

2025 Enrollment Request Form

☐ UHC Medicare Advantage TX-0030 (Regional PPO) R6801-012-000

Select optional supplemental benefits in addition to what is included with your plan

You can add the following benefit rider for an extra cost. You can purchase the rider now while you are enrolling, or within 3 months after your effective date. See the Summary of Benefits for more information, including costs.

☐ Platinum Dental Rider					
Information about you (Please	type or pri	nt in black or l	blue ink		
Last name	First name			Middle initial	
Birth date	Sex ☐ Male ☐ Fema		е		
Home phone number ()	_	Mobile phone	number (() —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	hone nui	mber(s) I have provided	
Medicare number					
Permanent residence street address (Don't enter a P.O. box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address)					
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				 UHTX25RP0220481_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	ou 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	X25RP0220481_000	

If you don't see the language or format you want, please call us toll-free at **1-844-723-6473**, 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)	5, ETB coverage, workers compensation,	☐ Yes ☐ No		
If yes, please complete the following:				
Enrollee name				
Enrollee nameAgent name/ID number	·			
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Name of health insurance company	
Member number	
7. Please give us the name of your primary care provider (PCP), clinic or health of	center.
You aren't limited to this list. You may go to any doctor who accepts Medicare and the payment terms.	ne plan's

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 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 seen this	provider?

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone.

If you would rather have hard copies of required materials mailed to you, please check here:

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Please read and sign

By completing this form, I agree to the following:

- ☐ I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information.
- □ I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.

Enrollee name	
Agent name/ID number	
Y0066_ERFMA_2025_C	UHTX25RP0220481_000

I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA)					
 plans). Release of information: By joining this M will share my information with Medicare, we payments, and for other purposes allowed 	who may use it to tra d by Federal law that	ck my enrollment, to make			
 I give UnitedHealthcare permission to sha or person(s) for permissible purposes und 	or person(s) for permissible purposes under applicable law as required to administer my health				
 plan. The information on this form is correct to intentionally provide false information on My response to this form is voluntary. How plan. 	this form I will be dis	enrolled from the plan.			
When I sign below, it means that I have read	d and understand th	e information on this form			
understand that I will need to submit written p behalf of the member beyond this application. received my UnitedHealthcare UCard®, I can of UnitedHealthcare UCard to update my authori Signature of applicant/member/authorized If you are the authorized representation	. After this application call Customer Service ization information or representative	n has been approved and I have e at the number on my n file. Today's date			
information below (*Not a Sales Agent	1)				
Last name	First name				
Address					
City	State	Zip code			
Phone number () —	Relationship to applicant				
Enrollee name					
Agent name/ID number Y0066 ERFMA 2025 C		UHTX25RP0220481_000			

For individuals hel	ning enrollee with	comi	alet	ing this form o	nlv
Complete this section		_		_	-
members, or other thir	d parties) helping an e	enrollee	e fill	out this form.	
Name		Relati	onsl	hip to enrollee	
Signature		Natio	nal F	Producer Number	(Agents/Brokers only)
For Licensed Sales	s Representative/	agend	y u	se only	
Licensed Sales representative/Writing ID			Initial receipt date		Э
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) ☐ OEP (Newly eligible) ☐ SEP (Chronic) ☐ SEP (SEP reason) _	☐ ICEP (MA enrolled ☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	e 2 C re	nroll nd II] SE eside] AE	P (MA-PD lees eligible for EP) EP (Change in ence) EP (October 15- mber 7)	☐ OEP (Jan 1 – Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C	•				UHTX25RP0220481_000

Licensed Sales representative signature (optional)

Date

Please mail or fax this completed form to:

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 Medicare Advantage TX-0030 (Regional PPO) 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.

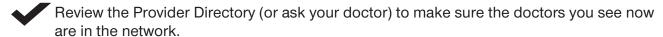
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

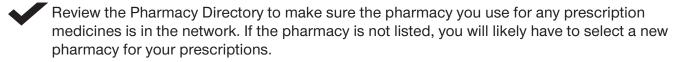
Enrollment checklist

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

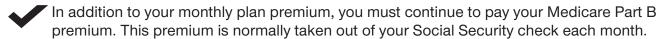




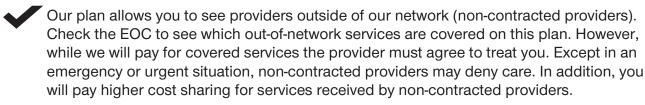




Understanding important rules







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.