

2025 Enrollment Request Form

☐ UHC Complete Care Support GA-9 (PPO C-SNP) H1889-028-000

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 ()	_	Mobile phone r	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	County		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				UHGA25LP0221134_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		UHG	A25LP0221134_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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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.	ovidos Disoctos
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 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? ☐ Yes ☐ No
Providing your email address above automatica your plan communications.	
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 h 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 go the 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 Healthcare "Evidence of Coverage" document ber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number	
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 I understand that I can be enrolled in only of that enrollment in this plan will automaticall apply for MA Private Fee-for-Service (PFFS) 	y end my enrollment in ano	ther MA plan (exceptions		
 plans). Release of information: By joining this Mewill share my information with Medicare, who payments, and for other purposes allowed I information (see Privacy Act Statement below I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan. The information on this form is correct to the intentionally provide false information on this 	no may use it to track my erectory Federal law that authorized w). The my protected health inform applicable law as required to best of my knowledge. It	rollment, to make the collection of this mation with organizations d to administer my health understand that if I		
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 a	and understand the inform	nation on this form		
show written proof (power of attorney, guardians understand that I will need to submit written probehalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can ca UnitedHealthcare UCard to update my authorizations. Signature of applicant/member/authorized received.	of of this right, to the plan, after this application has be Il Customer Service at the ration information on file. Epresentative Today	if I wish to take action on en approved and I have number on my y's date		
If you are the authorized representative information below (*Not a Sales Agent)	e, please sign above a	nd complete the		
Last name	First name			
Address				
City	State	Zip code		
Phone number () —	Relationship to applicar	nt		
Enrollee name				
Agent name/ID number Y0066_ERFMA_2025_C		 UHGA25LP0221134_000		

For individuals hel	ning enrollee with	comi	alet	ing this form o	nlv
Complete this section		_		_	-
members, or other thir	d parties) helping an e	enrollee	e fill	out this form.	•
Name		Relati	onsl	nip to enrollee	
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sales	s Representative/	agenc	v u	se only	
Licensed Sales representative/Writing ID		- 3		Initial receipt date	е
Licensed Sales repres	entative/agent name			Proposed effective	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)	e 2 C re	nroll nd II] SE eside] AE	P (MA-PD lees eligible for EP) P (Change in ence) P (October 15- mber 7)	☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C	-				UHGA25LP0221134_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 Complete Care Support GA-9 (PPO 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.

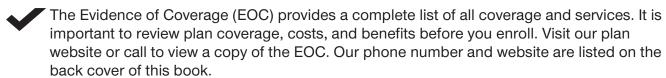
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

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

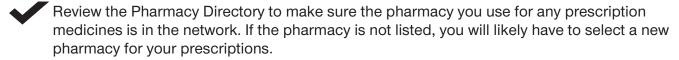
Enrollment checklist

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





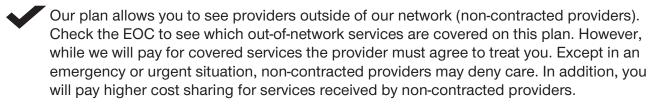


Review the Formulary to make sure your drugs are covered.

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.