

2025 Enrollment Request Form

 \square UHC Complete Care Support CA-6AP (HMO C-SNP) H0543-246-000

Information about you (Please	type or pri	nt in black or	blue ink)	
Last name	First name			Middle initial	
Birth date		Sex □ Male	□ Femal	e	
Home phone number ()	_	Mobile phone	number (() —	
☐ I give consent for UnitedHealthcard using an autodialer and/or prerecord		-	ohone 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 different	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			Ų	JHCA25HM0221312_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 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		UHCA	A25HM0221312_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	usurance 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
, , p		
Enrollee name		
Agent name/ID number	LIHCA 25HMO	
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	Page 4 of 8
Name of health insurance company	
Member number	
7. Please give us the name of your pri	mary care provider (PCP), clinic or health center.
You can find a list on the plan website o	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	y seen this provider? ☐ Yes ☐ No
Providing your email address above a your plan communications.	utomatically enrolls you in paperless delivery for some of
an email when new communications (Fo	communications delivered electronically. We will send you or example: Explanation of Benefits or the Annual Notice of access these communications through any device such as a
If you would rather have hard copies o	of required materials mailed to you, please check here:
	mail you hard copies of required materials. Please note that and may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the	e following:
paying my Part B premium if I have I understand that people with Medi the country, except for limited cove	and Medical (Part B) to stay in UnitedHealthcare. I must keep one, unless Medicaid or someone else pays for it. I care are generally not covered under Medicare while out of erage near the U.S. border. This plan covers emergency and the Summary of Benefits for more information.

Enrollee name	
Agent name/ID number	
Y0066_ERFMA_2025_C	UHCA25HM0221312_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

nor UnitedHealthcare will pay for benefits or services that are not covered.

	apply for MA Private Fee-for-Service (PFFS), N plans).	MA Medicare Medical Savi	ngs Account (MSA)
	Release of information: By joining this Medicare, who will 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 en	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.
Wh	en I sign below, it means that I have read an	d understand the informa	ation on this form
sho und beh rece Unit	sign as an authorized representative, it means w written proof (power of attorney, guardiansh lerstand that I will need to submit written proof talf of the member beyond this application. Afterived my UnitedHealthcare UCard®, I can call tedHealthcare UCard to update my authorization nature of applicant/member/authorized rep	rip, etc.) of this right if Med of this right, to the plan, it er this application has bee Customer Service at the non information on file.	dicare asks for it. I f I wish to take action on en approved and I have
_	ou are the authorized representative,	please sign above an	d complete the
	ormation below (*Not a Sales Agent) t name	First name	
Las	thame	That hame	
Add	dress		
City	,	State	Zip code
Pho	one number () —	Relationship to applican	t
For	r individuals helping enrollee with con	npleting this form only	v
	llee name		
	nt name/ID number		
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•	if you're an individual or 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 repres	sentative/agent name			Proposed effecti	ve date
Employer group name)			l	
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	e ☐ ICEP (MA enrollee	enrollees 2nd IEP) LIS □ SEP (0 tus) residence LIS □ AEP (0		P (MA-PD lees eligible for EP)	☐ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)			EP (Change in	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _					
Licensed Sales repre	esentative signature (c	optiona	al)	ı	Date
	Please mail or fax	this c	omp	oleted form to:	
Enrollee name					
Agent name/ID numbe Y0066_ERFMA_2025_C					UHCA25HM0221312_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-6AP (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.

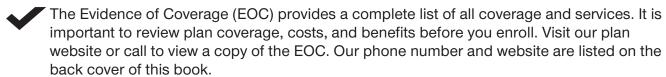
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

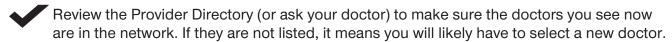
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

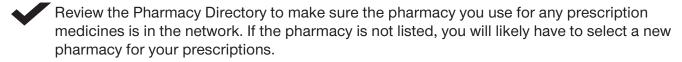
Enrollment checklist

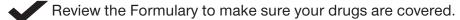
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

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.