

2025 Enrollment Request Form

☐ UHC Complete Care Support TC-6 (HMO-POS C-SNP) H5253-194-001

Information about you (Place	type or pri	nt in black or b	luo ink	
Information about you (Please Last name	First name	III III DIACK OF D	iue irik	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			ı	UHTN25HP0220601_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 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	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		UHTI	N25HP0220601_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)	s, Erb coverage, workers compensation,	☐ Yes ☐ No
If yes, please complete the following:		
Enrollee name		
Agent name/ID number		
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Na	ame of health insurance company	
M	ember number	
7. F	Please give us the name of your prima	ary care provider (PCP), clinic or health center.
Υοι	u can find a list on the plan website or i	n the Provider Directory.
Pro	ovider or PCP full name	
Pro	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 s	seen this provider?
You an Cha	email when new communications (For	ommunications delivered electronically. We will send you example: Explanation of Benefits or the Annual Notice of cess these communications through any device such as a
lf y	ou would rather have hard copies of	required materials mailed to you, please check here:
S	• •	ail you hard copies of required materials. Please note that nd may not fit in all mailboxes. You can change your
	ease read and sign	
Ву	completing this form, I agree to the f	ollowing:
	paying my Part B premium if I have on I understand that people with Medica the country, except for limited covera urgent care outside of the U.S. See the I understand that when my UnitedHear	d Medical (Part B) to stay in UnitedHealthcare. I must keep ne, unless Medicaid or someone else pays for it. are are generally not covered under Medicare while out of age near the U.S. border. This plan covers emergency and ne Summary of Benefits for more information. althcare coverage begins, I must get all of my medical and dHealthcare. Benefits and services authorized by

Enrollee name	
Agent name/ID number	
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nor UnitedHealthcare will pay for benefits or services that are not covered.

(also known as a member contract or subscriber agreement) will be covered. Neither Medicare

that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions

□ I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and

apply for MA Private Fee-for-Service (PFFS), I	MA Medicare Medical Sav	ings Account (MSA)		
Release of information: By joining this Medi will share my information with Medicare, who	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 organization 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. Howev plan. 	form I will be disenrolled to	from the plan.		
When I sign below, it means that I have read an	d understand the inform	ation on this form		
If I sign as an authorized representative, it means show written proof (power of attorney, guardiansh understand that I will need to submit written proof behalf of the member beyond this application. Aft received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizations. Signature of applicant/member/authorized rep	nip, etc.) of this right if Med f of this right, to the plan, it ter this application has been Customer Service at the notion information on file.	dicare asks for it. I f 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 an	d complete the		
Last name	First name			
Address				
City	State	Zip code		
Phone number () —	Relationship to applican	t		
For individuals helping enrollee with con	npleting this form onl	у		
Enrollee name				
Agent name/ID number				

•	if you're an individual rd parties) helping an e	•	_		ounselors, family
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sale	es Representative/	agen	icy ι	ise only	
Licensed Sales repres	sentative/Writing ID		-	Initial receipt dat	е
Licensed Sales repres	sentative/agent name			Proposed effective date	
Employer group name	9				
Employer group ID			Е	Branch ID	
Agent must complete ☐ IEP (MA-PD enrollees) ☐ OEP (Newly	☐ ICEP (MA enrollees) ☐ el		☐ IEP (MA-PD enrollees eligible for 2nd IEP) ☐ SEP (Change in		☐ OEP (Jan 1 – Mar 31)
eligible)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	resid □ Al		lence) EP (October 15- ember 7)	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason)					
Licensed Sales repre	esentative signature (optior	nal)		Date
	Please mail or fax	k this	com	pleted form to:	
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C					UHTN25HP0220601_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 Support TC-6 (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.

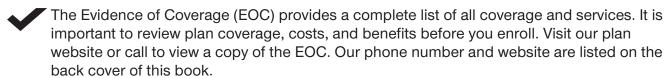
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

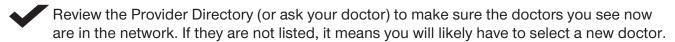
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

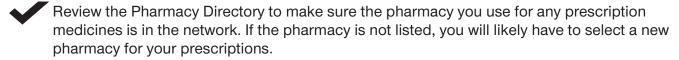
Enrollment checklist

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



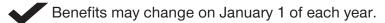


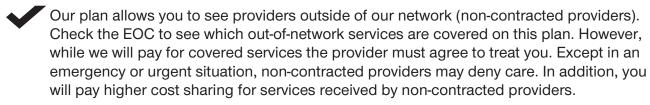


Review the Formulary to make sure your drugs are covered.

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.