

2025 Enrollment Request Form

☐ UHC Complete Care Support CA-3AP (HMO C-SNP) H0543-241-000

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	JHCA25HM0221314_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				
☐ 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		UHCA	A25HM0221314_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.

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<i>'</i> .	
Black or African American	
Native Hawaiian or Pacific Islander:	
Guamanian or Chamorro	
Native Hawaiian	
Samoan	
Other Pacific Islander	
White	
I choose not to answer	
e recognized Tribe (name of Tribe)	
I use a different term:	
I choose not to answer	
s how you think of yourself? Select one.	
I use a different term:	
I don't know	
I choose not to answer	
	☐ Yes ☐ No
surance that will cover medical services?	
e, ETB ooverage, workers compensation,	☐ Yes ☐ No
	_ 100 _ 110
	001014 000
	Native Hawaiian or Pacific Islander: Guamanian or Chamorro Native Hawaiian Samoan Other Pacific Islander White I choose not to answer e recognized Tribe (name of Tribe) I use a different term: I choose not to answer s how you think of yourself? Select one. I use a different term: I don't know

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N	Name of health insurance company	
M	Member number	
7.	Please give us the name of your primary care	provider (PCP), clinic or health center.
Yo	ou can find a list on the plan website or in the Pro	ovider Directory.
Pro	ovider or PCP full name	
Pro	rovider/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	re you now seeing or have you recently seen this	provider? ☐ Yes ☐ No
Yo an Ch	n email when new communications (For example	eations delivered electronically. We will send you example: Explanation of Benefits or the Annual Notice of ese communications through any device such as a
lf y	you would rather have hard copies of required	l materials mailed to you, please check here:
;	Instead of paperless delivery, we will mail you has some communications are very large and may repreference for delivery at any time.	ard copies of required materials. Please note that not fit in all mailboxes. You can change your
	lease read and sign	
Ву	y completing this form, I agree to the following	j:
	paying my Part B premium if I have one, unless I understand that people with Medicare are gother the country, except for limited coverage near urgent care outside of the U.S. See the Summ I understand that when my UnitedHealthcare operacription drug benefits from UnitedHealthcare.	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

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),	MA Medicare Medical Sav	vings Account (MSA)		
Release of information: By joining this Med will share my information with Medicare, who	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 or person(s) for permissible purposes under plan. 	my protected health inforr	•		
 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	from the plan.		
When I sign below, it means that I have read ar	nd understand the inform	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 proof 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 this right, to the plan, iter this application has be Customer Service at the ricion information on file.	dicare asks for it. I if I wish to take action on en approved and I have		
If you are the authorized representative, information below (*Not a Sales Agent)	, please sign above ar	nd complete the		
Last name	First name			
Address				
City	State	Zip code		
Phone number () —	Relationship to applicar	nt		
For individuals helping enrollee with cor	mpleting this form on	ly		
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	es Representative/a	agenc	y u	se only	
Licensed Sales repres	sentative/Writing ID			Initial receipt dat	e
Licensed Sales repres	sentative/agent name			Proposed effecti	ve date
Employer group name	9				
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	e □ ICEP (MA enrollee	enrollees 2nd IEP) □ SEP (0 residence □ 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	ptiona	ıl)	ı	Date
	Please mail or fax	this co	omp	oleted form to:	
Enrollog namo					
Enrollee name Agent name/ID numbe Y0066_ERFMA_2025_C					UHCA25HM0221314_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-3AP (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.

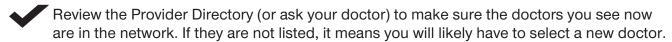
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

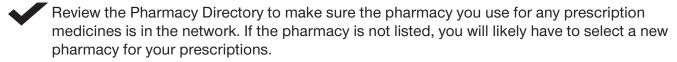
Enrollment checklist

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





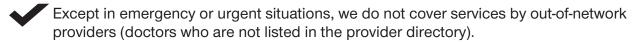


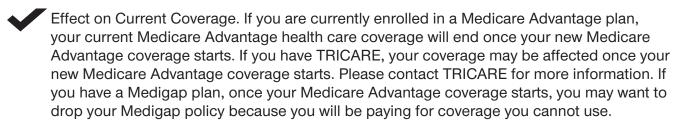


Understanding important rules









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.