

2025 Enrollment Request Form

☐ UHC Complete Care OH-18 (HMO-POS C-SNP) H5253-190-000

Information about you (Please Last name	First name			Middle initial
Birth date		Sex □ Male □	Female	e
Home phone number ()	_	Mobile phone nu	ımber (() –
☐ I give consent for UnitedHealthca using an autodialer and/or prerecor		•	one nur	mber(s) I have provided
Medicare number				
Permanent residence street address homelessness, a PO Box may be o	-			
City	County	5	State	Zip code
Mailing address (Only if it's different	nt from above	e. You can give a	P.O. bo	ox.)
City		5	State	Zip code
Email address (optional)				
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C			-	UHEX25HP0220605_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 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-II	RMAA),
Social Security (SS) will send y	ou a letter and ask you how yo	ou want to pay it:	
☐ You can pay it from you	r 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	,		
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		UHE	X25HP0220605_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)	, , , , , , , , , , , , , , , , , , , ,	☐ Yes ☐ No
If yes, please complete the following:		
Enrollee name		
Agent name/ID number		
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		Page 4 of 8
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 at the country, except for limited coverage near urgent care outside of the U.S. See the Sumbunderstand 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 _	
Y0066_ERFMA_2025_C	UHEX25HP0220605_000

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

Plans). 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 organization or person(s) for permissible purposes under applicable law as required to administer my healt 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 ca 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® and 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	ns th
□ 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 healthcare 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 obehalf 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)	th ⇒
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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 thin	•	•	_		ounselors, family
Name	<u> </u>			ship to enrollee	
Signature		National Producer Number (Agents/Brokers only)			(Agents/Brokers only)
For Licensed Sale	s Representative/	agen	су и	ise only	
Licensed Sales repres	entative/Writing ID			Initial receipt dat	е
Licensed Sales repres	Licensed Sales representative/agent name			Proposed effective date	
Employer group name	,				
Employer group ID			В	Branch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	D ICEP (MA enrollee	,	enrol	P (MA-PD llees eligible for	☐ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) r ☐ SEP (Dual LIS [2nd IEP) ☐ SEP (Change in residence) ☐ AEP (October 15-December 7)		☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _				·	
Licensed Sales repre	sentative signature (d	option	al)	1	Date
	Please mail or fax	this o	com	oleted form to:	
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C	r				UHEX25HP0220605_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 OH-18 (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.

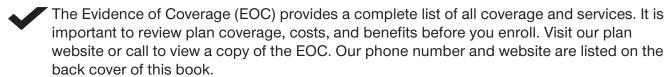
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

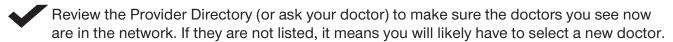
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

Enrollment checklist

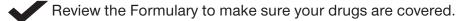
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





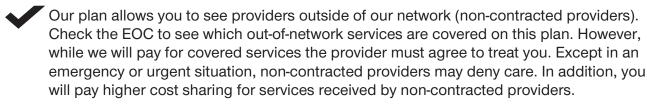




Understanding important rules







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.