

# **2025 Enrollment Request Form**

☐ UHC Complete Care GA-3 (PPO C-SNP) H1889-020-000

Select optional supplemental benefits in addition to what is included with your plan

You can add the following benefit rider for an extra cost. You can purchase the rider now while you are enrolling, or within 3 months after your effective date. See the Summary of Benefits for more information, including costs.

☐ Platinum Dental Rider					
Information about you (Please	type or pri	nt in black or	blue ink	)	
Last name	First name		Middle initial		
Birth date	Sex □ Male □		□ Femal	le	
Home phone number ( )	<ul> <li>Mobile phone</li> </ul>		number	( ) –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			ohone 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 different from above. You can give a P.O. box.)					
City		State	Zip code		
Email address (optional)					
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C				UHGA25LP0221140_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	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	pelow, 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 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	• • •			
1. Would you prefer plan info				
	rmation in another language or Braille □ Large print □ Audi		•	
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C		UHG	A25LP0221140_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	<b>'.</b>			
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)		l Yes □ No		
If yes, please complete the following:	_	. 00 =		
Enrollee name				
Agent name/ID number				
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Page	4	of	8

	Page 4 of 8
Name of health insurance company	
Member number	
7. Please give us the name of your primary car	re provider (PCP), clinic or health center.
You aren't limited to this list. You may go to any	doctor who accepts Medicare and the plan's
payment terms.	
You can find a list on the plan website or in the F	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 th	nis provider?
your plan communications.  You will get many of your required plan communan email when new communications (For example)	nications delivered electronically. We will send you ble: Explanation of Benefits or the Annual Notice of hese communications through any device such as a
	ed materials mailed to you, please check here:
	hard copies of required materials. Please note that y not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the following	ng:
paying my Part B premium if I have one, unl I understand that people with Medicare are the country, except for limited coverage nea urgent care outside of the U.S. See the Sum I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealt UnitedHealthcare and contained in my United	generally not covered under Medicare while out of ar the U.S. border. This plan covers emergency and nmary of Benefits for more information. The coverage begins, I must get all of my medical and theore. Benefits and services authorized by the edhealthcare "Evidence of Coverage" document criber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	UHGA25LP0221140_000

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), MA Medicare Medical Savings 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).							
☐ 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							
<ul> <li>plan.</li> <li>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.</li> <li>My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.</li> </ul>							
When I sign below, it means that I ha	ave read and understand the	information on this form					
show written proof (power of attorney, understand that I will need to submit when behalf of the member beyond this appreceived my UnitedHealthcare UCard UnitedHealthcare UCard to update my Signature of applicant/member/authorized representations.	vritten proof of this right, to the plication. After this application B, I can call Customer Service y authorization information on horized representative	e plan, if I wish to take action on has been approved and I have at the number on my file.  Today's date					
information below (*Not a Sales							
Last name	First name						
Address							
City	State	Zip code					
Phone number ( ) —	) — Relationship to applicant						
Agent name/ID number Y0066_ERFMA_2025_C		UHGA25LP0221140_000					
<del>_</del>							

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		Natio	nal F	Producer Number	(Agents/Brokers only)
For Licensed Sales	s Representative/	agenc	v u	se only	
Licensed Sales repres		- <b>3</b>	Initial receipt date		е
Licensed Sales repres	entative/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)	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	-				UHGA25LP0221140_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 GA-3 (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.

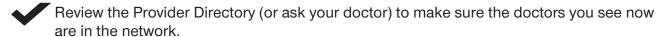
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

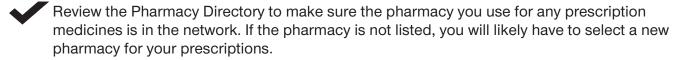
# **Enrollment checklist**

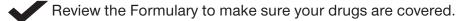
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the benefits





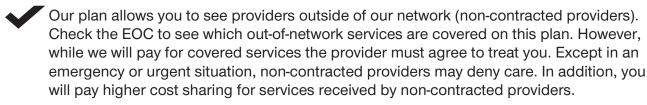




### **Understanding important rules**







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.