

2025 Enrollment Request Form

☐ UHC Complete Care MA-7 (HMO-POS C-SNP) H5253-155-000

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 b	lue ink)		
Last name	First name			Middle initial	
Birth date	•	Sex □ Male □] Femal	Э	
Home phone number ()	_	Mobile phone n	umber () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			none 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 differen	t from above	e. You can give a	P.O. bo	x.)	
City			State	Zip code	
Email address (optional)		<u>'</u>			
Enrollee nameAgent name/ID number					
Y0066 FRFMA 2025 C			ι	JHMA25HP0220637 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	•	onth to your mailir	ng address.
If you must pay a Part D-Incom		-	
Social Security (SS) will send y	•	•	,
☐ You can pay it from you	r SS check		
☐ Medicare can bill you			
•	t Board (RRB) can bill you		
☐ I want to pay from my Social	, ,		
☐ I want to pay from my Railro	•	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 UHMA25HP0220637_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)	s, Erb coverage, workers compensation,	['] □ Yes □ No
If yes, please complete the following:		_ 100 _ 110
		
Enrollee name		
Agent name/ID number	I IHMA 25HPO	1220627 000

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Naı	me of health insurance company	
Me	ember number	
7. P	lease give us the name of your primary card	e provider (PCP), clinic or health center.
You	can find a list on the plan website or in the Pr	rovider Directory.
Prov	vider or PCP full name	
	vider/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 thi	s provider?
	viding your email address above automaticar r plan communications.	ally enrolls you in paperless delivery for some of
an e Cha	mail when new communications (For example	cations delivered electronically. We will send you e: Explanation of Benefits or the Annual Notice of ese communications through any device such as a
lf yo	ou would rather have hard copies of require	d materials mailed to you, please check here:
S	istead of paperless delivery, we will mail you home communications are very large and may reference for delivery at any time.	nard copies of required materials. Please note that not fit in all mailboxes. You can change your
Ple	ase read and sign	
Вус	completing this form, I agree to the followin	g:
	paying my Part B premium if I have one, unled I understand that people with Medicare are g	generally not covered under Medicare while out of r the U.S. border. This plan covers emergency and

Enrollee name	
Agent name/ID number	
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nor UnitedHealthcare will pay for benefits or services that are not covered.

□ 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

□ 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) plans).	, MA Medicare Medical Sav	vings Account (MSA)
Release of information: By joining this Medwill share my information with Medicare, who payments, and for other purposes allowed information (see Privacy Act Statement belowed).	no may use it to track my er by Federal law that authoriz	rollment, to make
 I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan. 	e my protected health inforr	· ·
 The information on this form is correct to the intentionally provide false information on the My response to this form is voluntary. Howen plan. 	is form I will be disenrolled	from the plan.
When I sign below, it means that I have read a	and understand the inform	nation on this form
If I sign as an authorized representative, it mean 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 authorized Signature of applicant/member/authorized re	ship, etc.) of this right if Me of of this right, to the plan, after this application has be Il Customer Service at the ration information on file.	dicare asks for it. I if I wish to take action on en approved and I have
If you are the authorized representative information below (*Not a Sales Agent)	e, please sign above ar	nd complete the
Last name	First name	
Address		
City	State	Zip code
Phone number () — Relationship to applicant		nt
For individuals helping enrollee with co	empleting this form on	ly
Enrollee name		
Agent name/ID number		IHMA 25HP0220637 000

	if you're an individual rd parties) helping an e	•	_		ounselors, family	
			elationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)				
For Licensed Sale	s Representative/a	agen	icy u	ise only		
Licensed Sales representative/Writing ID				Initial receipt date		
Licensed Sales repres	Licensed Sales representative/agent name			Proposed effective date		
Employer group name)					
Employer group ID			В	ranch ID		
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees) ☐ er		enrol	P (MA-PD llees eligible for	□ OEP (Jan 1 – Mar 31)	
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	residence		EP (Change in ence) EP (October 15-	☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ SEP (SEP reason) _				, 		
Licensed Sales repre	esentative signature (c	option	nal)	1	Date	
	Please mail or fax	this	com	oleted form to:		
Enrollee name						
Enrollee name Agent name/ID numbe Y0066_ERFMA_2025_C					UHMA25HP0220637_000	

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 MA-7 (HMO-POS 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.

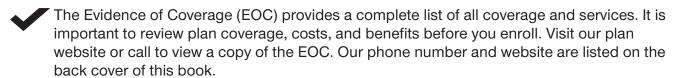
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

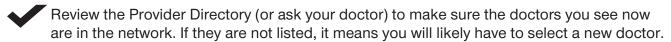
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

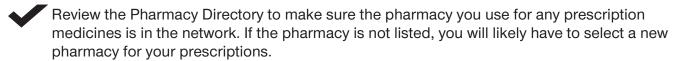
Enrollment checklist

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





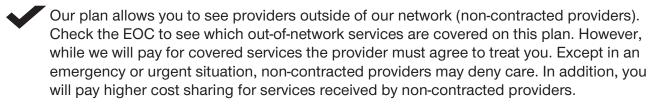


Review the Formulary to make sure your drugs are covered.

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.