

2025 Enrollment Request Form

☐ UHC Complete Care Support TC-6 (HMO-POS C-SNP) H5253-194-002

Information about you (Please	type or pri	nt in black or b	olue ink)
Last name	First name			Middle initial
Birth date		Sex □ Male [☐ Femal	e
Home phone number ()	_	Mobile phone	number (() –
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	hone 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 name				
Agent name/ID number				
Y0066_ERFMA_2025_C				UHEX25HP0220600_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 automation Board (RRB) benefit check each Electronic Funds Transfer (EFT	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-Income Related Monthly Adjustment Amount (Part D-IRMAA),			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	
\square I want to pay directly from a	bank account		
Account type ☐ Checking I	☐ Savings		
Account holder name:			
Bank routing number/,	/_/_/_/_/_		
Bank account number/_	<i> _ _ _ _ </i>		
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 of Braille		•
Enrollee name			
Agent name/ID number			
Y0066_ERFMA_2025_C		UHE	X25HP0220600_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 ☐ 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)	o,	☐ Yes ☐ No
If yes, please complete the following:		
Enrollee name		
Agent name/ID number		
V0066 EREMA 2025 C	LIHEY25HD0	220600 000

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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.
Pro	vider or PCP full name	
Pro	vider/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?
you You an e Cha	r plan communications. I will get many of your required plan 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
Ple	ase read and sign	
Ву	completing this form, I agree to the followin	g:
	paying my Part B premium if I have one, unle I understand that people with Medicare are g	generally not covered under Medicare while out of the U.S. border. This plan covers emergency and
	I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealth	coverage begins, I must get all of my medical and care. Benefits and services authorized by

Enrollee name	
Agent name/ID number	
Y0066 ERFMA 2025 C	UHEX25HP0220600 000

nor UnitedHealthcare will pay for benefits or services that are not covered.

UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare

□ 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

Release of information: By joining this Medicare Advantage Plan, I acknowledge that the pla 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 organizatio or person(s) for permissible purposes under applicable law as required to administer my heal 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 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 cashow 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 of 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	ns th e
□ 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 heal 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 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 to 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	th e n
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	-
information below (*Not a Sales Agent)	
Last name First name	
Address	
City State Zip code	
Phone number () — Relationship to applicant	
For individuals helping enrollee with completing this form only	
Enrollee name	
Agent name/ID number	

Complete this section members, or other thir	•				ounselors, family
Name			ionship to enrollee		
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sales	s Representative/a	agend	cy u	se only	
Licensed Sales repres	entative/Writing ID			Initial receipt dat	е
Licensed Sales repres	entative/agent name			Proposed effecti	ve date
Employer group name					
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	□ ICEP (MA enrollee	é		P (MA-PD lees eligible for EP)	☐ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	SEP (Dual LIS reange of status) reSEP (Dual LIS		EP (Change in ence) EP (October 15-mber 7)	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _					
Licensed Sales repres	sentative signature (c	ption	al)		Date
	Please mail or fax	this c	omp	oleted form to:	
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C	·				UHEX25HP0220600_000

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 Support TC-6 (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.

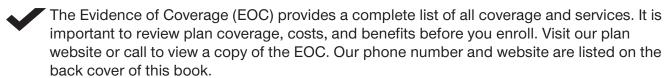
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

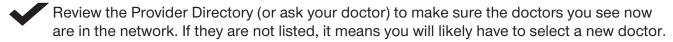
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

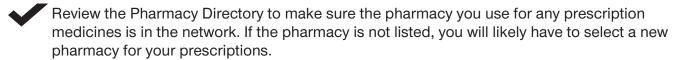
Enrollment checklist

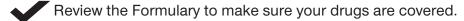
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits



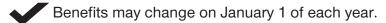


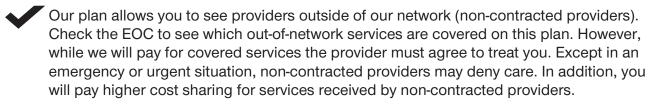




Understanding important rules







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.