

# **2025** Enrollment Request Form

☐ UHC Medicare Advantage Essentials GA-2 (PPO) H1889-013-000

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	е
Home phone number ( )	_	Mobile phone	number (	( ) –
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	hone 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 differen	t from above	e. You can give	a P.O. bo	ox.)
City			State	Zip code
Email address (optional)				
Enrollee nameAgent name/ID number				
Y0066_ERFMA_2025_C				UHGA25LP0221147_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 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		UHG	A25LP0221147_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	panish 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	usurance that will cover medical services?	
(Examples: Other employer group coverage		
auto liability, or Veterans benefits)		☐ Yes ☐ No
If yes, please complete the following:		_ 100 _ 110
3		
Enrollee name		
Agent name/ID number	LIHGA25I PO	
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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 doctor who accepts Medicare and the plan's payment terms.

You can find a list on the plan website or in the Provider Directory.

I	Provider	or	PCP	full	name
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1 10 110 01 01 1 01 1011 1101 110	
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	s provider? ☐ Yes ☐ No

# Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone.

#### If you would rather have hard copies of required materials mailed to you, please check here:

Instead of paperless delivery, we will mail you hard copies of required materials. Please note that
some communications are very large and may not fit in all mailboxes. You can change your
preference for delivery at any time.

#### Please read and sign

#### By completing this form, I agree to the following:

- ☐ I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information.
- I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.

Enrollee name	
Agent name/ID number	
Y0066_ERFMA_2025_C	UHGA25LP0221147_000

that enrollment apply for MA Pi	in this plan will automa	tically end my enrollmen	tage (MA) plan at a time – and t in another MA plan (exceptions ical Savings Account (MSA)
will share my in payments, and	formation with Medicar	re, who may use it to tract wed by Federal law that a	an, I acknowledge that the plan k my enrollment, to make authorize the collection of this
☐ I give UnitedHe	althcare permission to	share my protected healt	ch information with organizations required to administer my health
<ul><li>The information intentionally pro</li></ul>	ovide false information o	on this form I will be dise	edge. I understand that if I nrolled from the plan. nd may affect enrollment in the
When I sign below,	it means that I have re	ead and understand the	information on this form
understand that I wi behalf of the memb received my United! UnitedHealthcare U Signature of applic	Il need to submit writter er beyond this applicati Healthcare UCard®, I ca Card to update my auth ant/member/authoriz	n proof of this right, to the ion. After this application an call Customer Service norization information on ed representative	-
_	w (*Not a Sales Age		·
Last name		First name	
Address			
City		State	Zip code
Phone number (	) —	Relationship to a	applicant
For individuals h	elping enrollee wit	h completing this fo	rm only
Agent name/ID numl Y0066_ERFMA_2025_C	oer		UHGA25LP0221147_000

Name	members, or other third parties) helping an e							
Name		Relationship to enrollee						
Signature		Nationa	al F	Producer Number	(Agents/Brokers only)			
	s Representative/a	gency	u:	se only				
Licensed Sales repres			Initial receipt date					
Licensed Sales representative/agent name				Proposed effective date				
Employer group name	)							
Employer group ID			Bı	ranch ID				
Agent must complete								
☐ IEP (MA-PD enrollees)	e		roll	P (MA-PD ees eligible for	☐ OEP (Jan 1 - Mar 31)			
☐ OEP (Newly	☐ SEP (Dual LIS		2nd IEP) □ SEP (Change in		☐ SEP (Loss of			
eligible)	change of status)		•		EGHP coverage)			
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)			P (October 15- mber 7)	□ OEPI			
☐ SEP (SEP reason) _				<b>,</b>				
Licensed Sales repre	sentative signature (o	ptional	)	Da	ate			
	Please mail or fax	this co	mp	leted form to:				
Enrollee name Agent name/ID numbe								

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 Medicare Advantage Essentials GA-2 (PPO) 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.

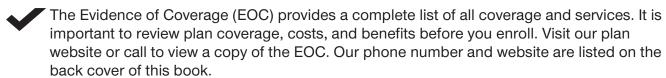
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

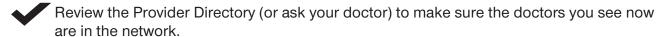
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

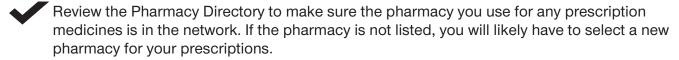
## **Enrollment checklist**

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



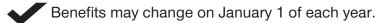


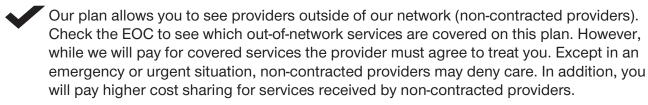


Review the Formulary to make sure your drugs are covered.

#### **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.