

# **2025 Enrollment Request Form**

☐ UHC Complete Care Support CA-1AP (HMO C-SNP) H0543-239-000

Last name	type or print in black or blue ink			Middle initial	
Birth date		Sex □ Male □	l Femal	e	
Home phone number ( )	_	Mobile phone n	umber (	( ) –	
☐ I give consent for UnitedHealthca using an autodialer and/or prerecon		•	one nur	mber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be o	-				
City	County		State	Zip code	
Mailing address (Only if it's differe	nt from above	e. You can give a	P.O. bo	ox.)	
City		,	State	Zip code	
Email address (optional)		I			
Enrollee name					
Agent name/ID number					
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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-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 [	☐ Savings			
Account holder name:	Account holder name:			
Bank routing number/,	/_/_/_/_/_			
Bank account 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		UHCA	A25HM0221316_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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Name of health insurance company	
Member number	
7. Please give us the name of your prima	ry care provider (PCP), clinic or health center.
You can find a list on the plan website or in	the Provider Directory.
Provider or PCP full name	
Provider/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.)
Are you now seeing or have you recently se	een this provider?
Providing your email address above auto your plan communications.	matically enrolls you in paperless delivery for some of
an email when new communications (For e	mmunications delivered electronically. We will send you example: Explanation of Benefits or the Annual Notice of cess these communications through any device such as a
If you would rather have hard copies of re	equired materials mailed to you, please check here:
• •	il you hard copies of required materials. Please note that d may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the fo	ollowing:
	l Medical (Part B) to stay in UnitedHealthcare. I must keep

Enrollee name	
Agent name/ID number	
Y0066_ERFMA_2025_C	UHCA25HM0221316_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), plans).	MA Medicare Medical Sav	vings Account (MSA)
Release of information: By joining this Med will share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below	o may use it to track my en y Federal law that authoriz	rollment, to make
<ul> <li>I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan.</li> </ul>	my protected health inforr	•
<ul> <li>The information on this form is correct to the intentionally provide false information on this</li> <li>My response to this form is voluntary. However plan.</li> </ul>	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 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 representative, it means show written proof that I will need to submit written proceed that I will need to submit written proceed that I will need to submit written proof that I will need to submit written proof behalf of the member beyond this application. Af	hip, etc.) of this right if Me of this right, to the plan, ter this application has be Customer Service at the right 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		

•	n if you're an individual ( ird parties) helping an e	nrollee	fill out this form.	, <b>,</b>		
Name F		Relation	Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)				
For Licensed Sale	es Representative/a	agency	use only			
Licensed Sales repre	sentative/Writing ID		Initial receipt da	te		
Licensed Sales representative/agent name			Proposed effective date			
Employer group nam	e					
Employer group ID			Branch ID			
Agent must complet		` _				
☐ IEP (MA-PD enrollees)	er		IEP (MA-PD rollees eligible for d IEP)	□ OEP (Jan 1 – Mar 31)		
☐ OEP (Newly	☐ SEP (Dual LIS	☐ SEP (Dual LIS ☐		☐ SEP (Loss of		
eligible)  ☐ SEP (Chronic)	☐ SEP (Dual LIS ☐		sidence) AEP (October 15- ecember 7)	EGHP coverage) □ OEPI		
☐ SEP (SEP reason)						
Licensed Sales repr	esentative signature (o	ptional	)	Date		
	Please mail or fax	this co	mpleted form to:			
			•			
T						
	 er					
/0066_ERFMA_2025_C				UHCA25HM0221316_00		

## 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-1AP (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.

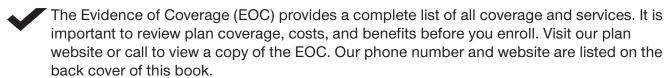
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

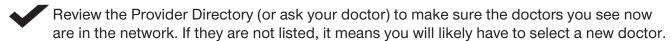
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

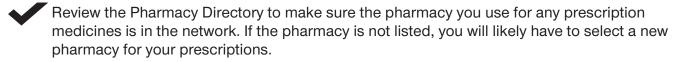
## **Enrollment checklist**

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**



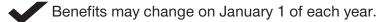


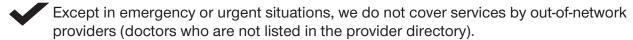


Review the Formulary to make sure your drugs are covered.

#### **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.

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.