

2025 Enrollment Request Form

☐ UHC Complete Care GS-2 (Regional PPO C-SNP) R2604-003-000

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 l	olue ink		
Last name	First name			Middle initial	
Birth date Sex ☐ Male ☐ Female				е	
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 differen	t from above	e. You can give	a P.O. bo	ox.)	
City			State	Zip code	
Email address (optional)					
Enrollee nameAgent 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 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 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 I	☐ 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	X25RP0220492_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 Spa	•	
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		
3. What's your race? Select all that apply.		
o. What a your race: Gelect 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
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)	e, LTD coverage, workers Compensation,	☐ Yes ☐ No
If yes, please complete the following:		□ 103 □ 140
ii yoo, picago complete the following.		
Enrollee name		
Agent name/ID number		
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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 doctor who accepts Medicare and the plan's payment terms.

You can find a list on the plan website or in the Provider Directory.

Ρ	r	ovid	er	or	Ρ	CP	full	name
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1 10 110 0 1 0 1 10 110 110			
Provider/PCP number	ovider/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? ☐ Yes ☐ No		

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone.

If you would rather have hard copies of required materials mailed to you, please check here:

I Instead of paperless delivery, we will mail you hard copies of required materials. Please note that
some communications are very large and may not fit in all mailboxes. You can change your
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 Medical (Part B) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- □ I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information.
- I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.

Enrollee name	
Agent name/ID number	
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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 apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA)								
 plans). 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 								
 I give UnitedHealthcare permission to sha or person(s) for permissible purposes und 	 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 							
The information on this form is correct to intentionally provide false information on t	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							
When I sign below, it means that I have read	l and understand th	e information on this form						
understand that I will need to submit written probebalf of the member beyond this application. received my UnitedHealthcare UCard®, I can of UnitedHealthcare UCard to update my authority. Signature of applicant/member/authorized If you are the authorized representative.	After this application call Customer Service zation information or representative	n has been approved and I have e at the number on my n file. Today's date						
information below (*Not a Sales Agent)							
Last name	First name	First name						
Address								
City	State	Zip code						
Phone number () —	Relationship to	applicant						
Enrollee name								
Agent name/ID number Y0066 ERFMA 2025 C		UHFX25RP0220492_000						

For individuals hel	ning enrollee with	comi	nlat	ing this form o	nly
Complete this section		_		_	-
members, or other thir	d parties) helping an e	enrollee	e fill	out this form.	
Name		Relati	ons	nip to enrollee	
Signature		Natio	nal F	Producer Number	(Agents/Brokers only)
For Licensed Sales	s Representative/	agenc	ev u	se only	
Licensed Sales repres				Initial receipt date	е
Licensed Sales repres	entative/agent name			Proposed effective	ve date
Employer group name					
Employer group ID			В	ranch 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)	e 2 C re	nrol nd II 3 SE eside 3 AE	P (MA-PD lees eligible for EP) P (Change in ence) P (October 15- mber 7)	☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C					UHEX25RP0220492_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 Complete Care GS-2 (Regional PPO 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.

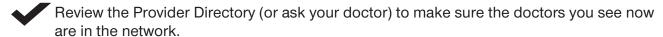
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

Enrollment checklist

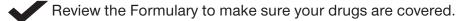
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





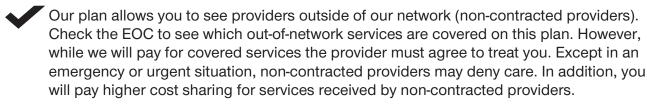




Understanding important rules







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.