

## **2025 Enrollment Request Form**

☐ UHC Nursing Home Plan EX-F003 (PPO I-SNP) H0710-026-000

Information about you (Please	type or pri	nt in black or b	lue ink		
Last name	First name			Middle initial	
		I			
Birth date		Sex □ Male □	l Femal	е	
Home phone number ( )	_	Mobile phone number (		) –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	one nur	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	x.)	
City		(	State	Zip code	
Email address (optional)				,	
Enrollee name					
Agent name/ID number					
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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-I	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 Retirement 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 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		•
Enrollee name			
Agent name/ID number			
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If you don't see the language or format you want, please call us toll-free at **1-855-544-4342**, 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 Spanish origin			
Yes, Mexican, Mexican American, or Chicano/a			
Yes, Puerto Rican			
Yes, Cuban			
Yes, another Hispanic, Latino, or Sp	panish origin		
I choose not to answer			
3. What's your race? Select all that apply.			
American Indian or Alaska Native	Black or African Ame	rican	
Asian:	Native Hawaiian or Pacific	Islander	:
Asian Indian	Guamanian or Cham	orro	
Chinese	Native Hawaiian		
Filipino	Samoan		
Japanese	Other Pacific Islande	<del>)</del> r	
Korean			
Vietnamese	White		
Other Asian	I choose not to answ	ver	
Member/Citizen of a federal or state	recognized Tribe (name of T	ribe)	
4. What is your gender? Select one.			
Woman	I use a different ter	m:	
Man			
Non-binary	I choose not to ar	ıswer	
5. Which of the following best represents	how you think of yourself?	Select o	ne.
Lesbian or gay	I use a different te	rm:	
Straight, that is, not gay or lesbian	I don't know		
Bisexual	I choose not to a	nswer	
6. Do you live in a nursing home, long-term	m care facility, or a senior c	ommuni	ty? □ Yes □ No
If yes, please give us information on the nur	sing home, long-term care fa	cility, or	senior community:
Name			
Address	City	State	Zip code
	Oity	Jiaie	21p 000e
Enrollee name			
Agent name/ID number			
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Date you moved there		
7. Do you or your spouse work?		☐ Yes ☐ No
Do you or your spouse have other health insurance (Examples: Other employer group coverage, LTD of auto liability, or Veterans benefits) If yes, please complete the following:		□ Yes □ No
Name of health insurance company		
Member number		
8. Please give us the name of your primary care You aren't limited to this list. You may go to any do payment terms. You can find a list on the plan website or in the Pro	ctor who accepts Medicare and the	
Provider or PCP full name		
Provider/PCP number	(Please enter the number exactly a the website or in the Provider Direct 10 to 12 digits. Don't include dashe	ctory. It will be
Are you now seeing or have you recently seen this	provider? ☐ Yes ☐ No	
Providing your email address above automatical your plan communications.	lly enrolls you in paperless deliver	y for some of
You will get many of your required plan communic an email when new communications (For example Changes) are available online. You can access the computer, tablet or mobile phone.	: Explanation of Benefits or the Ann	ual Notice of
If you would rather have hard copies of required	materials mailed to you, please o	heck here:
Instead of paperless delivery, we will mail you has some communications are very large and may no 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 Medica paying my Part B premium if I have one, unles	•	•

Enrollee name \_\_\_\_\_ Agent name/ID number \_\_\_\_\_ Y0066\_ERFMA\_2025\_C UHEX25LP0221247\_000

Enro Agei	ollee name nt name/ID number 6_ERFMA_2025_C	UHEX25LP0221247_000			
Add	dress				
Las	et name	First name			
inf	ormation below (*Not a Sales Agent)				
oig	nature of applicant/member/authorized repr	oresentative Today's date			
If I s sho und beh rec Uni	plan.  The I sign below, it means that I have read and a sign as an authorized representative, it means I have written proof (power of attorney, guardiansh derstand that I will need to submit written proof half of the member beyond this application. After the development of the UC ard and the control of the delth of the delth care UC ard and the delth care UC ard and the delth of	nd understand the information on this form I have the legal right under state law to sign. I can hip, etc.) of this right if Medicare asks for it. I of of this right, to the plan, if I wish to take action on iter this application has been approved and I have Customer Service at the number on my tion information on file.			
<ul> <li>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.</li> <li>My response to this form is voluntary. However, failure to respond may affect enrollment in the</li> </ul>					
	or person(s) for permissible purposes under applicable law as required to administer my health plan.				
	will share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below	y Federal law that authorize the collection of this w).			
	(also known as a member contract or subscrib nor UnitedHealthcare will pay for benefits or s I understand that I can be enrolled in only one that enrollment in this plan will automatically eapply for MA Private Fee-for-Service (PFFS), N	edHealthcare "Evidence of Coverage" document riber agreement) will be covered. Neither Medicare services that are not covered. ne Medicare Advantage (MA) plan at a time – and end my enrollment in another MA plan (exceptions MA Medicare Medical Savings Account (MSA)			
	the country, except for limited coverage near I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcare	e coverage begins, I must get all of my medical and neare. Benefits and services authorized by			

City	St	ate	Zip code
Phone number ( ) —	Re	elationship to applicar	nt
For individuals helping enrollee with	-		-
Complete this section if you're an individual members, or other third parties) helping an			nseiors, family
Name		ship 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	
enrollees) e		☐ IEP (MA-PD ☐ OEP (Jan enrollees eligible for Mar 31) 2nd IEP)	
Enrollee name			
Agent name/ID number			
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☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	☐ SEP (Change in residence) ☐ AEP (October 15-December 7)	☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ SEP (SEP reason) _				
Licensed Sales representative signature (optional)  Date				

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 Nursing Home Plan EX-F003 (PPO I-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.

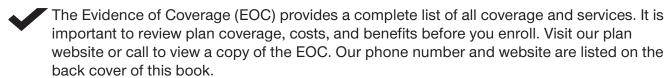
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

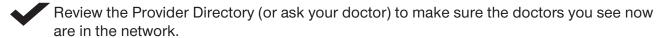
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

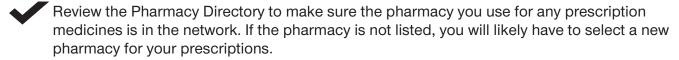
## **Enrollment checklist**

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**





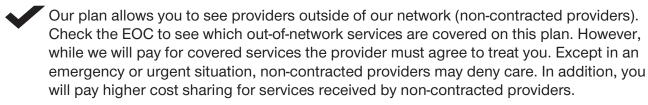


Review the Formulary to make sure your drugs are covered.

## **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 an Institutional Special Needs Plan (I-SNP). Your ability to enroll will be based on verification that you, for 90 days or longer, have had or are expected to need the level of services provided in a skilled nursing facility, a nursing facility, an intermediate care facility for individuals with intellectual and developmental disabilities, a psychiatric hospital or unit, a rehabilitation hospital or unit, a long-term care hospital, a swing-bed hospital or a facility approved by CMS that furnishes similar services. Or you live in a senior community and our plan has obtained certification that you need the type of care that is usually provided in a nursing home.