

2025 Enrollment Request Form

☐ UHC Complete Care MN-7 (PPO C-SNP) H2001-133-000

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	Information about you (Please type or print in black or blue ink)					
Last name	First name		Middle initial			
Birth date	Sex ☐ Male ☐ Femal		Female	е		
Home phone number ()	 Mobile phone number 		umber () —		
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			one nur	nber(s) I have provided		
Medicare number						
Permanent residence street address (Don't enter a P.O. box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address)						
City	County		State	Zip code		
Mailing address (Only if it's different from above. You can give a P.O. box.)						
City		5	State	Zip code		
Email address (optional)						
Enrollee name						
Agent name/ID number						
V0066 FREMA 2025 C LIHMN25I P0221009 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 premium (including any late enrollment penalty you may owe), you can pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT).				
If you don't choose an option b	pelow, 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 your 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 □ Savings				
Account holder name:				
Bank routing number///				
Bank account number//////				
A few questions to help u	is manage your plan			
1. Would you prefer plan info	rmation in another language	or an accessible	format?	
If you would prefer plan information in another language or accessible format, please check what you'd like: ☐ Spanish ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD				
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C		UHM	N25LP0221009_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	Filipino Samoan			
Japanese	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)		☐ Yes ☐ No		
If yes, please complete the following:				
Enrollee name				
Agent name/ID number				
V0066 EREMA 2025 C	LIHMN25LP02	21000 000		

Page	4	of	8	

	Page 4 of 8
Name of health insurance company	
Member number	
7. Please give us the name of your primary care	e provider (PCP), clinic or health center.
You aren't limited to this list. You may go to any d	octor who accepts Medicare and the plan's
payment terms.	
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 or 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 communi	
•	e: Explanation of Benefits or the Annual Notice of ese communications through any device such as a
If you would rather have hard copies of require	d materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you have 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, unled I understand that people with Medicare are go the country, except for limited coverage near urgent care outside of the U.S. See the Summary I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealth UnitedHealthcare and contained in my United	generally not covered under Medicare while out of r the U.S. border. This plan covers emergency and mary of Benefits for more information. coverage begins, I must get all of my medical and care. Benefits and services authorized by dHealthcare "Evidence of Coverage" document iber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	
1 0000_LI 11 IVIA_2023_O	OFININZ3LF0221009_000

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 Sa	vings Account (MSA)				
 □ Release of information: By joining this Me will share my information with Medicare, when payments, and for other purposes allowed information (see Privacy Act Statement below of person(s) for permissible purposes under plan. 	no may use it to track my er by Federal law that authoriz bw). e my protected health infor	rrollment, to make ze the collection of this mation with organizations				
 The information on this form is correct to the best of my knowledge. I 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 a	and understand the inform	nation on this form				
understand that I will need to submit written probehalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can cau UnitedHealthcare UCard to update my authorized Signature of applicant/member/authorized received.	After this application has be Il Customer Service at the ration information on file.	een approved and I have number on my y's date				
If you are the authorized representative information below (* Not a Sales Agent)	e, piease sign above a	na complete the				
Last name	First name					
Address						
City	State	Zip code				
Phone number () —	ne number () — Relationship to applicant					
Enrollee nameAgent name/ID number						
V0066 EREMA 2025 C		IHMN25I P0221009 000				

For individuals helping enrollee with completing this form only					
Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family					
-	members, or other third parties) helping an enrollee fill out this form.				
Name		Relati	ons	hip to enrollee	
Signature		Natio	nal F	Producer Number	(Agents/Brokers only)
For Licensed Sales	s Representative/	agend	y u	se only	
Licensed Sales repres	entative/Writing ID		Initial receipt date		е
Licensed Sales repres	entative/agent name			Proposed effective date	
Employer group name					
Employer group ID			В	ranch ID	
Agent must complete IEP (MA-PD enrollees) OEP (Newly eligible) SEP (Chronic) SEP (SEP reason)	☐ ICEP (MA enrolled ☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	e 2 C re	nrol nd I SE eside	P (MA-PD lees eligible for EP) EP (Change in ence) EP (October 15- mber 7)	☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI
Enrollee name Agent name/ID number					
Y0066_ERFMA_2025_C					UHMN25LP0221009_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 MN-7 (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.

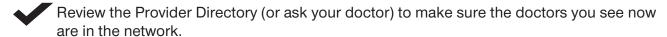
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

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





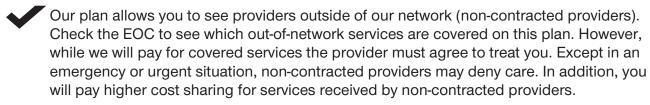


Review the Formulary to make sure your drugs are covered.

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.