

2025 Enrollment Request Form

☐ UHC Complete Care Support OR-1A (PPO C-SNP) H2001-045-000

Information about you (Places	type or pri	nt in blook or b	المام أماد	
Information about you (Please type or print in black or blue ink			iue irik,	
Last name	First name			Middle initial
Birth date		Sex ☐ Male ☐] Femal	е
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	(Don't enter	a P.O. box. Note	e: For in	dividuals experiencing
homelessness, a PO Box may be co	onsidered yo	our permanent re	esidence	e address)
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)				1
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C				JHOR25LP0221092_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 you a letter and ask you how you want to pay it:					
☐ You can pay it from your SS check					
□ 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			
\square I want to pay directly from a	☐ I want to pay directly from a bank account				
Account type ☐ Checking I	□ Savings				
Account holder name:					
Bank routing number/	/_/_/_/_				
Bank account number/_	Bank account number/////				
A few questions to help u	• • •				
1. Would you prefer plan info					
If you would prefer plan information in another language or accessible format, please check what you'd like: ☐ Spanish ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD					
Enrollee name					
Agent name/ID number					
'0066_ERFMA_2025_C UHOR25LP0221092_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, 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)		☐ Yes ☐ No				
If yes, please complete the following:						
Enrollee name						
Agent name/ID number						
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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 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 Provider Directory.

I	Provider	or	PCP	full	nam	ıe.

1 10 110 01 01 1 01 1011 1101 110			
Provider/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? ☐ Yes ☐ No		

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone.

If you would rather have hard copies of required materials mailed to you, please check here:

Instead of paperless delivery, we will mail you hard copies of required materials. Please note that
some communications are very large and may not fit in all mailboxes. You can change your
preference for delivery at any time.

Please read and sign

By completing this form, I agree to the following:

- ☐ 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 coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.

Enrollee name	
Agent name/ID number	
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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), MA Medicare Medical Savings Account (MSA)					
plans). Release of information: By joining this Medwill share my information with Medicare, when payments, and for other purposes allowed be information (see Privacy Act Statement below I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan. The information on this form is correct to the intentionally provide false information on this	o may use it to track my ency Federal law that authorized). my protected health inform applicable law as required best of my knowledge. It	rollment, to make the collection of this mation with organizations d to administer my health understand that if I			
My response to this form is voluntary. Howe plan.	ver, failure to respond may	affect enrollment in the			
When I sign below, it means that I have read a	nd understand the inform	nation on this form			
show written proof (power of attorney, guardians understand that I will need to submit written produced behalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can cal UnitedHealthcare UCard to update my authorization. Signature of applicant/member/authorized re	of of this right, to the plan, fter this application has be I Customer Service at the ration information on file.	if I wish to take action on en approved and I have			
If you are the authorized representative information below (*Not a Sales Agent)	, please sign above ar	nd complete the			
Last name	First name				
Address					
City	State	Zip code			
Phone number () —	Relationship to applicar	nt			
Enrollee name					
Agent name/ID numberY0066_ERFMA_2025_C		 JHOR25LP0221092_000			

For individuals hel	ping enrollee with	cor	nple	ting this form o	only
Complete this section	if you're an individual	(i.e. a	agents	s, brokers, SHIP co	-
members, or other third parties) helping an e				out this form. ship to enrollee	
Name		1161	ations	silip to efficiee	
Signature		Nat	ional	Producer Number	(Agents/Brokers only)
For Licensed Sales	s Representative/	ageı	ncy ι	ise only	
Licensed Sales repres	entative/Writing ID		Initial receipt date		e
Licensed Sales repres	entative/agent name			Proposed effective date	
Employer group name					
Employer group ID			Е	Branch 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)	es)	enro	P (MA-PD Ilees eligible for IEP) EP (Change in Ience) EP (October 15- ember 7)	☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C	·				UHOR25LP0221092_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 OR-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.

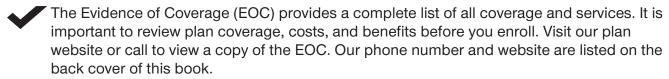
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

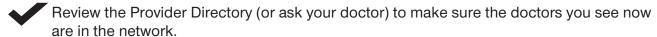
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

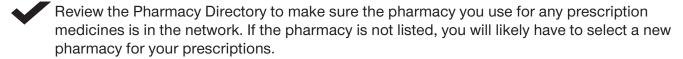
Enrollment checklist

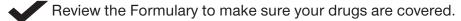
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

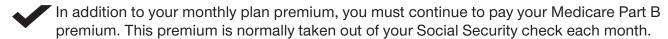


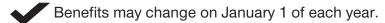


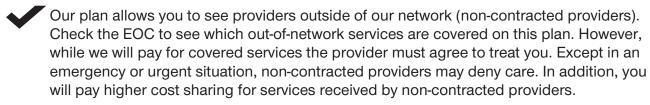




Understanding important rules







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.