

2025 Enrollment Request Form

☐ UHC Complete Care Support EP-1A (PPO C-SNP) H2001-043-000

Information about you (Please	type or pri	nt in black or b	lue 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	x.)	
City			State	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C			ι	JHNM25LP0221094_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-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 you	r 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 Large print Audi		•
Enrollee name			
Agent name/ID number			
Y0066_ERFMA_2025_C		UHN	M25LP0221094_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 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:	•	_ 100 _ 140		
Enrollee name				
Enrollee nameAgent name/ID number				
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Page 4	of 8

	. age i ei e
Name of health insurance company	
Member number	
7. Please give us the name of your primary	y care provider (PCP), clinic or health center.
You aren't limited to this list. You may go to a payment terms.	any doctor who accepts Medicare and the plan's
You can find a list on the plan website or in t	the Provider 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 see	en this provider? ☐ Yes ☐ No
your plan communications. You will get many of your required plan com an email when new communications (For ex	natically enrolls you in paperless delivery for some of immunications delivered electronically. We will send you cample: Explanation of Benefits or the Annual Notice of less these communications through any device such as a
If you would rather have hard copies of re-	quired materials mailed to you, please check here:
	you hard copies of required materials. Please note that may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the following	lowing:
paying my Part B premium if I have one I understand that people with Medicare the country, except for limited coverage urgent care outside of the U.S. See the I understand that when my UnitedHealth prescription drug benefits from UnitedH UnitedHealthcare and contained in my U	Medical (Part B) to stay in UnitedHealthcare. I must keep e, unless Medicaid or someone else pays for it. e are generally not covered under Medicare while out of e near the U.S. border. This plan covers emergency and Summary of Benefits for more information. I hcare coverage begins, I must get all of my medical and Healthcare. Benefits and services authorized by UnitedHealthcare "Evidence of Coverage" document ubscriber agreement) will be covered. Neither Medicare
nor UnitedHealthcare will pay for benefi	
Enrollee name Agent name/ID number	
Y0066_ERFMA_2025_C	UHNM25LP0221094_000

I understand that I can be enrolled in only of that enrollment in this plan will automatical apply for MA Private Fee-for-Service (PFFS)	lly end my enrollment in and	other MA plan (exceptions			
plans). Release of information: By joining this Me	edicare Advantage Plan, I ad	cknowledge that the plan			
will share my information with Medicare, w payments, and for other purposes allowed information (see Privacy Act Statement bel	by Federal law that authorize				
☐ I give UnitedHealthcare permission to shar or person(s) for permissible purposes under plan.	re my protected health infor	_			
 The information on this form is correct to the intentionally provide false information on the intention on the intention on the intention of the i					
My response to this form is voluntary. How plan.	☐ My response to this form is voluntary. However, failure to respond may affect enrollment in the				
When I sign below, it means that I have read	and understand the inforn	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 all Customer Service at the cation information on file.	en approved and I have			
If you are the authorized representative information below (*Not a Sales Agent)		nd complete the			
Last name	First name				
Address					
City	State	Zip code			
Phone number () —	Relationship to applicant				
Enrollee name					
Agent name/ID number					

For individuals hel	ning enrollee with	com	nlat	ing this form o	nly
Complete this section			-	_	-
members, or other thir	•	. •			
Name		Relat	ions	nip to enrollee	
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sales	s Representative/	ageno	cy u	se only	
Licensed Sales repres			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 5 7 7	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	·				UHNM25LP0221094_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 Support EP-1A (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.

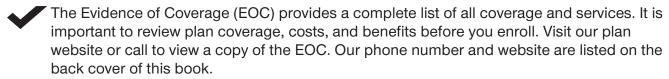
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

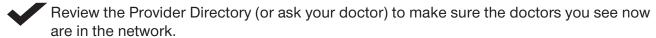
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

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





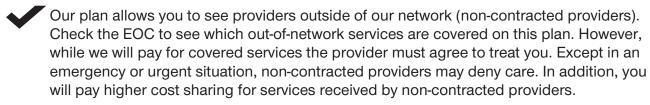


Review the Formulary to make sure your drugs are covered.

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.