

2025 Enrollment Request Form

☐ UHC Complete Care TX-19 (HMO-POS C-SNP) H4527-042-000

Information about you (Please	type or pri	nt in black or blu	e ink)	
Last name	First name			Middle initial
		T		
Birth date		Sex □ Male □	Female	e
Home phone number ()	Mobile phone number () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	ne nun	nber(s) I have provided
Medicare number				
Permanent residence street address homelessness, a PO Box may be co	-			
City	County	St	ate	Zip code
Mailing address (Only if it's differen	t from above	e. You can give a P	.O. bo	x.)
City		St	ate	Zip code
Email address (optional)				
Enrollee name				
Agent name/ID number				
Y0066 ERFMA 2025 C				JHTX25HP0220763 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-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	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 ☐ 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		UHT	X25HP0220763_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, 2.2 coverage, mornere compensation,	☐ Yes ☐ No	
If yes, please complete the following:			
Enrollee name			
Agent name/ID number			
V0066 EREMA 2025 C	LIHTY25HP0	220763 000	

		Page 4 of 8
Na	me of health insurance company	
Me	ember number	
7. F	Please give us the name of your primary care	are provider (PCP), clinic or health center. 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.) this provider?
You	ı can find a list on the plan website or in the Pr	ovider Directory.
Pro	vider or PCP full name	
Pro	vider/PCP number	the website or in the Provider Directory. It will be
Are	you now seeing or have you recently seen this	s provider?
You an e Cha	email when new communications (For example	e: Explanation of Benefits or the Annual Notice of
lf yo	ou would rather have hard copies of required	d materials mailed to you, please check here:
S		
	ease read and sign	
Ву	completing this form, I agree to the following	g:
	paying my Part B premium if I have one, unled I understand that people with Medicare are go the country, except for limited coverage near urgent care outside of the U.S. See the Summanderstand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcare	ess Medicaid or someone else pays for it. Idenerally not covered under Medicare while out of the U.S. border. This plan covers emergency and mary of Benefits for more information. Coverage begins, I must get all of my medical and

Enrollee name	
Agent name/ID number	
Y0066_ERFMA_2025_C	UHTX25HP0220763_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

	apply for MA Private Fee-for-Service (PFFS), N	MA Medicare Medical Savi	ngs Account (MSA)	
	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).			
	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 f	rom the plan.	
Whe	en I sign below, it means that I have read and	d understand the informa	ation on this form	
show und beh rece Unit	sign as an authorized representative, it means low written proof (power of attorney, guardiansh terstand that I will need to submit written proof alf of the member beyond this application. Afterived my UnitedHealthcare UCard®, I can call the dealthcare UCard to update my authorization atture of applicant/member/authorized representations.	ip, etc.) of this right if Med of this right, to the plan, it er this application has bee Customer Service at the no on information on file.	dicare asks for it. I I wish to take action on en approved and I have	
If v	ou are the authorized representative,	please sign above an	d complete the	
_	prmation below (*Not a Sales Agent)			
Last	t name	First name		
Add	Iress			
City	,	State	Zip code	
Phone number () — Relationship to applicant		t		
F				
	rindividuals helping enrollee with com	-	y	
	llee name nt name/ID number			
_	S EREMA 2025 C		IHTY25HP0220763 000	

•	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	s Representative/a	agen	cy u	se only	
Licensed Sales representative/Writing ID			Initial receipt date		e
Licensed Sales repres	sentative/agent name			Proposed effective date	
Employer group name)				
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)		2nd IEP) ☐ SEP (Dual LIS ☐ SEP (Change of status) residence) ☐ SEP (Dual LIS ☐ AEP (Oct		lees eligible for	□ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)			EP (Change in ence) EP (October 15-	☐ 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					UHTX25HP0220763_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 TX-19 (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.

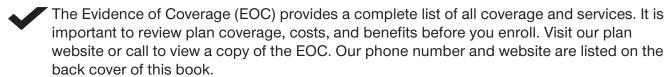
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

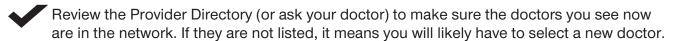
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

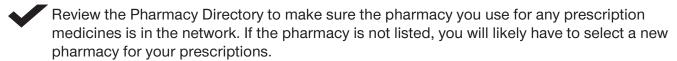
Enrollment checklist

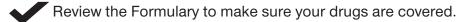
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





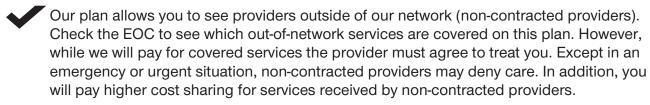




Understanding important rules







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.