



# **2025 Enrollment Request Form**

☐ UHC The Villages Medicare Advantage FL-004P (HMO-POS) H1045-056-000

Information about you (Please	type or pri	nt in black or b	olue ink	)
Last name	First name			Middle initial
Birth date		Sex □ Male [	□ Femal	e
Home phone number ( )	_	<ul> <li>Mobile phone number</li> </ul>		( ) –
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	hone nui	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 name				
Agent name/ID number				
Y0066_ERFMA_2025_C				UHFL25HP0221196_000

Do you have other insurance (Examples: Other private insura programs.) If yes, what is it?		•	☐ Yes ☐ No A 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	pecause you don't	
How do you want to pay?  If you have a monthly plan prer pay your premium by automati Board (RRB) benefit check each Electronic Funds Transfer (EFT)	mium (including any late enroll c deduction from your Social S ch month. You can also pay fro	Security or Railroa	ad Retirement	
If you don't choose an option b	pelow, we'll send a bill each mo	onth to your maili	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:  U You can pay it from your SS check  Medicare can bill you				
☐ The Railroad Retiremen				
☐ I want to pay from my Social	Security check			
☐ I want to pay from my Railroad Retirement Board (RRB) check				
☐ 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	is manage your plan			
1. Would you prefer plan info	rmation in another language	or an accessible	format?	
-	rmation in another language o Braille □ Large print □ Aud			
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 **1-844-723-6473**, 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	Samoan				
Japanese	Other Pacific Islander	c 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:		0010			
Enrollee name					
Enrollee nameAgent name/ID number	·	<del></del>			
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Nar	ne of health insurance company	
Me	mber number	
7. Pl	lease give us the name of your primary car	e of your primary care provider (PCP), clinic or health center.  Ian website or in the Provider Directory.  (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.)  e you recently seen this provider?
You	can find a list on the plan website or in the P	rovider Directory.
Prov	ider or PCP full name	
Prov	ider/PCP number	the website or in the Provider Directory. It will be
Are y	you now seeing or have you recently seen thi	is provider? ☐ Yes ☐ No
You an e Chai	mail when new communications (For exampl	e: Explanation of Benefits or the Annual Notice of
lf yo	u would rather have hard copies of require	ed materials mailed to you, please check here:
sc		
	ase read and sign	
Ву с	completing this form, I agree to the following	ıg:
	paying my Part B premium if I have one, unled I understand that people with Medicare are of the country, except for limited coverage near urgent care outside of the U.S. See the Sum I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealth	ess Medicaid or someone else pays for it. generally not covered under Medicare while out of r the U.S. border. This plan covers emergency and mary of Benefits for more information. e coverage begins, I must get all of my medical and

Enrollee name	
Agent name/ID number	
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nor UnitedHealthcare will pay for benefits or services that are not covered.

(also known as a member contract or subscriber agreement) will be covered. Neither Medicare

that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions

□ I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and

	apply for MA Private Fee-for-Service (PFFS), N	MA Medicare Medical Savi	ings 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 information (see Privacy Act Statement below).			
	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.			
Wh	en I sign below, it means that I have read an	d understand the informa	ation on this form	
sho und beh rece Unit	sign as an authorized representative, it means w written proof (power of attorney, guardiansh lerstand that I will need to submit written proof all of the member beyond this application. Afterived my UnitedHealthcare UCard®, I can call dedHealthcare UCard to update my authorization nature of applicant/member/authorized rep	ip, etc.) of this right if Med of this right, to the plan, if er this application has bee Customer Service at the non information on file.	dicare asks for it. I  I wish to take action on  approved and I have	
_	ou are the authorized representative,	please sign above an	d complete the	
	ormation below (*Not a Sales Agent) t name	First name		
Add	dress			
City	,	State	Zip code	
Phone number ( ) — Relationship to applicant			t	
Foi	r individuals helping enrollee with con	npleting this form onl	y	
	llee name			
Ager	nt name/ID number			
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Complete this section members, or other thir	•	•	_		ounselors, family
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sales	-	agen	cy u	se only	
Licensed Sales repres	entative/Writing ID			Initial receipt dat	e
Licensed Sales representative/agent name			Proposed effective date		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)		enrollees eligible for 2nd IEP)  ☐ SEP (Change in residence)  ☐ AEP (October 15-December 7)		☐ OEP (Jan 1 – Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI
Enrollee name Agent name/ID number					
Agent name/ID number Y0066_ERFMA_2025_C	ſ				UHFL25HP0221196_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 The Villages Medicare Advantage FL-004P (HMO-POS) 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.

UnitedHealthcare pays royalty fees to Holding Company of The Villages, Inc. (The Villages) for the use of its intellectual property. The Villages and its affiliates are not insurers. You do not need to reside in The Villages to enroll. The Villages encourages you to consider your needs when selecting products and does not make specific product recommendations for individuals.

This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

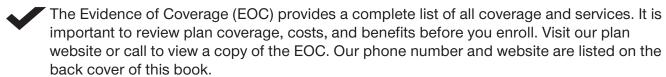
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

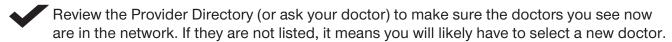
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

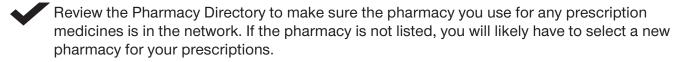
# **Enrollment checklist**

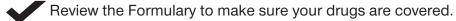
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

### Understanding the benefits

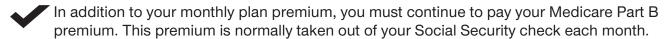


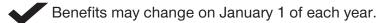


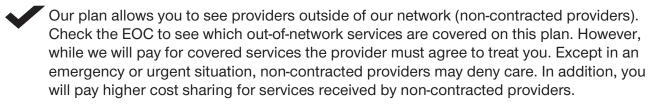




## **Understanding important rules**







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.