

2025 Enrollment Request Form

☐ UHC Medicare Advantage AM-0002 (Regional PPO) R3444-012-000

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 b	olue ink		
Last name	First name		Middle initial		
Birth date	Sex □ Male □ Fe		□ Femal	le	
Home phone number ()	 Mobile phone 		number (() –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			hone 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 different from above. You can give a P.O. box.)					
City		State	Zip code		
Email address (optional)		-			
Enrollee nameAgent name/ID number					
Y0066_ERFMA_2025_C				UHEX25RP0220488_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	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	u 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 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			
Y0066_ERFMA_2025_C		UHE	X25RP0220488_000

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				
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	Filipino Samoan			
Japanese	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)	s, Erb coverage, workers compensation,	☐ Yes ☐ No		
If yes, please complete the following:				
Enrollee name				
Agent name/ID number				
VOICE EREMA 2025 C	LIHEY25DD0	220488 000		

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Name of health insurance company	
Member number	
7. Please give us the name of your primary care	provider (PCP), clinic or health center.
You aren't limited to this list. You may go to any do	octor who accepts Medicare and the plan's
payment terms.	
You can find a list on the plan website or in the Pro	ovider Directory.
Provider or PCP full name	
Provider/PCP number	(Please enter the number exactly as it appears or 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	provider?
Providing your email address above automatical your plan communications. You will get many of your required plan communication an email when new communications (For example Changes) are available online. You can access the computer, tablet or mobile phone.	cations delivered electronically. We will send you e: Explanation of Benefits or the Annual Notice of
If you would rather have hard copies of required	d materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you has some communications are very large and may repreference for delivery at any time.	
Please read and sign	
By completing this form, I agree to the following	g:
paying my Part B premium if I have one, unless I understand that people with Medicare are go the country, except for limited coverage near urgent care outside of the U.S. See the Summ I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcare and contained in my United	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and nary of Benefits for more information. coverage begins, I must get all of my medical and care. Benefits and services authorized by IHealthcare "Evidence of Coverage" document ber agreement) will be covered. Neither Medicare

Enrollee name	
Agent name/ID number	
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 I understand that I can be enrolled in only o that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS), 	y end my enrollment in ano	ther MA plan (exceptions	
 plans). Release of information: By joining this Medwill share my information with Medicare, when payments, and for other purposes allowed kinformation (see Privacy Act Statement below I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan. The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. Hower plans 	o may use it to track my ency Federal law that authorized). my protected health information applicable law as required to best of my knowledge. It is form I will be disenrolled	rollment, to make the collection of this mation with organizations d to administer my health understand that if I from the plan.	
plan. When I sign below, it means that I have read a			
understand that I will need to submit written probehalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can cal UnitedHealthcare UCard to update my authorizations. Signature of applicant/member/authorized relatives of the authorized representatives.	fter this application has be I Customer Service at the ration information on file. presentative Today	en approved and I have number on my y's date	
<pre>information below (*Not a Sales Agent) Last name</pre>	First name		
Address			
City	State	Zip code	
Phone number () —	Relationship to applicant		
Enrollee name			
Agent name/ID numberY0066_ERFMA_2025_C		 UHEX25RP0220488_000	

For individuals hel	ping enrollee with	cor	nple	ting this form o	only
Complete this section	if you're an individual	(i.e. a	agents	s, brokers, SHIP co	-
members, or other third parties) helping an e				out this form. ship to enrollee	
- Name		11010	ations	inp to enfonce	
Signature		Nati	ional I	Producer Number	(Agents/Brokers only)
For Licensed Sales	s Representative/	ager	ncy u	ise only	
Licensed Sales repres	entative/Writing ID		Initial receipt date		е
Licensed Sales repres	entative/agent name		Proposed effective date		ve date
Employer group name					
Employer group ID			В	Branch ID	
Agent must complete ☐ IEP (MA-PD enrollees) ☐ OEP (Newly eligible) ☐ SEP (Chronic) ☐ SEP (SEP reason)	□ ICEP (MA enrolled □ SEP (Dual LIS change of status) □ SEP (Dual LIS maintaining)	es)	enrol 2nd I □ SE resid □ AE	P (MA-PD llees eligible for IEP) EP (Change in lence) EP (October 15- ember 7)	☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C	ſ				UHEX25RP0220488_000

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
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 Medicare Advantage AM-0002 (Regional PPO) 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.

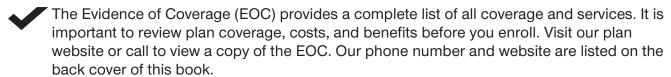
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

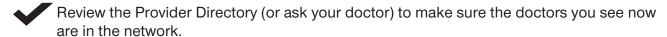
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

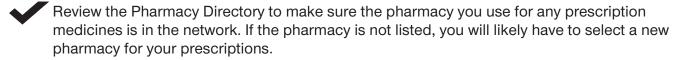
Enrollment checklist

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

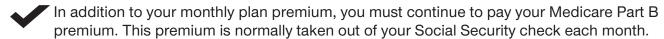


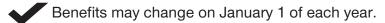


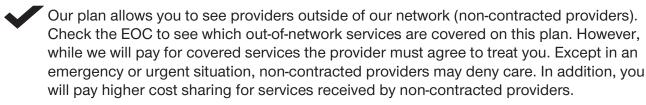


Review the Formulary to make sure your drugs are covered.

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.