

2025 Enrollment Request Form

☐ UHC Complete Care TC-0005 (HMO-POS C-SNP) H5253-193-001

Information about you (Please Last name	First name			Middle initial	
Birth date		Sex □ Male □	Femal	e	
Home phone number ()	_	Mobile phone nu	ımber (_	
☐ I give consent for UnitedHealthcausing an autodialer and/or prerecor		•	one nur	mber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be o	-				
City	County	5	State	Zip code	
Mailing address (Only if it's different	nt from above	e. You can give a	P.O. bo	ox.)	
City		5	State	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C			Į	UHTN25HP0220603_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 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	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		•
Enrollee name			
Agent name/ID number			
Y0066_ERFMA_2025_C		UHTI	N25HP0220603_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)	o, _ · _ coreage, rremere compensation,	☐ Yes ☐ No
If yes, please complete the following:		
Enrollee name		
Agent name/ID number		
V0066 EREMA 2025 C	LIHTNI25HDD	220603 000

	Page 4 of 8
Name of health insurance company	
Member number	
7. Please give us the name of your primary ca	(Please enter the number exactly as it appears on the website or in the Provider Directory. (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.) (In seen this provider?
You can find a list on the plan website or in the	Provider Directory.
Provider or PCP full name	
Provider/PCP number	the website or in the Provider Directory. It will be
Are you now seeing or have you recently seen t	:his provider?
an email when new communications (For exam	ple: Explanation of Benefits or the Annual Notice of
lf you would rather have hard copies of requi	red materials mailed to you, please check here:
	·
Please read and sign	
By completing this form, I agree to the follow	ring:
paying my Part B premium if I have one, ur I understand that people with Medicare are the country, except for limited coverage ne urgent care outside of the U.S. See the Su I understand that when my UnitedHealthca prescription drug benefits from UnitedHeal	nless Medicaid or someone else pays for it. e generally not covered under Medicare while out of ear the U.S. border. This plan covers emergency and mmary of Benefits for more information. are coverage begins, I must get all of my medical and

Enrollee name	
Agent name/ID number	
Y0066_ERFMA_2025_C	UHTN25HP0220603_000

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

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. I he information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan. My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. When I sign below, it means that I have read and understand the information on this form If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file. Signature of applicant/member/authorized representative Today's date If you are the authorized representative, please sign above and complete the information below (*Not a Sales Agent) Last name Address City State Zip code Phone number () — Relationship to applicant		apply for MA Private Fee-for-Service (PFFS), N	MA Medicare Medical Sav	ings Account (MSA)	
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 best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan. My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. When I sign below, it means that I have read and understand the information on this form If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard*, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file. Signature of applicant/member/authorized representative Today's date If you are the authorized representative, please sign above and complete the information below (*Not a Sales Agent) Last name First name Address City State Zip code		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			
The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan. My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. When I sign below, it means that I have read and understand the information on this form If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file. Signature of applicant/member/authorized representative Today's date If you are the authorized representative, please sign above and complete the information below (*Not a Sales Agent) Last name First name Address City State Zip code Phone number () — Relationship to applicant For individuals helping enrollee with completing this form only		☐ 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			
If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file. Signature of applicant/member/authorized representative		The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. However,	form I will be disenrolled	from the plan.	
show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file. Signature of applicant/member/authorized representative If you are the authorized representative, please sign above and complete the information below (*Not a Sales Agent) Last name Address City State Zip code For individuals helping enrollee with completing this form only Enrollee name	Wh	en I sign below, it means that I have read an	d understand the inform	ation on this form	
Information below (*Not a Sales Agent) Last name Address City State Zip code Phone number () — Relationship to applicant For individuals helping enrollee with completing this form only Enrollee name	sho und beh rece Uni	w written proof (power of attorney, guardiansh lerstand that I will need to submit written proof alf of the member beyond this application. Aft eived my UnitedHealthcare UCard®, I can call tedHealthcare UCard to update my authorizati	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 I wish to take action on en approved and I have umber on my	
Last name Address City State Zip code Phone number () — Relationship to applicant For individuals helping enrollee with completing this form only Enrollee name	_		please sign above an	d complete the	
City State Zip code Phone number () — Relationship to applicant For individuals helping enrollee with completing this form only Enrollee name	Las	t name	First name		
Phone number () — Relationship to applicant For individuals helping enrollee with completing this form only Enrollee name	Add	dress			
For individuals helping enrollee with completing this form only Enrollee name	City	,	State	Zip code	
Enrollee name	Phone number () — Relationship to applicant		t		
	Foi	r individuals helping enrollee with con	npleting this form onl	y	
	Enro	llee name			
/0.066 EREMA 2025 C	Ager	nt name/ID number		III TNOST I DOGGOGG	

•	if you're an individual				ounselors, family	
members, or other third parties) helping an enrollee fit Name Relation				ship to enrollee		
Signature	Signature Natio		nal F	Producer Number	(Agents/Brokers only)	
For Licensed Sale	es Representative/	agend	y u	se only		
Licensed Sales repres	sentative/Writing ID		Initial receipt date			
Licensed Sales repres	sentative/agent name			Proposed effective date		
Employer group name	Э					
Employer group ID			В	ranch ID		
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees) ☐ en		nrol	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	□ SE resid □ AE		EP (Change in ence) EP (October 15-	☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ SEP (SEP reason) _	maintaining)	D	ece	ember 7)		
Licensed Sales repre	esentative signature (optiona	al)		Date	
	Please mail or fax	this c	omp	oleted form to:		
Enrollee name						
Agent name/ID number						
Y0066_ERFMA_2025_C					UHTN25HP0220603_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 TC-0005 (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.

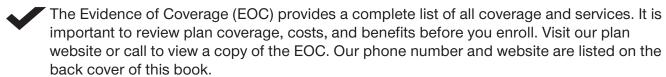
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

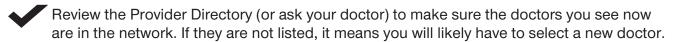
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

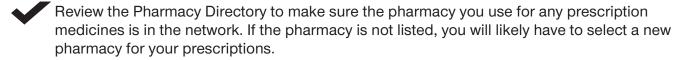
Enrollment checklist

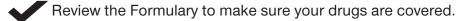
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





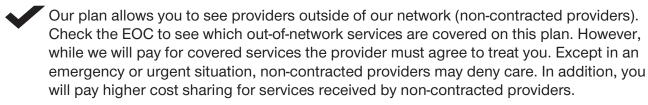




Understanding important rules







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.