

2025 Enrollment Request Form

☐ UHC Complete Care OR-5 (HMO-POS C-SNP) H3805-040-000

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	blue ink)
Last name	First name		Middle initial	
Birth date	Sex ☐ Male ☐ Femal		е	
Home phone number ()	_	 Mobile phone number 		() –
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			ohone nu	mber(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			State	Zip code
Email address (optional)				
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C			Į	JHOR25HP0220789_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	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	ou a letter and ask you how yo	u want to pay it:		
☐ You can pay it from you	□ You can pay it from your SS check			
☐ Medicare can bill you	□ 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	ieck		
☐ 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				
1. Would you prefer plan info				
	rmation in another language or Braille □ Large print □ Audi		•	
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C		UHO	R25HP0220789_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	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)	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	LIHOR25HP0220789 000

		Page 4 of 8	
Na	ame of health insurance company		
Me	ember number		
7. F	Please give us the name of your primary care	e provider (PCP), clinic or health center.	
Υοι	ı can find a list on the plan website or in the Pr	ovider Directory.	
Pro	vider or PCP full name		
	vider/PCP number	(Please enter the number exactly as it appears on 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?	
you You an e Cha con	ur plan communications. u will get many of your required plan communications (For example anges) are available online. You can access the aputer, tablet or mobile phone.	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 y	ou would rather have hard copies of require	d materials mailed to you, please check here:	
S	nstead of paperless delivery, we will mail you he 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	
Ple	ease read and sign		
Ву	completing this form, I agree to the followin	g:	
	I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it. I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information.		
	I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealth	coverage begins, I must get all of my medical and care. Benefits and services authorized by	

Enrollee name	
Agent name/ID number	
Y0066 ERFMA 2025 C	UHOR25HP0220789 00

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

 Release of information: By joining this Med will share my information with Medicare, who payments, and for other purposes allowed by 	•	an. I acknowledge that the plan		
information (see Privacy Act Statement beloved)	plans). Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).			
☐ I give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health plan.				
 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 disen	rolled from the plan.		
When I sign below, it means that I have read ar	nd understand the	information 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 proof 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 of this right, to the ter this application l Customer Service a ion information on f	et if Medicare asks for it. I e plan, if I wish to take action on has been approved and I have at the number on my		
If you are the authorized representative, information below (*Not a Sales Agent)	please sign abo	ove and complete the		
Last name	First name			
Address				
City	State	Zip code		
Phone number () — Relationship to applicant		pplicant		
For individuals helping enrollee with cor	npleting this for	m only		
Enrollee name				
Agent name/ID number		LIHOR25HP0220780 000		

•	if you're an individual or rd parties) helping an e	•	_		ounselors, family
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sale	s Representative/a	agen	cy u	se only	
Licensed Sales representative/Writing ID			Initial receipt date		e
Licensed Sales repres	sentative/agent name			Proposed effecti	ive date
Employer group name)				
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	e ☐ ICEP (MA enrollee	enrolle 2nd IE □ SEI reside □ AE		P (MA-PD lees eligible for EP)	□ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)			EP (Change in	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _					
Licensed Sales repre	esentative signature (c	ption	nal)		Date
	Please mail or fax	this	comp	oleted form to:	
- "					
Enrollee name Agent name/ID numbe					
Y0066_ERFMA_2025_C	I				UHOR25HP0220789_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 OR-5 (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.

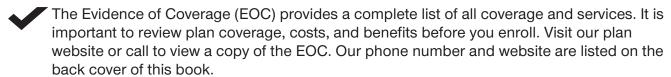
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

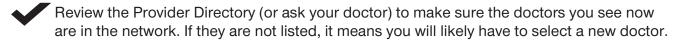
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

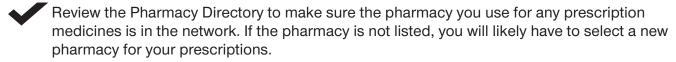
Enrollment checklist

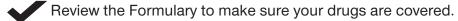
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





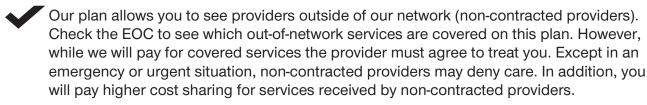




Understanding important rules







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.