

# **2025 Enrollment Request Form**

☐ UHC Medicare Advantage NV-001P (HMO-POS) H0609-032-000

Last name	type or print in black or blue ink			Middle initial	
Birth date		Sex □ Male □	l Femal	e	
Home phone number ( )	_	<ul><li>Mobile phone number (</li></ul>			
☐ I give consent for UnitedHealthca using an autodialer and/or prerecon		•	ione nur	mber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be o	•				
City	County	County State		Zip code	
Mailing address (Only if it's differe	nt 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				UHNV25HP0221299_00	

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 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		UHN	V25HP0221299_000

If you don't see the language or format you want, please call us toll-free at **1-844-723-6473**, 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			
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?	□Ү	′es □ 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)		es 🗆 No	
If yes, please complete the following:			
Enrollee name			
Agent name/ID number			
V0066 EREMA 2025 C	LIHNI\/25HD022120		

		Page 4 of 8
Nam	e of health insurance company	
Men	nber number	
7. Ple	ease give us the name of your primary care	e provider (PCP), clinic or health center.
You c	an find a list on the plan website or in the Pr	rovider Directory.
Provid	der or PCP full name	
Provid	der/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 y	ou now seeing or have you recently seen this	s provider?
your   You w an em Chan	plan communications.  vill get many of your required plan communications (For example)	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 you	would rather have hard copies of require	d materials mailed to you, please check here:
sor		nard copies of required materials. Please note that not fit in all mailboxes. You can change your
Plea	se read and sign	
Ву со	empleting this form, I agree to the following	g:
□ I t	paying my Part B premium if I have one, unle understand that people with Medicare are g he 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
	rescription drug benefits from UnitedHealth	

Enrollee name	
Agent name/ID number _	
Y0066_ERFMA_2025_C	UHNV25HP0221299_000

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), Neglans).	MA Medicare Medical Sav	ings Account (MSA)
	Release of information: By joining this Medicare, who will share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below	may use it to track my en Federal law that authorize	rollment, to make
	I give UnitedHealthcare permission to share r or person(s) for permissible purposes under a plan.	my protected health inform	•
	The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. However plan.	form I will be disenrolled	from the plan.
Wh	en I sign below, it means that I have read an	d understand the inform	ation on this form
sho und beh rece Uni	sign as an authorized representative, it means we written proof (power of attorney, guardiansherstand that I will need to submit written proof talf of the member beyond this application. Afteived my UnitedHealthcare UCard®, I can call tedHealthcare UCard to update my authorization nature of applicant/member/authorized rep	nip, etc.) of this right if Med f of this right, to the plan, if er this application has been Customer Service at the noninformation on file.	dicare asks for it. I  f I wish to take action on en approved and I have
_	ou are the authorized representative, ormation below (*Not a Sales Agent)	please sign above an	d complete the
Las	t name	First name	
Add	dress		
City	1	State	Zip code
Pho	one number ( ) —	Relationship to applican	t
Foi	r individuals helping enrollee with con	npleting this form onl	у
Enro	llee name		
_	nt name/ID number		

•	n if you're an individual ( ird parties) helping an e	nrollee	fill c	out this form.	· •
Name		Relationship to enrollee			
Signature		Nation	al P	roducer Number	(Agents/Brokers only)
For Licensed Sale	es Representative/a	agenc	y us	se only	
Licensed Sales representative/Writing ID				Initial receipt date	
Licensed Sales representative/agent name				Proposed effective date	
Employer group name	е				
Employer group ID			Br	anch ID	
Agent must complet ☐ 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	□ S resid □ A		P (Change in ence) P (October 15-	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason)	maintaining)	De	ecer 	mber 7) 	
Licensed Sales repre	esentative signature (o	ptiona	I)		Date
	Please mail or fax	this co	mp	leted form to:	
Agent name/ID numbe ′0066_ERFMA_2025_C	er				UHNV25HP0221299_00

## 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 Medicare Advantage NV-001P (HMO-POS) 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.

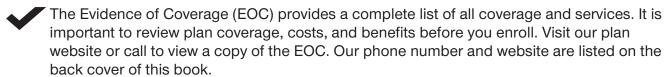
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

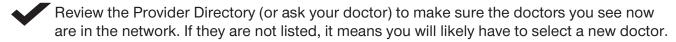
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

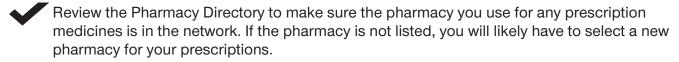
## **Enrollment checklist**

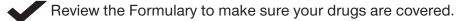
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

### Understanding the benefits



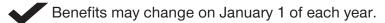


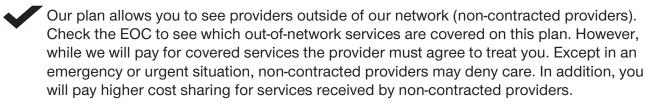




#### **Understanding important rules**







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.