

2025 Enrollment Request Form

☐ UHC Complete Care Support CA-7AP (HMO C-SNP) H0543-247-000

Information about you (Please	type or pri	nt in black or b	olue ink)
Last name	First name			Middle initial
Birth date		Sex □ Male [☐ Femal	e
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 homelessness, a PO Box may be co	-			
City	County		State	Zip code
Mailing address (Only if it's differen	t from above	e. You can give	a P.O. bo	ox.)
City			State	Zip code
Email address (optional)				
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C			ι	JHCA25HM0221311_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	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-II	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	ieck	
☐ 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		UHCA	\25HM0221311_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)		☐ Yes ☐ No			
If yes, please complete the following:		_ 100 _ 110			
Enrollee name					
Enrollee nameAgent name/ID number					
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		Page 4 of 8
Na	ame of health insurance company	
Me	ember number	
7. F	Please give us the name of your primary care	provider (PCP), clinic or health center.
Yοι	u can find a list on the plan website or in the Pr	ovider Directory.
>ro	ovider or PCP full name	
Pro	ovider/PCP number	(Please enter the number exactly as it appears or the website or in the Provider Directory. It will be 10 to 12 digits. Don't include dashes.)
٩re	e you now seeing or have you recently seen this	s provider?
/o u You an c Cha	ur plan communications. u will get many of your required plan communicemail when new communications (For example)	cations delivered electronically. We will send you explanation of Benefits or the Annual Notice of ese communications through any device such as a
f y	ou would rather have hard copies of require	d materials mailed to you, please check here:
S	nstead of paperless delivery, we will mail you he some communications are very large and may oreference for delivery at any time.	nard copies of required materials. Please note that not fit in all mailboxes. You can change your
	ease read and sign	
3у	completing this form, I agree to the following	g:
	paying my Part B premium if I have one, unled I understand that people with Medicare are go the country, except for limited coverage near urgent care outside of the U.S. See the Summar I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcare	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and mary of Benefits for more information. coverage begins, I must get all of my medical and

Enrollee name	
Agent name/ID number	
Y0066_ERFMA_2025_C	UHCA25HM0221311_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 Sa	vings Account (MSA)
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 my e y Federal law that authori	nrollment, to make
 I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan. 	my protected health infor	•
 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 disenrolled	I from the plan.
When I sign below, it means that I have read ar	nd understand the inforr	nation 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. Af received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizat Signature of applicant/member/authorized rep	hip, etc.) of this right if Me of of this right, to the plan, fter this application has be Customer Service at the tion 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)	, please sign above a	nd complete the
Last name	First name	
Address		
City	State	Zip code
Phone number () —	Relationship to applica	nt
For individuals helping enrollee with co	mpleting this form or	nly
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 repres	entative/Writing ID			Initial receipt dat	e
Licensed Sales representative/agent name				Proposed effective date	
Employer group name	;				
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees) ☐ e		☐ 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 maintaining)	□ S resi □ A		EP (Change in ence) EP (October 15-ember 7)	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _					
Licensed Sales repre	sentative signature (o	ptiona	ıl)		Date
	Please mail or fax	this co	omp	oleted form to:	
Enrollee name					
Agent name/ID number	r				UHCA25HM0221311_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 Support CA-7AP (HMO 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.

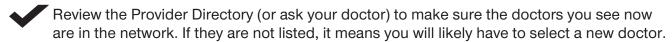
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

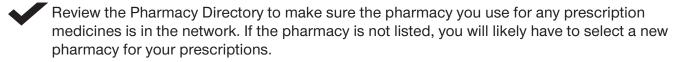
Enrollment checklist

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



- Benefits may change on January 1 of each year.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- 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.