

2025 Enrollment Request Form

☐ UHC Complete Care FL-14 (HMO-POS C-SNP) H1045-048-001

Information about you (Please Last name	First name			Middle initial
Birth date		Sex □ Male □] Femal	e
Home phone number ()	_	Mobile phone number () —		() –
☐ I give consent for UnitedHealthcausing an autodialer and/or prerecor		•	none nur	mber(s) I have provided
Medicare number				
Permanent residence street address homelessness, a PO Box may be o	•			
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)		I		
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C				UHFL25HP0221201_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 Railroad Retirement Board (RRB) check			
☐ 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		UHF	L25HP0221201_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)		☐ 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	us the name of your primary care provider (PCP), clinic or health center. list on the plan website or in the Provider Directory. P full name (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.) Peing or have you recently seen this provider?
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.
Prov	vider or PCP full name	
Prov	vider/PCP number	the website or in the Provider Directory. It will be
Are	you now seeing or have you recently seen this	s provider?
You an e Cha	email when new communications (For example	e: Explanation of Benefits or the Annual Notice of
lf yo	ou would rather have hard copies of require	d materials mailed to you, please check here:
S		·
	ase read and sign	
Ву	completing this form, I agree to the following	g:
	paying my Part B premium if I have one, unled I understand that people with Medicare are gothe country, except for limited coverage near urgent care outside of the U.S. See the Summanderstand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcare	ess Medicaid or someone else pays for it. Interest years and the U.S. border. This plan covers emergency and mary of Benefits for more information. Coverage begins, I must get all of my medical and

Enrollee name	
Agent name/ID number _	
Y0066_ERFMA_2025_C	UHFL25HP0221201_00

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), Neglans).	MA Medicare Medical Savi	ings Account (MSA)
Release of information: By joining this Medicare, who 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 end Federal law that authorize	rollment, to make
 I give UnitedHealthcare permission to share r or person(s) for permissible purposes under a 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 plan. 	form I will be disenrolled f	rom the plan.
When I sign below, it means that I have read an	d understand the informa	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, if er this application has bee Customer Service at the n on information on file.	dicare asks for it. I I wish to take action on 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	y
Enrollee name		
Agent name/ID number		IHEL 25HP0221201 000

members, or other third parties) helping an enrollee fill out this form. Name Relationship to enrollee Signature National Producer Number (Agents For Licensed Sales Representative/agency use only Licensed Sales representative/Writing ID Initial receipt date	s/Brokers only)
For Licensed Sales Representative/agency use only	s/Brokers only)
Licensed Sales representative/Writing ID Initial receipt date	
Licensed Sales representative/agent name Proposed effective date	
Employer group name	
Employer group ID Branch ID	
enrollees) enrollees eligible for 2nd IEP) OEP (Newly SEP (Dual LIS SEP (Change in SEP)	EP (Loss of
☐ SEP (Chronic) ☐ SEP (Dual LIS ☐ AEP (October 15- ☐ OI maintaining) ☐ December 7)	IP coverage) EPI
☐ SEP (SEP reason)	
Licensed Sales representative signature (optional) Date	
Please mail or fax this completed form to:	
Enrollee name	
Agent name/ID number	 25HP0221201_000

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.

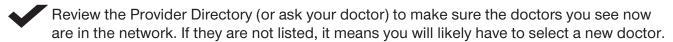
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

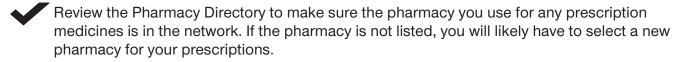
Enrollment checklist

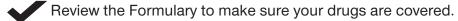
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





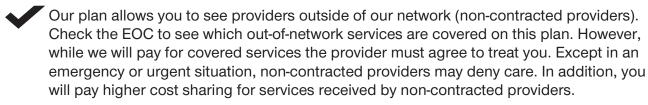




Understanding important rules







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.