

2025 Enrollment Request Form

 \square UHC Complete Care Support ST-1A (PPO C-SNP) H2001-037-000

Information about you (Disease		امليم باممام مياما	ادامان		
Information about you (Please	T	nt in black or bi	ue ink)		
Last name	First name			Middle initial	
Birth date		Sex ☐ Male ☐	x 🗆 Male 🗆 Female		
Home phone number ()	 Mobile phone number 		ımber (
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	one nur	nber(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		S	State	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C				UHIL25LP0221100_000	
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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	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		UH	IL25LP0221100_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 □ I		
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 □ N		
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 ca	are provider (PCP), clinic or health center.
You aren't limited to this list. You may go to any payment terms.	doctor who accepts Medicare and the plan's
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 of 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	his provider? ☐ Yes ☐ No
Providing your email address above automatic your plan communications.	cally enrolls you in paperless delivery for some of
an email when new communications (For examp	nications delivered electronically. We will send you ole: Explanation of Benefits or the Annual Notice of these communications through any device such as a
If you would rather have hard copies of requir	red materials mailed to you, please check here:
	u hard copies of required materials. Please note that by not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the followi	ing:
paying my Part B premium if I have one, un I understand that people with Medicare are the country, except for limited coverage nea urgent care outside of the U.S. See the Sun I understand that when my UnitedHealthcar prescription drug benefits from UnitedHealt UnitedHealthcare and contained in my Unite	e generally not covered under Medicare while out of ar 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 redHealthcare "Evidence of Coverage" document criber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	

 I understand that I can be enrolled in only on that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS), I 	end my enrollment in ano	ther MA plan (exceptions		
plans). Release of information: By joining this Mediwill share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below I give UnitedHealthcare permission to share ror person(s) for permissible purposes under plan. The information on this form is correct to the intentionally provide false information on this	may use it to track my end Federal law that authorized). my protected health informapplicable law as required best of my knowledge. I use the many series of my knowledge.	rollment, to make e the collection of this nation with organizations d to administer my health understand that if I		
 intentionally provide false information on this form I will be disenrolled from the plan. 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 an	d understand the inform	ation on this form		
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 authorizations. Signature of applicant/member/authorized rep	f of this right, to the plan, inter this application has been Customer Service at the notion information on file. Presentative Today	f I wish to take action on en approved and I have number on my r's date		
If you are the authorized representative, information below (*Not a Sales Agent)	please sign above ar	nd complete the		
Last name	First name			
Address				
City	State	Zip code		
Phone number () —	Relationship to applicant			
Enrollee name				
Agent name/ID number Y0066_ERFMA_2025_C		 UHIL25LP0221100_000		

For individuals hel	ping enrollee with	ı co	mple	etina this form o	nlv
Complete this section	if you're an individual	(i.e.	agent	ts, brokers, SHIP co	-
members, or other third parties) helping an e					
Name		Rei	lation	ship to enrollee	
Signature		Nat	tional	Producer Number	(Agents/Brokers only)
For Licensed Sales	s Representative/	age	ncy	use only	
Licensed Sales representative/Writing ID			Initial receipt date		e
Licensed Sales repres	entative/agent name		Proposed effective date		ve date
Employer group name					
Employer group ID			ı	Branch ID	
Agent must complete					_
☐ IEP (MA-PD	☐ ICEP (MA enrolle	•		EP (MA-PD	☐ OEP (Jan 1 – Mar 31)
enrollees)				ollees eligible for IEP)	iviai 31)
☐ OEP (Newly	☐ SEP (Dual LIS			EP (Change in	☐ SEP (Loss of
eligible)	change of status)			dence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)			EP (October 15- ember 7)	□ OEPI
☐ SEP (SEP reason) _					
Enrollee name Agent name/ID number					
Y0066_ERFMA_2025_C					UHIL25LP0221100_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 ST-1A (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.

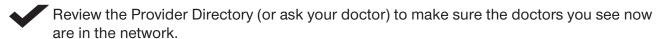
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

Enrollment checklist

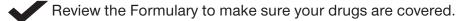
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





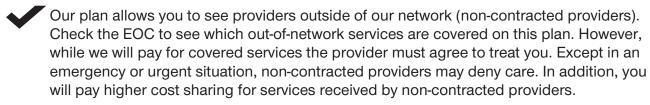




Understanding important rules







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.