

2025 Enrollment Request Form

☐ UHC Northern Light Health ME-0001 (HMO-POS) H5253-162-001

Information about you (Please	type or pri	nt in black or b	olue ink)
Last name	First name		Middle initial	
Birth date		Sex ☐ Male ☐] Femal	e
Home phone number ()	_	Mobile phone n	umber (() —
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			none 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 differen	t from above	e. You can give a	P.O. bo	ox.)
City			State	Zip code
Email address (optional)				
Enrollee name				
Agent name/ID number				
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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.	Answering these questions is your choice. You can't be denied coverage because you don't fill them out.				
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	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-II	RMAA),		
Social Security (SS) will send you a letter and ask you how you want to pay it:					
□ You can pay it from your SS check					
□ Medicare can bill you					
☐ 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					
Y0066_ERFMA_2025_C		UHM	E25HP0220632_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	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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Na	ame of health insurance company		
Me	ember number		
7. F	Please give us the name of your primary care	e provider (PCP), clinic or health center.	
Υοι	ı can find a list on the plan website or in the Pr	ovider Directory.	
Pro	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 this	s provider?	
you You an e Cha con	ur plan communications. u will get many of your required plan communications (For example anges) are available online. You can access the aputer, tablet or mobile phone.	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 y	ou would rather have hard copies of require	d materials mailed to you, please check here:	
S	nstead of paperless delivery, we will mail you he 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	
Ple	ease read and sign		
Ву	completing this form, I agree to the followin	g:	
	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 prescription drug benefits from UnitedHealth	coverage begins, I must get all of my medical and care. Benefits and services authorized by	

Enrollee name	
Agent name/ID number	
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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 (P plans).	PFFS), MA Medicare Med	ical Savings Account (MSA)	
Release of information: By joining this will share my information with Medicar payments, and for other purposes allowinformation (see Privacy Act Statement)	re, who may use it to track wed by Federal law that a	k my enrollment, to make	
I give UnitedHealthcare permission to share my protected health information with organization or person(s) for permissible purposes under applicable law as required to administer my healt plan.			
 The information on this form is correct intentionally provide false information of the My response to this form is voluntary. In 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, guarunderstand that I will need to submit written behalf of the member beyond this applicati received my UnitedHealthcare UCard®, I caunitedHealthcare UCard to update my authorizes applicant/member/authorizes.	n proof of this right, to the ion. After this application an call Customer Service norization 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 representation 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 individua 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			
Licensed Sales repres	entative/Writing ID		Initial receipt date			
Licensed Sales representative/agent name			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 maintaining)	☐ AEP (October 15- December 7)		□ OEPI		
☐ SEP (SEP reason) _	•					
Licensed Sales repre	esentative signature (o	ptional) D	ate		
	Please mail or fax		•			
		dHealth Box 307				
	1.0.	DOX 307	70			
Enrollee name						
Agent name/ID numbe Y0066_ERFMA_2025_C	r					
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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.

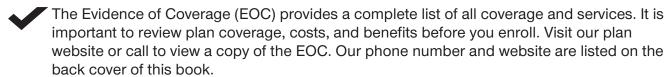
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

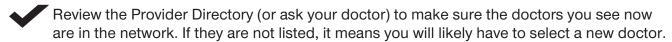
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

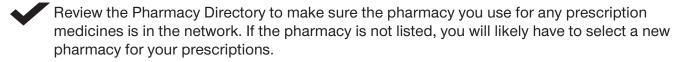
Enrollment checklist

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





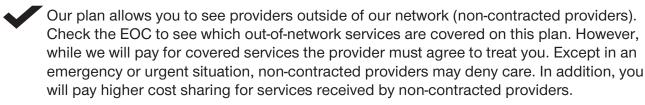




Understanding important rules







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.