

2025 Enrollment Request Form

☐ UHC Complete Care ME-6 (HMO-POS C-SNP) H5253-161-000

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			ohone 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 name Agent name/ID number					
Y0066_ERFMA_2025_C				 JHME25HP0220633_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	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 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		UHM	E25HP0220633_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)	o,	☐ Yes ☐ No		
If yes, please complete the following:				
Enrollee name				
Agent name/ID number				
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N	ame of health insurance company	
M	lember number	
7.	Please give us the name of your primary care	e provider (PCP), clinic or health center.
Yo	ou can find a list on the plan website or in the Pr	rovider Directory.
Pro	ovider or PCP full name	
Pro	ovider/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	e you now seeing or have you recently seen thi	s provider?
	oviding your email address above automatica ur plan communications.	ally enrolls you in paperless delivery for some of
an Ch	email when new communications (For exampl	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:
;	Instead of paperless delivery, we will mail you had 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 following	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

plans).		vings Account (MSA)
Release of information: By joining this Med will share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below	o may use it to track my e y Federal law that authori	nrollment, to make
 I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan. 	my protected health infor	· ·
 The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. However plan. 	s form I will be disenrolled	I from the plan.
When I sign below, it means that I have read a	nd understand the inform	nation on this form
If I sign as an authorized representative, it means show written proof (power of attorney, guardians understand that I will need to submit written proceed behalf of the member beyond this application. Af received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizate Signature of applicant/member/authorized rep	hip, etc.) of this right if Me of of this right, to the plan, fter this application has be Customer Service at the tion information on file.	edicare asks for it. I if I wish to take action on een approved and I have
If you are the authorized representative information below (*Not a Sales Agent)	, please sign above a	nd complete the
Last name	First name	
Address		
City	State	Zip code
Phone number () —	Relationship to applica	nt
For individuals helping enrollee with co	mpleting this form or	nly
Enrollee name		
Agent name/ID number		

•	if you're an individual (d parties) helping an e	. •			ounselors, family
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sale	s Representative/a	agenc	y u	se only	
Licensed Sales repres	entative/Writing ID			Initial receipt dat	e
Licensed Sales representative/agent name				Proposed effecti	ve date
Employer group name	3				
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees) ☐ e		☐ IEP (MA-PD enrollees eligible for 2nd IEP)		□ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	s □ S s) resi s □ A		EP (Change in ence) EP (October 15-ember 7)	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _					
Licensed Sales repre	sentative signature (c	ptiona	ıl)		Date
	Please mail or fax	this co	omp	oleted form to:	
Enrollee name					
Agent name/ID numbe Y0066_ERFMA_2025_C	r				UHME25HP0220633_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 ME-6 (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.

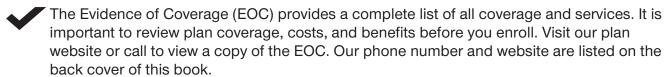
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

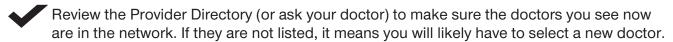
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

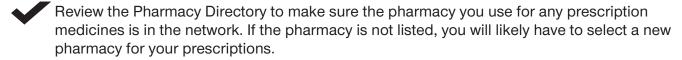
Enrollment checklist

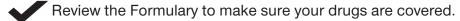
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

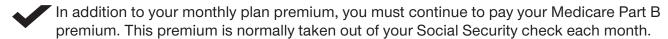


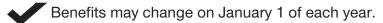


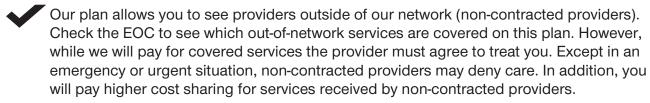




Understanding important rules







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.