

2025 Enrollment Request Form

☐ UHC Complete Care NC-25 (HMO-POS C-SNP) H5253-186-000

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	olue ink	
Last name	First name		Middle initial	
Birth date	Sex ☐ Male ☐ Femal		e	
Home phone number ()	_	Mobile phone r	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 differen	t from above	e. You can give a	a P.O. bo	x.)
City			State	Zip code
Email address (optional)				
Enrollee nameAgent name/ID number				
Y0066 FRFMA 2025 C			(JHNC25HP0220609 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-II	RMAA),
Social Security (SS) will send y You can pay it from you Medicare can bill you The Railroad Retiremen		ou want to pay it:	
☐ I want to pay from my Social			
☐ I want to pay from my Railro	•	neck	
☐ I want to pay directly from a	,	·oon	
Account type ☐ Checking [
Bank routing number/			
Bank account number/_			
A few questions to help u	s manage your plan		
1. Would you prefer plan info	• • •	or an accessible	format?
	rmation in another language or Braille □ Large print □ Audi		•
Enrollee name			
Agent name/ID number Y0066_ERFMA_2025_C			

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:		0010
Enrollee name		
Enrollee nameAgent name/ID number		
V0066 EREMA 2025 C	LIHNC25HP0	

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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 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?
Providing your email address above automatica	ally enrolls you in paperless delivery for some of
•	cations delivered electronically. We will send you 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 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 (PFFS), plans).	MA Medicare Medical Sa	vings Account (MSA)
Release of information: By joining this Med will share my information with Medicare, who payments, and for other purposes allowed b 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 ar	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 authorizat Signature of applicant/member/authorized rep	hip, etc.) of this right if Me of of this right, to the plan, iter 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 (rd 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 representative/Writing ID				Initial receipt date	
Licensed Sales representative/agent name				Proposed effecti	ve date
Employer group name	;				
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees) ☐ e		nrol	P (MA-PD lees eligible for EP)	□ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS ☐ change of status) re ☐ SEP (Dual LIS ☐		□ SEP (Change in □ Eresidence) E		☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _					
Licensed Sales repre	esentative signature (o	ptiona	ıl)		Date
	Please mail or fax	this co	omp	oleted form to:	
Enrollee name					
Agent name/ID numbe Y0066_ERFMA_2025_C	r				UHNC25HP0220609_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 NC-25 (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.

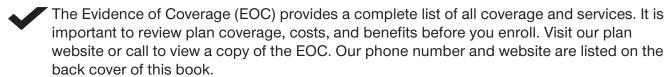
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

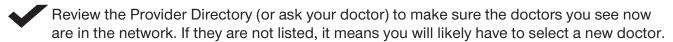
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

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





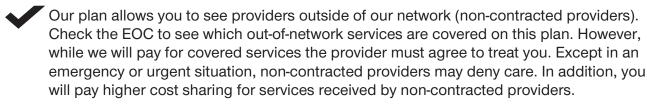


Review the Formulary to make sure your drugs are covered.

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.