



# **2025 Enrollment Request Form**

☐ UHC The Villages Medicare Advantage FL-0004 (HMO-POS) H1045-025-000

Information about you (Please Last name	First name			Middle initial
Birth date		Sex □ Male □	Femal	e
Home phone number ( )	_	Mobile phone nu	umber (	( ) –
☐ I give consent for UnitedHealthcarusing an autodialer and/or prerecor		•	one nur	mber(s) I have provided
Medicare number				
Permanent residence street address homelessness, a PO Box may be o	•			
City	County	5	State	Zip code
Mailing address (Only if it's different	nt from above	e. You can give a	P.O. bo	)x.)
City		(	State	Zip code
Email address (optional)		I		
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C				UHFL25HP0221216_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	ou 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   Large print   Audi		•
Enrollee name			
Agent name/ID number			
Y0066_ERFMA_2025_C		UHF	L25HP0221216_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, 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	Chinese Native Hawaiian			
Filipino Samoan				
Japanese				
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, memore compensation,	☐ Yes ☐ No		
If yes, please complete the following:				
Enrollee name				
Agent name/ID number				
V0066 EREMA 2025 C	LIHEL 25HP0	221216 000		

	Page 4 of 8
Name of health insurance company	
Member number	
7. Please give us the name of your primary ca	are provider (PCP), clinic or health center.
You can find a list on the plan website or in the	Provider Directory.
Provider or PCP full name	
Provider/PCP number	(Please enter the number exactly as it appears or 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 t	his provider? ☐ Yes ☐ No
an email when new communications (For exam	nications delivered electronically. We will send you ple: Explanation of Benefits or the Annual Notice of these communications through any device such as a
If you would rather have hard copies of requi	red materials mailed to you, please check here:
	u hard copies of required materials. Please note that ay not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the follow	
paying my Part B premium if I have one, understand that people with Medicare are the country, except for limited coverage neurgent care outside of the U.S. See the Sur I understand that when my UnitedHealthca prescription drug benefits from UnitedHeal	dical (Part B) to stay in UnitedHealthcare. I must keep aless Medicaid or someone else pays for it. e generally not covered under Medicare while out of ear the U.S. border. This plan covers emergency and mmary of Benefits for more information. re coverage begins, I must get all of my medical and thcare. Benefits and services authorized by tedHealthcare "Evidence of Coverage" document

Enrollee name	
Agent name/ID number	
Y0066 ERFMA 2025 C	UHFL25HP0221216_000

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), plans).	MA Medicare Medical Sav	ings Account (MSA)		
	<b>Release of information:</b> 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).  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 plan.				
	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 ar	nd understand the inform	ation on this form		
und beh rece Unit	w written proof (power of attorney, guardians derstand that I will need to submit written proceeding of the member beyond this application. Af eived my UnitedHealthcare UCard®, I can call tedHealthcare UCard to update my authorizat nature of applicant/member/authorized reparts of the country of the countr	of of this right, to the plan, inter this application has been customer Service at the nation information on file.  Today	f I wish to take action on en approved and I have umber on my 's date		
_	ou are the authorized representative, ormation below (*Not a Sales Agent)	, piease sign above an	id complete the		
Las	t name	First name			
Add	dress				
City	1	State	Zip code		
Pho	one number ( ) —	Relationship to applican	t		
	r individuals helping enrollee with cor		у		
	illee name nt name/ID number				
~y€I	к паше/ ID пашьег				

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		
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 nameAgent name/ID number					
Y0066_ERFMA_2025_C					UHFL25HP0221216_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-0004 (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.

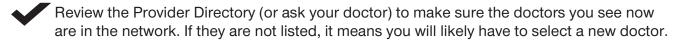
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

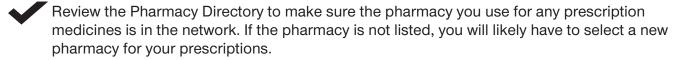
# **Enrollment checklist**

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

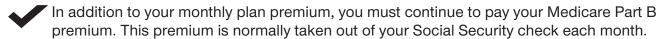




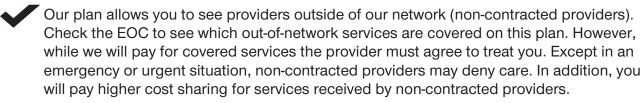




## **Understanding important rules**







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.