

2025 Enrollment Request Form

☐ UHC Medicare Advantage VT-001A (PPO) H2001-029-000

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	е	
Home phone number ()	_	Mobile phone no	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	County		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				UHVT25LP0221108_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				
☐ 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 □ 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	T25LP0221108_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, o	or Chicano/a
Yes, Puerto Rican	
Yes, Cuban	
Yes, another Hispanic, Latino, or Sp	panish 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
•	e recognized Tribe (name of Tribe)
4. What is your gender? Select one.	1
Woman	I use a different term:
Man	Laborate makka amanan
Non-binary	I choose not to answer
5. Which of the following best represents	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)	□ Yes □ No
If yes, please complete the following:	
Enrollee name	
Agent name/ID number	
V0066 EREMA 2025 C	LIHVT251 P0221108 000

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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 center.
You aren't limited to this list. You may go to any do	octor who accepts Medicare and the plan's
payment terms.	
You can find a list on the plan website or in the Pro	ovider 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	s provider? ☐ Yes ☐ No
Providing your email address above automatications.	lly enrolls you in paperless delivery for some of
You will get many of your required plan communication an email when new communications (For example Changes) are available online. You can access the computer, tablet or mobile phone.	•
If you would rather have hard copies of required	d materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you h some communications are very large and may preference for delivery at any time.	
Please read and sign	
By completing this form, I agree to the following	g:
paying my Part B premium if I have one, unless I understand that people with Medicare are go the country, except for limited coverage near urgent care outside of the U.S. See the Summal I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcare unitedHealthcare and contained in my United	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and nary of Benefits for more information. coverage begins, I must get all of my medical and care. Benefits and services authorized by IHealthcare "Evidence of Coverage" document ber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number	LIIIV/T051 D0001109 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 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).					
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. 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. My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. 					
When I sign below, it means that I have read an	d understand the inform	ation on this form			
show written proof (power of attorney, guardiansh understand that I will need to submit written proof behalf of the member beyond this application. Aft received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizations. Signature of applicant/member/authorized reputify you are the authorized representative,	f of this right, to the plan, i er this application has been Customer Service at the non information on file. resentative Today	f I wish to take action on en approved and I have umber on my 's date			
information below (*Not a Sales Agent)	process organ case of an				
Last name	First name				
Address					
City	State Zip code				
Phone number () —	Relationship to applican	t			
Enrollee name					
Agent name/ID numberY0066_ERFMA_2025_C		 UHVT25LP0221108_000			

For individuals hel	ning enrollee with	comi	nlat	ing this form o	nlv
Complete this section				_	_
members, or other thir	•	. •			
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sales	s Representative/	agenc	ev u	se only	
Licensed Sales representative/Writing ID		Initial receipt date			Э
Licensed Sales representative/agent name				Proposed effective	ve 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	nrol nd I SE eside	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					UHVT25LP0221108_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 VT-001A (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.

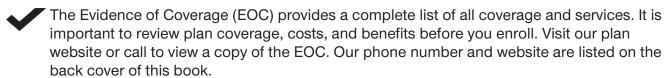
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

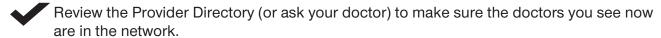
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

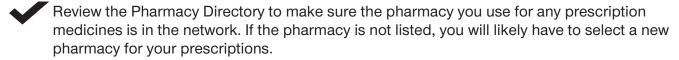
Enrollment checklist

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





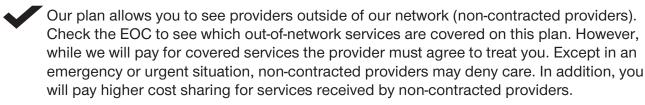


Review the Formulary to make sure your drugs are covered.

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.