

2025 Enrollment Request Form

☐ UHC Northern Light Health ME-0001 (HMO-POS) H5253-162-002

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 l	olue 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 nur	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 nameAgent name/ID number					
Y0066_ERFMA_2025_C			·	JHME25HP0220631_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	☐ The Railroad Retirement 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				
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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	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:		0010
Enrollee name		
Enrollee nameAgent 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 can find a list on the plan website or in the Pr	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	s provider?
your plan communications. You will get many of your required plan communications (For example)	cations delivered electronically. We will send you explanation of Benefits or the Annual Notice of ese communications through any device such as a
computer, tablet or mobile phone.	230 communications through any device such as a
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 preference for delivery at any time.	nard copies of required materials. Please note that not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the following	g:
paying my Part B premium if I have one, unle I understand that people with Medicare are g the country, except for limited coverage near urgent care outside of the U.S. See the Sumr	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and

Enrollee name	
Agent name/ID number	
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prescription drug benefits from UnitedHealthcare. Benefits and services authorized by

nor UnitedHealthcare will pay for benefits or services that are not covered.

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 (F plans).	PFFS), MA Medicare Medi	ical Savings Account (MSA)
Release of information: By joining thi will share my information with Medicar payments, and for other purposes allowinformation (see Privacy Act Statemen	re, who may use it to tracl wed by Federal law that a	k my enrollment, to make
☐ I give UnitedHealthcare permission to or person(s) for permissible purposes plan.	share my protected healt	<u> </u>
 The information on this form is correct intentionally provide false information My response to this form is voluntary. plan. 	on this form I will be dise	nrolled from the plan.
When I sign below, it means that I have re	ead and understand the	information on this form
show written proof (power of attorney, gual understand that I will need to submit writte behalf of the member beyond this applicative received my UnitedHealthcare UCard®, I card UnitedHealthcare UCard to update my authorized Signature of applicant/member/authorized to update my authorized to u	n proof of this right, to the ion. After this application an call Customer Service horization information on	e plan, if I wish to take action on has been approved and I have at the number on my
If you are the authorized represent information below (*Not a Sales Age		ove and complete the
Last name	First name	
Address		
City	State	Zip code
Phone number () —	Relationship to a	applicant
For individuals helping enrollee wit	th completing this fo	rm only
Complete this section if you're an individual members, or other third parties) helping an		
Enrollee name		
Agent name/ID number		

Name			Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)				
For Licensed Sale	s Representative/a	agency	use only	7		
Licensed Sales repres	sentative/Writing ID		Initial receipt date			
Licensed Sales representative/agent name			Propose	Proposed effective date		
Employer group name)					
Employer group ID			Branch ID			
Agent must complete	e					
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollee	es) ☐ IEP (MA-PD enrollees eligible for 2nd IEP)			□ OEP (Jan 1 – Mar 31)	
☐ OEP (Newly	☐ SEP (Dual LIS	☐ SEP (Change in		☐ SEP (Loss of		
eligible)	change of status)	residence)			EGHP coverage)	
☐ SEP (Chronic)	☐ SEP (Dual LIS	☐ AEP (October 15- December 7)		□ OEPI		
☐ SEP (SEP reason) _	g)	naintaining) Decem				
Licensed Sales repre	esentative signature (o	ptional)	Da	ate	
	Please mail or fax	this co		rm to:		
		Box 30				
Enrollee name						
Enrollee nameAgent name/ID numbe						
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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 Northern Light Health ME-0001 (HMO-POS) 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.

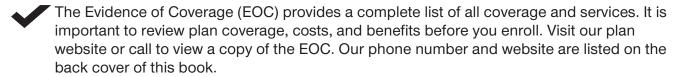
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

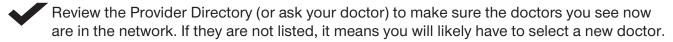
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

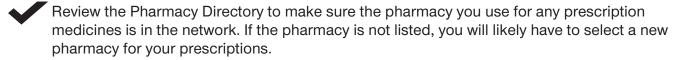
Enrollment checklist

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





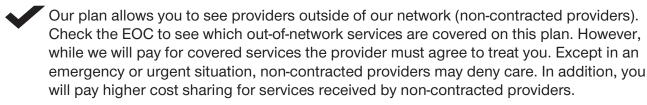


Review the Formulary to make sure your drugs are covered.

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.