

2025 Enrollment Request Form

☐ UHC Medicare Advantage GS-0001 (Regional PPO) R2604-001-000

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 [| | □ Femal | 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 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 | | | | UHEX25RP0220494_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-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 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 | X25RP0220494_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, 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 | | |
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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 on |
| Trovidoly For Hambol | 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 automatica your plan communications. | lly enrolls you in paperless delivery for some of |
| You will get many of your required plan communications an email when new communications (For example Changes) are available online. You can access the computer, tablet or mobile phone. | • |
| 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 have some communications are very large and may reference 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 gother 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 | |

| I understand that I can be enrolled in only on that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS), | end my enrollment in anot | ther MA plan (exceptions | |
|--|---|--------------------------|--|
| plans). Release of information: By joining this Med | icare Advantage Plan, I ac | knowledge that the 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 authoriz | | |
| ☐ I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan. | my protected health inform | _ | |
| The information on this form is correct to the intentionally provide false information on this | • | | |
| 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 ar | nd understand the inform | ation on this form | |
| understand that I will need to submit written proceed behalf of the member beyond this application. Af received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizat Signature of applicant/member/authorized rep | ter this application has been customer Service at the nation information on file. | en approved and I have | |
| If you are the authorized representative, information below (*Not a Sales Agent) | , please sign above ar | nd complete the | |
| Last name | First name | | |
| Address | | | |
| City | State | Zip code | |
| Phone number () — | Relationship to applicar | it | |
| | | | |
| Enrollee name | | | |
| Agent name/ID number | | IHEX25RP0220494_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 | | 1101 | | | |
| Signature | | Nati | ional I | Producer Number | (Agents/Brokers only) |
| For Licensed Sales | s Representative/ | ager | າcy ເ | 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 | | | | UHEX25RP0220494_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 GS-0001 (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.

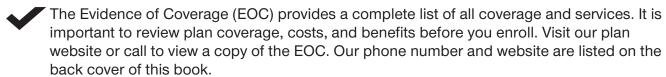
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

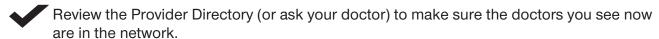
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

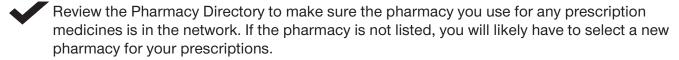
Enrollment checklist

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





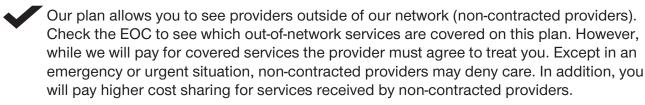


Review the Formulary to make sure your drugs are covered.

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.