

## **2025 Enrollment Request Form**

☐ UHC Complete Care NM-11 (PPO C-SNP) H2001-070-000

# 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.

Information about you (Please type or print in black or blue ink)         Last name       First name       Middle initial         Birth date       Sex □ Male □ Female         Home phone number ( ) −       Mobile phone number ( ) −         □ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided				
Birth date  Sex ☐ Male ☐ Female  Home phone number ( ) — Mobile phone number ( ) —  ☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided				
Home phone number ( ) — Mobile phone number ( ) — □ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided				
☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided				
using an autodialer and/or prerecorded voice technology.				
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 State Zip code				
Email address (optional)				
Enrollee name				
Agent name/ID number				

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 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		UHN	M25LP0221064_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, o	or Chicano/a
Yes, Puerto Rican	
Yes, Cuban	
Yes, another Hispanic, Latino, or Sp	panish 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:	
(Examples: Other employer group coverage auto liability, or Veterans benefits)	e, LTD coverage, workers Compensation,   Yes  No
If yes, please complete the following:	
ii yos, piease complete the following.	
Agent name/ID number	
V0066 EREMA 2025 C	LIHNM25LP0221064_000

	1 490 1 0. 0
Name of health insurance company	
Member number	
7. Please give us the name of your primary ca	re provider (PCP), clinic or health center.
You aren't limited to this list. You may go to any	doctor who accepts Medicare and the plan's
payment terms.  You can find a list on the plan website or in the F	Provider Directory
Tod can find a list on the plan website of in the f	Tovider Birectory.
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 the	nis provider? ☐ Yes ☐ No
an email when new communications (For examp	nications delivered electronically. We will send you ble: Explanation of Benefits or the Annual Notice of these communications through any device such as a
•	red materials mailed to you, please check here:
	hard copies of required materials. Please note that y not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the following	ing:
paying my Part B premium if I have one, un I understand that people with Medicare are the country, except for limited coverage nea urgent care outside of the U.S. See the Sun I understand that when my UnitedHealthcar prescription drug benefits from UnitedHealt UnitedHealthcare and contained in my Unite	generally not covered under Medicare while out of ar the U.S. border. This plan covers emergency and mary of Benefits for more information. The coverage begins, I must get all of my medical and theore. Benefits and services authorized by the deduction of Coverage document criber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	UHNM25LP0221064_000

I understand that I can be enrolled in only that enrollment in this plan will automatic apply for MA Private Fee-for-Service (PFF	cally end my enrollmer	nt in another MA plan (excep	tions
plans).  ☐ Release of information: By joining this N	Medicare Advantage F	Plan, I acknowledge that the	
will share my information with Medicare, payments, and for other purposes allowe information (see Privacy Act Statement b	ed by Federal law that		nis
<ul> <li>I give UnitedHealthcare permission to sha or person(s) for permissible purposes un plan.</li> </ul>	are my protected hea	_	
The information on this form is correct to intentionally provide false information on	this form I will be dise	enrolled from the plan.	
My response to this form is voluntary. Ho plan.	owever, failure to respo	ond may affect enrollment in	the
When I sign below, it means that I have read	d and understand the	e information on this form	
understand that I will need to submit written p behalf of the member beyond this application received my UnitedHealthcare UCard®, I can UnitedHealthcare UCard to update my author Signature of applicant/member/authorized	n. After this application call Customer Service rization information or	n has been approved and I he at the number on my	
If you are the authorized representation below (*Not a Sales Agent	-	pove and complete the	
Last name	First name		
Address			
City	State	Zip code	
Phone number ( ) -	Relationship to	applicant	
Enrollee name			
Agent name/ID number			Λ

For individuals hel	ning enrollee with	com	nlat	ing this form o	nlv
Complete this section			-	_	-
members, or other thir	•				, , , , , , ,
Name		Relat	ions	nip to enrollee	
Signature		Natio	nal F	Producer Number	(Agents/Brokers only)
For Licensed Sales	s Representative/	agend	cy u	se only	
Licensed Sales representative/Writing ID				Initial receipt dat	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)	6 2 [ r [	enrol 2nd I 3 SE eside 3 AE	P (MA-PD lees eligible for EP) P (Change in ence) P (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	ſ <sub></sub>				UHNM25LP0221064_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 NM-11 (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.

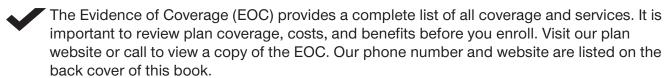
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

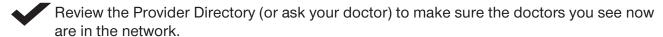
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

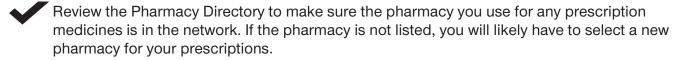
### **Enrollment checklist**

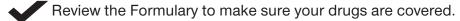
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

#### **Understanding the benefits**





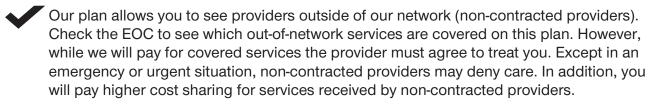




#### **Understanding important rules**







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.