



2025 Enrollment Request Form

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

Information about you (Please type or print in black or blue ink)

| | | |
|-----------|------------|----------------|
| Last name | First name | Middle initial |
|-----------|------------|----------------|

| | |
|------------|-------------------------------------------------------------------|
| Birth date | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female |
|------------|-------------------------------------------------------------------|

| | |
|-------------------------------------|---------------------------------------|
| Home phone number () – | Mobile phone number () – |
|-------------------------------------|---------------------------------------|

I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology.

Medicare number

Permanent residence street address (**Don't enter a P.O. box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address**)

| | | | |
|------|--------|-------|----------|
| City | County | State | Zip code |
|------|--------|-------|----------|

Mailing address (**Only if it's different from above. You can give a P.O. box.**)

| | | |
|------|-------|----------|
| City | State | Zip code |
|------|-------|----------|

Email address (optional)

Enrollee name _____

Agent name/ID number _____

Do you have other insurance that will cover your prescription drugs? Yes No

(Examples: Other private insurance, TRICARE, federal employee coverage, VA benefits or state programs.)

If **yes**, what is it?

Name of other insurance

| | | | |
|---------------|--------------|-------|------------------|
| Member number | Group number | RxBin | RxPCN (optional) |
|---------------|--------------|-------|------------------|

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

How do you want to pay?

If you have a monthly plan premium (including any late enrollment penalty you may owe), you can pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT).

If you don't choose an option below, we'll send a bill each month to your mailing address.

If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA),

Social Security (SS) will send you a letter and ask you how you want to pay it:

- You can pay it from your SS check
- Medicare can bill you
- The Railroad Retirement Board (RRB) can bill you

- I want to pay from my Social Security check
- I want to pay from my Railroad Retirement Board (RRB) check
- 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 us manage your plan

1. Would you prefer plan information in another language or an accessible format?

If you would prefer plan information in another language or accessible format, please check what you'd like: Spanish Braille Large print Audio CD Data CD

Enrollee name _____

Agent name/ID number _____

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 origin? Select all that apply.

- No, not of Hispanic, Latino/a, or Spanish origin
- Yes, Mexican, Mexican American, or Chicano/a
- Yes, Puerto Rican
- Yes, Cuban
- Yes, another Hispanic, Latino, or Spanish origin
- I choose not to answer**

3. What's your race? Select all that apply.

- | | |
|-----------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black or African American |
| Asian: | Native Hawaiian or Pacific Islander: |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Korean | |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> White |
| <input type="checkbox"/> Other Asian | <input type="checkbox"/> I choose not to answer |
- Member/Citizen of a federal or state recognized Tribe (name of Tribe) _____

4. What is your gender? Select one.

- | | |
|-------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Woman | <input type="checkbox"/> I use a different term: _____ |
| <input type="checkbox"/> Man | |
| <input type="checkbox"/> Non-binary | <input type="checkbox"/> I choose not to answer |

5. Which of the following best represents how you think of yourself? Select one.

- | | |
|----------------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Lesbian or gay | <input type="checkbox"/> I use a different term: _____ |
| <input type="checkbox"/> Straight, that is, not gay or lesbian | <input type="checkbox"/> I don't know |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> I choose not to answer |

6. Do you or your spouse work?

Yes No

Do you or your spouse have other health insurance that will cover medical services?

(Examples: Other employer group coverage, LTD coverage, Workers' Compensation, auto liability, or Veterans benefits)

Yes No

If yes, please complete the following:

Enrollee name _____

Agent name/ID number _____

 Name of health insurance company

 Member number

7. Please give us the name of your primary 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 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 this provider? Yes No

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone.

If you would rather have hard copies of required materials mailed to you, please check here:

- Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Please read and sign
By completing this form, I agree to the following:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information.
- I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.
- 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

Enrollee name _____

Agent name/ID number _____

apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA) 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 my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health plan.
- The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan.
- My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

When I sign below, it means that I have read and understand the information on this form

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file.

Signature of applicant/member/authorized representative Today's date

If you are the authorized representative, please sign above and complete the information below (*Not a Sales Agent)

| | | |
|----------------------------------|---------------------------|----------|
| Last name | First name | |
| Address | | |
| City | State | Zip code |
| Phone number () — | Relationship to applicant | |

For individuals helping enrollee with completing this form only

Enrollee name _____

Agent name/ID number _____

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

| | |
|-----------|------------------------------------------------|
| Name | Relationship to enrollee |
| Signature | National Producer Number (Agents/Brokers only) |

For Licensed Sales Representative/agency use only

| | |
|------------------------------------------|-------------------------|
| Licensed Sales representative/Writing ID | Initial receipt date |
| Licensed Sales representative/agent name | Proposed effective date |
| Employer group name | |
| Employer group ID | Branch ID |

Agent must complete

- | | | | |
|-------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> IEP (MA-PD enrollees) | <input type="checkbox"/> ICEP (MA enrollees) | <input type="checkbox"/> IEP (MA-PD enrollees eligible for 2nd IEP) | <input type="checkbox"/> OEP (Jan 1 - Mar 31) |
| <input type="checkbox"/> OEP (Newly eligible) | <input type="checkbox"/> SEP (Dual LIS change of status) | <input type="checkbox"/> SEP (Change in residence) | <input type="checkbox"/> SEP (Loss of EGHP coverage) |
| <input type="checkbox"/> SEP (Chronic) | <input type="checkbox"/> SEP (Dual LIS maintaining) | <input type="checkbox"/> AEP (October 15-December 7) | <input type="checkbox"/> OEPI |
| <input type="checkbox"/> SEP (SEP reason) _____ | | | |

Licensed Sales representative signature (optional)

Date

Please mail or fax this completed form to:

Enrollee name _____

Agent name/ID number _____

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

UHCA25HM0221316_000

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

- ✓ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit our plan website or call to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.
- ✓ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ✓ Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ✓ Review the Formulary to make sure your drugs are covered.

Understanding important rules

- ✓ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ✓ 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.