

2025 Enrollment Request Form

 \square UHC Complete Care VA-23 (HMO-POS C-SNP) H5253-197-000

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 prii	nt in black or blue i	าk)		
Last name	First name		Mi	Middle initial	
Birth date		Sex □ Male □ Fer	nale		
Home phone number ()	_	Mobile phone number	er () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	numbe	er(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 different	t from above	e. You can give a P.O.	box.)		
City		State		Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number					
Y0066 ERFMA 2025 C UHVA25HP0220597 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	u want to pay it:		
□ You can pay it from your SS check				
☐ Medicare can bill you	□ Medicare can bill you			
☐ The Railroad Retiremen	☐ The Railroad Retirement 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	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		UHV	A25HP0220597_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				
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		220597 000		

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Na	ame of health insurance company	
M	ember number	
7. F	Please give us the name of your prima	ary care provider (PCP), clinic or health center.
Υοι	u can find a list on the plan website or i	n the Provider Directory.
Pro	ovider or PCP full name	
Pro	vider/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 s	seen this provider?
You an Cha	email when new communications (For	ommunications delivered electronically. We will send you example: Explanation of Benefits or the Annual Notice of cess these communications through any device such as a
lf y	ou would rather have hard copies of	required materials mailed to you, please check here:
S	• •	ail you hard copies of required materials. Please note that nd may not fit in all mailboxes. You can change your
	ease read and sign	
Ву	completing this form, I agree to the f	ollowing:
	paying my Part B premium if I have on I understand that people with Medica the country, except for limited covera urgent care outside of the U.S. See the I understand that when my UnitedHear	d Medical (Part B) to stay in UnitedHealthcare. I must keep ne, unless Medicaid or someone else pays for it. are are generally not covered under Medicare while out of age near the U.S. border. This plan covers emergency and ne Summary of Benefits for more information. althcare coverage begins, I must get all of my medical and dHealthcare. Benefits and services authorized by

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

	apply for MA Private Fee-for-Service (PFFS), N plans).	MA Medicare Medical Savi	ngs Account (MSA)
	Release of information: By joining this Medicavill share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below	may use it to track my enr Federal law that authorize	rollment, to make
	I give UnitedHealthcare permission to share nor person(s) for permissible purposes under a plan.	ny protected health inform	
	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.
Who	en I sign below, it means that I have read and	d understand the informa	ation on this form
sho und beh rece Unit	sign as an authorized representative, it means I w written proof (power of attorney, guardiansh erstand that I will need to submit written proof alf of the member beyond this application. Afterived my UnitedHealthcare UCard®, I can call the deleted the authorization atture of applicant/member/authorized representations.	ip, etc.) of this right if Meconf this right, to the plan, if er this application has been customer Service at the notion information on file.	dicare asks for it. I f I wish to take action on en approved and I have
If y	ou are the authorized representative,	please sign above an	d complete the
	ormation below (*Not a Sales Agent)		
Las	t name	First name	
Add	Iress		
City		State	Zip code
Pho	one number () —	Relationship to applican	t
For	r individuals helping enrollee with com	noleting this form only	V
	· ·		J
	llee name nt name/ID number		
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•	if you're an individual (rd parties) helping an e	. •			ounselors, family
Name		Relationship to enrollee			
Signature		Nation	nal F	Producer Number	(Agents/Brokers only)
For Licensed Sale	s Representative/a	agenc	y u	se only	
Licensed Sales representative/Writing ID			Initial receipt date		
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)	☐ ICEP (MA enrollees) [☐ IEP (MA-PD enrollees eligible for 2nd IEP)		□ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS	□ SE reside □ AE		P (Change in ence) P (October 15-	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _	maintaining)		ece	mber 7)	
Licensed Sales repre	esentative signature (o	ptiona	ıl)		Date
	Please mail or fax	this co	omp	oleted form to:	
Enrollee name Agent name/ID numbe					
Agent name/1D numbe Y0066_ERFMA_2025_C	· · · · · · · · · · · · · · · · · · ·				UHVA25HP0220597_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 VA-23 (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.

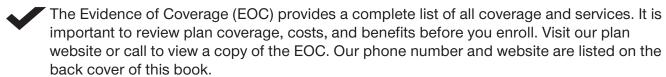
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

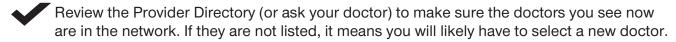
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

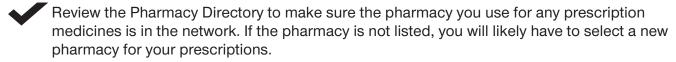
Enrollment checklist

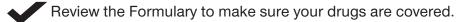
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

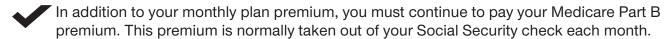


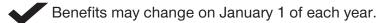


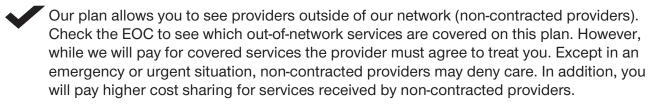




Understanding important rules







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.