

2025 Enrollment Request Form

☐ UHC Complete Care FL-14 (HMO-POS C-SNP) H1045-048-004

Information about you (Please	type or pri	nt in black or b	lue ink)		
Last name	First name			Middle initial	
Birth date	Sex □ Male □ Female			e	
Home phone number ()	Mobile phone number () —) –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			none 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					
Y0066_ERFMA_2025_C				UHFL25HP0221198_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 your 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		UHF	L25HP0221198_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 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	
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, 2.2 coverage, mornere compensation,	☐ Yes ☐ No
If yes, please complete the following:		
Enrollee name		
Agent name/ID number		
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Na	me of health insurance company	
Me	ember number	
7. P	Please give us the name of your primary care	e provider (PCP), clinic or health center.
You	can find a list on the plan website or in the Pr	ovider Directory.
Pro	vider or PCP full name	
Pro	vider/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?
you You an e Cha	r plan communications. I will get many of your required plan communications (For example)	cations delivered electronically. We will send you e: Explanation of Benefits or the Annual Notice of ese communications through any device such as a
lf yo	ou would rather have hard copies of require	d materials mailed to you, please check here:
S	nstead of paperless delivery, we will mail you home communications are very large and may preference for delivery at any time.	nard copies of required materials. Please note that not fit in all mailboxes. You can change your
Ple	ase read and sign	
Ву	completing this form, I agree to the followin	g:
	paying my Part B premium if I have one, unle I understand that people with Medicare are g	generally not covered under Medicare while out of the U.S. border. This plan covers emergency and
	I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealth	coverage begins, I must get all of my medical and care. Benefits and services authorized by

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

UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare

□ 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), I plans).	MA Medicare Medical Sav	ings Account (MSA)	
Release of information: By joining this Medi will share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below	may use it to track my en Federal law that authorize	rollment, to make	
I give UnitedHealthcare permission to share my protected health information with organization or person(s) for permissible purposes under applicable law as required to administer my health plan.			
 The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. Howev plan. 	form I will be disenrolled	from the plan.	
When I sign below, it means that I have read an	d understand the inform	ation on this form	
If I sign as an authorized representative, it means show written proof (power of attorney, guardiansh understand that I will need to submit written proof behalf of the member beyond this application. Aft received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizati Signature of applicant/member/authorized rep	nip, etc.) of this right if Med f of this right, to the plan, it ter this application has been Customer Service at the notion information on file.	dicare asks for it. I f I wish to take action on en approved and I have	
If you are the authorized representative, information below (*Not a Sales Agent)	please sign above an	d complete the	
Last name	First name		
Address			
City	State	Zip code	
Phone number () —	Relationship to applican	t	
For individuals helping enrollee with con	npleting this form onl	у	
Enrollee name			
Agent name/ID number		IHEL 25HP0221108 000	

•	ı if you're an individual (rd parties) helping an e	. •			ounselors, family
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sale	es Representative/a	agenc	y u	se only	
Licensed Sales representative/Writing ID				Initial receipt date	
Licensed Sales representative/agent name				Proposed effective date	
Employer group name	9				
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees) ☐ e		nrol	P (MA-PD lees eligible for	☐ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS	reside □ AEI		P (Change in ence) P (October 15-	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason)	maintaining)			mber 7)	
Licensed Sales repre	esentative signature (o	ptiona	ıl)		Date
	Please mail or fax	this co	omp	oleted form to:	
Enrollee name					
	er				

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 FL-14 (HMO-POS 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.

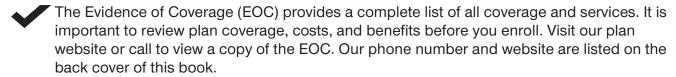
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

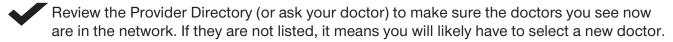
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

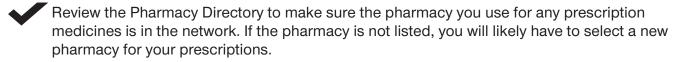
Enrollment checklist

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





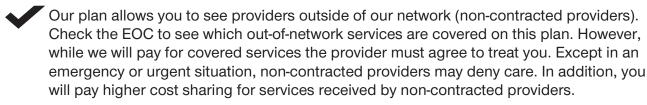


Review the Formulary to make sure your drugs are covered.

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 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.