

# **2025 Enrollment Request Form**

☐ UHC Complete Care TX-24 (HMO-POS C-SNP) H0609-058-000

| Information about you (Please   | type or pri | nt in black or bl | lue ink) |                         |  |
|---|-------------|-------------------|----------|-------------------------|--|
| Last name   | First name  |                   |          | Middle initial          |  |
|   |             |                   |          |                         |  |
| Birth date  |             | Sex □ Male □      | Femal    | е                       |  |
| Home phone number ( )   | _           | Mobile phone nu   | umber (  |                         |  |
| ☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord    |             | •                 | one nur  | mber(s) I have provided |  |
| Medicare number   |             |                   |          |                         |  |
| Permanent residence street address homelessness, a PO Box may be co           | •           |                   |          |                         |  |
| City  | County      | 5                 | State    | Zip code                |  |
| Mailing address (Only if it's different from above. You can give a P.O. box.) |             |                   |          |                         |  |
| City  |             | 5                 | State    | Zip code                |  |
| Email address (optional)  |             | '                 |          |                         |  |
|   |             |                   |          |                         |  |
|   |             |                   |          |                         |  |
|   |             |                   |          |                         |  |
|   |             |                   |          |                         |  |
|   |             |                   |          |                         |  |
| Enrollee name   |             |                   |          |                         |  |
| Agent name/ID number<br>Y0066_ERFMA_2025_C                                    |             |                   |          | <br>UHTX25HP0221275_000 |  |
| TUUUU_ENFIVIA_ZUZU_U  |             |                   |          | UIII                    |  |

| Do you have other insurance (Examples: Other private insura programs.) If yes, what is it?  | • • •   | •                   | ☐ Yes ☐ No<br>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<br>c deduction from your Social S<br>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 □ 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<br>Braille   |                     | •                               |  |
| Enrollee name   |   |                     |                                 |  |
| Agent name/ID number  |   |                     |                                 |  |
| Y0066_ERFMA_2025_C  |   | UHT                 | X25HP0221275_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, memore compensation,     | ☐ Yes ☐ No |  |
| If yes, please complete the following:     |   |            |  |
| Enrollee name                              |   |            |  |
| Agent name/ID number                       |   |            |  |
| V0066 EREMA 2025 C                         | LIHTY25HP0                                | 221275 000 |  |

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|------------------------|---|--|
| Nan                    | ne of health insurance company  |  |
| Mer                    | nber number   |  |
| 7. Pl                  | ease give us the name of your primary car   | e provider (PCP), clinic or health center.   |
| You                    | can find a list on the plan website or in the P   | rovider Directory.   |
| Provi                  | der or PCP full name  |  |
| Provi                  | der/PCP number  | (Please enter the number exactly as it appears on<br>the website or in the Provider Directory. It will be<br>10 to 12 digits. Don't include dashes.)   |
| Are y                  | ou now seeing or have you recently seen th  | is provider? ☐ Yes ☐ No  |
| You v<br>an er<br>Char | nail when new communications (For examp   | ications delivered electronically. We will send you<br>le: Explanation of Benefits or the Annual Notice of<br>nese communications through any device such as a                                   |
| lf you                 | u would rather have hard copies of require  | ed materials mailed to you, please check here:   |
| so                     |   | hard copies of required materials. Please note that not fit in all mailboxes. You can change your  |
|                        | se read and sign  |  |
| Ву с                   | ompleting this form, I agree to the following   | ng:  |
|                        | paying my Part B premium if I have one, unled understand that people with Medicare are at the country, except for limited coverage near urgent care outside of the U.S. See the Sumbunderstand that when my UnitedHealthcare prescription drug benefits from UnitedHealth | generally not covered under Medicare while out of ar the U.S. border. This plan covers emergency and amary of Benefits for more information. e coverage begins, I must get all of my medical and |

| Enrollee name          |                     |
|------------------------|---------------------|
| Agent name/ID number _ |                     |
| Y0066_ERFMA_2025_C     | UHTX25HP0221275_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) plans).   | , MA Medicare Medical Sav  | vings Account (MSA)  |
|---|--|--|
| Release of information: By joining this Me will share my information with Medicare, wh payments, and for other purposes allowed information (see Privacy Act Statement belowed).  | no may use it to track my er<br>by Federal law that authoriz   | nrollment, to make   |
| <ul> <li>I give UnitedHealthcare permission to share<br/>or person(s) for permissible purposes under<br/>plan.</li> </ul>   | e my protected health infor  | •  |
| <ul> <li>The information on this form is correct to the intentionally provide false information on the My response to this form is voluntary. Howen plan.</li> </ul>  | is form I will be disenrolled  | from the plan.   |
| When I sign below, it means that I have read a  | and understand the inform  | nation on this form  |
| If I sign as an authorized representative, it means show written proof (power of attorney, guardian understand that I will need to submit written probehalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can cau UnitedHealthcare UCard to update my authorized Signature of applicant/member/authorized received. | ship, etc.) of this right if Me<br>of of this right, to the plan,<br>After this application has be<br>Il Customer Service at the ration information on file. | edicare asks for it. I if I wish to take action on een approved and I have |
| If you are the authorized representative information below (*Not a Sales Agent)   | e, please sign above a   | nd complete the  |
| Last name   | First name   |  |
| Address   |  |  |
| City  | State  | Zip code   |
| Phone number ( ) — Relationship to applicant  |  | nt   |
| For individuals helping enrollee with co  | ompleting this form on   | ly   |
| Enrollee name   |  |  |
| Agent name/ID number  |  |  |

| Complete this section members, or other thin | •  | •  | _                        |                               | ounselors, family                    |  |
|--|--|--|--------------------------|-------------------------------|--------------------------------------|--|
|  |  |  | Relationship to enrollee |                               |                                      |  |
| Signature                                    |  | National Producer Number (Agents/Brokers only) |                          |                               |                                      |  |
| For Licensed Sale                            | s Representative/  | agen   | cy u                     | se only                       |                                      |  |
| Licensed Sales representative/Writing ID     |  |  | Initial receipt date     |                               | e                                    |  |
| Licensed Sales repres                        | entative/agent name  |  |                          | Proposed effective date       |                                      |  |
| Employer group name                          | )  |  |                          |                               |                                      |  |
| Employer group ID                            |  |  | В                        | ranch ID                      |                                      |  |
| Agent must complete ☐ IEP (MA-PD enrollees)  | ☐ ICEP (MA enrollees) ☐ en                                     |  | enrol                    | P (MA-PD<br>lees eligible for | □ OEP (Jan 1 –<br>Mar 31)            |  |
| ☐ OEP (Newly eligible) ☐ SEP (Chronic)       | ☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining) | resider<br>□ AEP                               |                          | EP (Change in                 | ☐ SEP (Loss of EGHP coverage) ☐ OEPI |  |
| ☐ SEP (SEP reason) _                         |  |  |                          | ,<br>                         |                                      |  |
| Licensed Sales repre                         | sentative signature (d   | option   | al)                      | 1                             | Date                                 |  |
|  | Please mail or fax   | this c   | comp                     | oleted form to:               |                                      |  |
|  |  |  |                          |                               |                                      |  |
|  |  |  |                          |                               |                                      |  |
|  |  |  |                          |                               |                                      |  |
|  |  |  |                          |                               |                                      |  |
|  |  |  |                          |                               |                                      |  |
| Enrollee name                                |  |  |                          |                               |                                      |  |
| Agent name/ID number Y0066_ERFMA_2025_C      | r  |  |                          |                               | UHTX25HP0221275_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-24 (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.

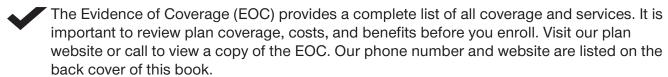
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

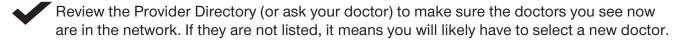
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

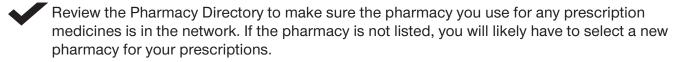
## **Enrollment checklist**

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





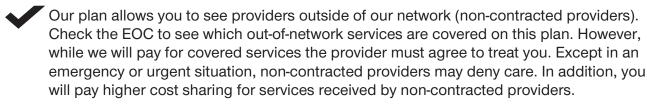




### **Understanding important rules**







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.