

2025 Enrollment Request Form

☐ UHC Complete Care WA-13 (HMO-POS C-SNP) H3805-043-000

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 blue	ink)		
Last name	First name			Middle initial	
Birth date	Sex ☐ Male ☐ Female)	
Home phone number ()	 Mobile phone number () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	e num	nber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be co	•				
City	County	Stat	te	Zip code	
Mailing address (Only if it's different	t from above	e. You can give a P.C	O. bo	x.)	
City		Stat	te	Zip code	
Email address (optional)		,		'	
Enrollee name					
Agent name/ID number					
V0066 EREMA 2025 C			- 11	HMA25HD0220787 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				
		Γ		
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 automation Board (RRB) benefit check each Electronic Funds Transfer (EFT	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 your 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		
\square 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 of Braille		•	
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C UHWA25HP0220787_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)	5, ETD coverage, workers compensation,	⊓ Yes □ No
If yes, please complete the following:		_ 100 _ 110
Enrollee name		
Agent name/ID number	I IHWA 25HPO	1220727 000

	Page 4 of 8
Name of health insurance company	
Member number	
7. Please give us the name of your primary ca	re provider (PCP), clinic or health center.
You can find a list on the plan website or in the F	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 th	nis provider?
an email when new communications (For examp	nications delivered electronically. We will send you ble: Explanation of Benefits or the Annual Notice of hese communications through any device such as a
lf you would rather have hard copies of requir	red materials mailed to you, please check here:
	hard copies of required materials. Please note that y not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the followi	ng:
paying my Part B premium if I have one, un I understand that people with Medicare are the country, except for limited coverage nea urgent care outside of the U.S. See the Sun I understand that when my UnitedHealthcar prescription drug benefits from UnitedHealt	generally not covered under Medicare while out of ar the U.S. border. This plan covers emergency and nmary of Benefits for more information. The coverage begins, I must get all of my medical and

Enrollee name	
Agent name/ID number	
Y0066_ERFMA_2025_C	UHWA25HP0220787_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

plans).			
Release of information: By joining this Med will share my information with Medicare, who payments, and for other purposes allowed b information (see Privacy Act Statement below	o may use it to track by Federal law that a	my enrollment, to make	
 I give UnitedHealthcare permission to share my protected health information with organization or person(s) for permissible purposes under applicable law as required to administer my healt plan. 			
 The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. However plan. 	s form I will be disen	rolled from the plan.	the
When I sign below, it means that I have read a	nd understand the	information on this form	
If I sign as an authorized representative, it means show written proof (power of attorney, guardians understand that I will need to submit written proceed behalf of the member beyond this application. At received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizate Signature of applicant/member/authorized representative, it means show written proof to submit written proof behalf of the member beyond this application. At received my UnitedHealthcare UCard to update my authorized representative, it means show written proof (power of attorney, guardians understand that I will need to submit written proof behalf of the member beyond this application. At received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard® authorized representative, it means show written proof (power of attorney, guardians understand that I will need to submit written proof behalf of the member beyond this application. At received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard® authorized representative, it means that I will need to submit written proof behalf of the member beyond this application. At received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard®, I can call UnitedHealthcare understand the proof of the pr	ship, etc.) of this right of of this right, to the fter this application I I Customer Service a tion information on f	t if Medicare asks for it. I plan, if I wish to take action has been approved and I has the number on my	n on
If you are the authorized representative information below (*Not a Sales Agent)	, please sign abo	ove and complete the	
Last name	First name		
Address			
City	State	Zip code	
Phone number () —	Relationship to a	oplicant	
For individuals helping enrollee with co	mpleting this for	m only	
Enrollee name			

•	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	y u	se only		
Licensed Sales representative/Writing ID				Initial receipt date		
Licensed Sales representative/agent name				Proposed effective date		
Employer group name)					
Employer group ID			В	ranch ID		
Agent must complete ☐ IEP (MA-PD enrollees)	e ☐ 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	P (Dual LIS		EP (Change in ence) EP (October 15-mber 7)	☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ SEP (SEP reason) _	maintaining)					
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	I				UHWA25HP0220787_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 WA-13 (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.

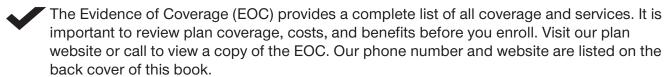
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

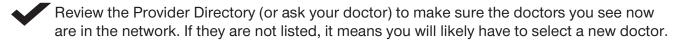
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

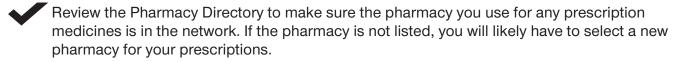
Enrollment checklist

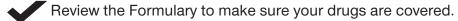
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





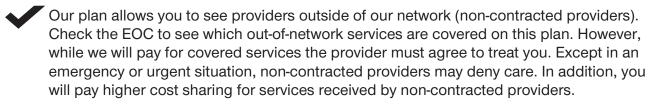




Understanding important rules







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.