

# **2025** Enrollment Request Form

☐ UHC Complete Care TX-17 (HMO-POS C-SNP) H4527-040-000

Information about you (Please	type or pri	nt in black or b	lue ink)		
Last name	First name			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					
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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		UHT	X25HP0220765_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,	☐ 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 ca	are provider (PCP), clinic or health center.
You can find a list on the plan website or in the	Provider Directory.
Provider or PCP full name	
Provider/PCP number	(Please enter the number exactly as it appears or 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 t	his provider? ☐ Yes ☐ No
an email when new communications (For exam	nications delivered electronically. We will send you ple: Explanation of Benefits or the Annual Notice of these communications through any device such as a
If you would rather have hard copies of requi	red materials mailed to you, please check here:
	u hard copies of required materials. Please note that ay not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the follow	
paying my Part B premium if I have one, understand that people with Medicare are the country, except for limited coverage neurgent care outside of the U.S. See the Sur I understand that when my UnitedHealthca prescription drug benefits from UnitedHeal	dical (Part B) to stay in UnitedHealthcare. I must keep aless 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. re coverage begins, I must get all of my medical and thcare. Benefits and services authorized by tedHealthcare "Evidence of Coverage" document

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

Add Cit	dress					
Add Cit	dress  y  one number ( ) —  or individuals helping enrollee with con	State  Relationship to applicant	t			
Ad Cit	dress	State	·			
Las	dress		Zip code			
La	st name	First name				
	,	First name				
inf	That a sales rigority					
If y	you are the authorized representative, formation below (*Not a Sales Agent)	please sign above an	d complete the			
If I she un be rec	nen I sign below, it means that I have read and sign as an authorized representative, it means tow written proof (power of attorney, guardians) derstand that I will need to submit written proof half of the member beyond this application. Afterived my UnitedHealthcare UCard®, I can call itedHealthcare UCard to update my authorization and update of applicant/member/authorized representative.	I have the legal right under hip, etc.) of this right if Med f of this right, to the plan, if the this application has been customer Service at the number on information on file.	r state law to sign. I can licare asks for it. I I wish to take action on en approved and I have			
	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.					
	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.					
		may use it to track my en				

Complete this section members, or other thin	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	agenc	cy u	se only	
Licensed Sales repres	entative/Writing ID			Initial receipt dat	e
Licensed Sales representative/agent name				Proposed effecti	ve date
Employer group name	3				
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollee	e		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)	ual LIS   status) resual LIS		EP (Change in ence) EP (October 15-ember 7)	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _					
Licensed Sales repre	sentative signature (c	ptiona	al)	1	Date
	Please mail or fax	this c	omp	oleted form to:	
Enrollee name					
Agent name/ID numbe Y0066_ERFMA_2025_C	r				UHTX25HP0220765_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, 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-17 (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.

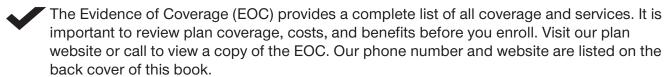
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

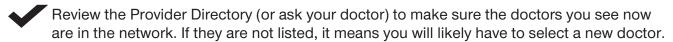
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

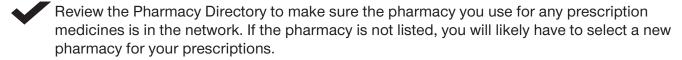
## **Enrollment checklist**

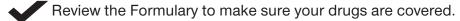
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

### Understanding the benefits





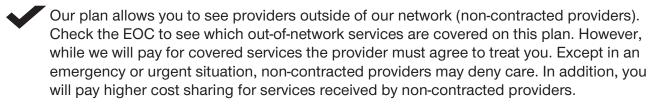




#### **Understanding important rules**







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.