____

4. What is your gender? Select one.

_____ Woman
_____ Man
_____ Non-binary
_____ I use a different term: _____
_____ **I choose not to answer**

5. Which of the following best represents how you think of yourself? Select one.

_____ Lesbian or gay
_____ Straight, that is, not gay or lesbian
_____ Bisexual
_____ I use a different term: _____
_____ I don't know
_____ **I choose not to answer**

6. Do you or your spouse work? ☐ Yes ☐ No

Do you or your spouse have other health insurance that will cover medical services? (Examples: Other employer group coverage, LTD coverage, Workers' Compensation, auto liability, or Veterans benefits) ☐ Yes ☐ No
If yes, please complete the following:

Enrollee name _____
Agent name/ID number _____

Name of health insurance company

Member number

7. Please give us the name of your doctor(s) and hospital, so we can give them information about the plan.

You don't have to give this information in order to join the plan, but it will allow us to give them billing information before you get services. You aren't limited to this list. You can visit any hospital or doctor that accepts Medicare and the plan's terms. If you don't have a doctor or hospital that you visit, please write "Not Available."

Doctor full name			
City	State	Zip code	Phone number ( ) –
Doctor full name			
City	State	Zip code	Phone number ( ) –
Hospital name			
City	State	Zip code	Phone number ( ) –

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone.

If you would rather have hard copies of required materials mailed to you, please check here:

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Please read and sign

By completing this form, I agree to the following:

☐ I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.

Enrollee name _____

Agent name/ID number _____

- If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan.
- Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7 of every year), or under certain special circumstances.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information.
- I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.
- I understand that this plan is a Medicare Advantage Private Fee-for-Service plan and I can be in only one Medicare health plan at a time.
- **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 the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan.
- This is a Private Fee-for-Service (PFFS) plan. I understand there is no plan network. My plan allows me to see any provider who accepts Medicare and agrees to the plan's terms. Before I visit a hospital or doctor for care, I need to make sure that they will accept the plan's terms. Except in an emergency or urgent situation, health care providers have the right to choose whether to accept my PFFS plan's payment terms and conditions every time I see them. If the hospital or doctor decides not to accept my PFFS plan, I will need to find one that will. The plan's terms and conditions may be found on uhcprovider.com website.
- Once UnitedHealthcare has my enrollment form, I will get a call from a plan representative. This call is to make sure that I understand how a Private Fee-for-Service plan works and to confirm my intent to enroll in the UnitedHealthcare PFFS plan. If UnitedHealthcare isn't able to reach me by telephone, then I will get a letter by mail that contains similar information.
- Joining this plan could affect my employer or union health benefits. If I have health coverage from an employer or union, joining this plan may change how my current coverage works. Me or my dependents could lose our other health or drug coverage completely and not get it back if I join this plan. I will talk to my employer or union. I will ask how joining this plan could affect my current plan. I may also want to check my employer or union's website, or read any information

Enrollee name _____

Agent name/ID number _____

sent to me. If there is no information on whom to contact, my benefits administrator or the office that answers questions about my coverage can help.

- ☐ This plan is a Medicare Private Fee-for-Service plan and has a contract with the federal government. This is not a Medicare Supplement plan.
- ☐ I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or Medicare prescription drug plan.
- ☐ I may have to pay a late enrollment penalty (LEP). This would only happen if I didn't sign up for and keep creditable prescription drug coverage when I first qualified for Medicare. "Creditable" means the coverage is as good as a Medicare Prescription Drug Plan. If I need to pay an LEP, the plan will tell me.
- ☐ This Medicare Private Fee-for-Service plan works differently than a Medicare supplement plan as well as other Medicare Advantage plans. The plan pays instead of Medicare, and I will be responsible for the amounts that the plan doesn't cover, such as copayments and coinsurances. Original Medicare won't pay for my health care while I am enrolled in this plan. Before I visit a hospital or doctor for care, I need to make sure that they will accept the plan's terms. I understand that my health care providers have the right to choose whether to accept my PFFS plan's payment terms and conditions every time I see them. If the hospital or doctor decides not to accept my PFFS plan, I will need to find one that will, except in emergencies.
- ☐ If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help.
- ☐ 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 and understand the information on this form

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file.

Signature of applicant/member/authorized representative **Today's date**

_____

If you are the authorized representative, please sign above and complete the information below (*Not a Sales Agent)

Last name	First name

Address

_____

Enrollee name _____

Agent name/ID number _____

City	State	Zip code
Phone number ( ) —	Relationship to applicant	

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name	Relationship to enrollee
Signature	National Producer Number (Agents/Brokers only)

For Licensed Sales Representative/agency use only

Licensed Sales representative/Writing ID	Initial receipt date
Licensed Sales representative/agent name	Proposed effective date

Employer group name

Employer group ID	Branch ID

Agent must complete

☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PD enrollees eligible for 2nd IEP)	☐ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible)	☐ SEP (Dual LIS change of status)	☐ SEP (Change in residence)	☐ SEP (Loss of EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)	☐ AEP (October 15-December 7)	☐ OEPI

☐ SEP (SEP reason) _____

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

Enrollee name _____
Agent name/ID number _____

Fax the front and back of each page

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

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

- ✔ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit our plan website or call to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.
- ✔ Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ✔ Review the Formulary to make sure your drugs are covered.

Understanding important rules

- ✔ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ✔ Benefits may change on January 1 of each year.
- ✔ 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.