

2025 Enrollment Request Form

☐ UHC Complete Care IA-5 (HMO-POS C-SNP) H5253-180-000

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 bl	lue ink)	
Last name	First name		Middle initial	
Birth date		Sex □ Male □	Female	е
Home phone number ()	_	Mobile phone nu	umber () —
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			one nur	nber(s) I have provided
Medicare number				
Permanent residence street address homelessness, a PO Box may be co	-			
City	County	5	State	Zip code
Mailing address (Only if it's different	t from above	e. You can give a	P.O. bo	x.)
City		S	State	Zip code
Email address (optional)				
Enrollee name				
Agent name/ID number				
V0066 EREMA 2025 C				IHEY25HP0220614_000

Member number	Do you have other insurance (Examples: Other private insura programs.) If yes, what is it?		_	☐ Yes ☐ No benefits or state	
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 Recount type Checking Savings Account holder name: Bank routing number/_/_/_/ Bank account number/_/_/_/ Bank account number/_/_/_/ Bank account number/_/_/_/ Bank account 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	Name of other insurance				
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Bank routing number///	Account type ☐ Checking ☐ Savings				
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Enrollee nameAgent name/ID number				•	
Agent name/ID number	Enrollee name				
	Agent name/ID number Y0066_ERFMA_2025_C				

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, o	r Chicano/a	
Yes, Puerto Rican		
Yes, Cuban		
Yes, another Hispanic, Latino, or Sp	panish origin	
I choose not to answer		
0.44		
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	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	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
		_ 100 _ 110
Do you or your spouse have other health in:		
(Examples: Other employer group coverage auto liability, or Veterans benefits)	e, LTD coverage, workers Compensation,	☐ Yes ☐ No
		□ res □ No
If yes, please complete the following:		
Enrollee name		
Agent name/ID number		
Y0066_ERFMA_2025_C	UHEX25HP0	220614_000

	Page 4 of 8
Name of health insurance company	
Member number	
7. Please give us the name of your primar	y care provider (PCP), clinic or health center.
You can find a list on the plan website or in	the Provider 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 se	en this provider? ☐ Yes ☐ No
your plan communications. You will get many of your required plan com an email when new communications (For ex	nmunications delivered electronically. We will send you cample: Explanation of Benefits or the Annual Notice of ess these communications through any device such as a
lf you would rather have hard copies of re	quired materials mailed to you, please check here:
	you hard copies of required materials. Please note that I may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the fol	lowing:
paying my Part B premium if I have one I understand that people with Medicare the country, except for limited coverage urgent care outside of the U.S. See the	Medical (Part B) to stay in UnitedHealthcare. I must keep e, unless Medicaid or someone else pays for it. e are generally not covered under Medicare while out of e near the U.S. border. This plan covers emergency and Summary of Benefits for more information. hcare coverage begins, I must get all of my medical and
•	Healthcare. Benefits and services authorized by

Enrollee name	
Agent name/ID number	
Y0066 ERFMA 2025 C	UHEX25HP0220614_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 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. 	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. My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. In I sign below, it means that I have read and understand the information on this form ign as an authorized representative, it means I have the legal right under state law to sign. I can written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I erstand that I will need to submit written proof of this right, to the plan, if I wish to take action on all of the member beyond this application. After this application has been approved and I have eited my UnitedHealthcare UCard®, I can call Customer Service at the number on my edHealthcare UCard to update my authorization information on file. In an authorized representative, please sign above and complete the formation below (*Not a Sales Agent) The authorized representative, please sign above and complete the formation below (*Not a Sales Agent) The authorized representative, please sign above and complete the formation below (*Not a Sales Agent) The authorized representative is a state of the product of the plan is a state of the product of the plan is a state of the plan is a	apply for MA Private Fee-for-Service (PFFS), I plans).	MA Medicare Medical Sav	ings Account (MSA)
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Information below (*Not a Sales Agent) Last name First name Address City State Zip code Relationship to applicant	ress State Zip code Relationship to applicant	show written proof (power of attorney, guardiansh understand that I will need to submit written proof behalf of the member beyond this application. Aft received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorization.	nip, etc.) of this right if Med f of this right, to the plan, it ter this application has been Customer Service at the nation information on file.	dicare asks for it. I f I wish to take action on en approved and I have umber on my
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City State Zip code Relationship to applicant	State Zip code ne number () — Relationship to applicant	Last name	First name	
Relationship to applicant	ne number () — Relationship to applicant	Address		
Phone number () — Relationship to applicant		City	State	Zip code
	individuals helping enrollee with completing this form only	t		
For individuals helping enrollee with completing this form only		For individuals helping enrollee with cor	npleting this form onl	у
Enrollee name	lee name	Enrollee name		
Agent name/ID number	t name/ID number			ULEVOEUD0000014 000

Complete this section members, or other thir	if you're an individual rd parties) helping an e				ounselors, family	
			Relationship to enrollee			
Signature		Natio	nal I	Producer Number	(Agents/Brokers only)	
For Licensed Sale	s Representative/a	agend	cy u	ise only		
Licensed Sales repres	entative/Writing ID			Initial receipt dat	е	
Licensed Sales repres	entative/agent name			Proposed effecti	ve date	
Employer group name	3					
Employer group ID			В	Branch ID		
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees) ☐ e			P (MA-PD llees eligible for	□ OEP (Jan 1 – Mar 31)	
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS ☐ change of status) re ☐ SEP (Dual LIS ☐		□ SE esid □ AE	EP (Change in lence) EP (October 15- ember 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 c	omp	oleted form to:		
Enrollee name						
Agent name/ID number Y0066_ERFMA_2025_C	r				UHEX25HP0220614_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 IA-5 (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.

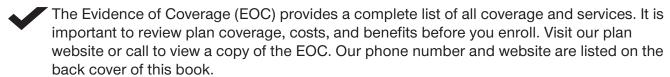
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

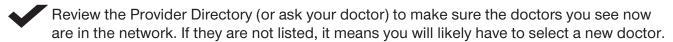
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

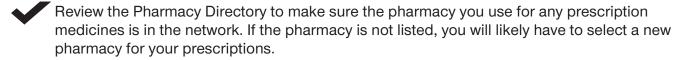
Enrollment checklist

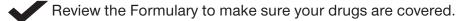
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





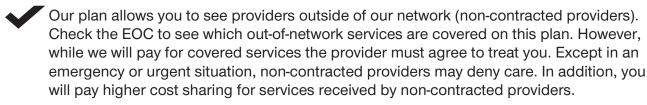




Understanding important rules







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.