

2025 Enrollment Request Form

☐ UHC Complete Care CA-25P (HMO-POS C-SNP) H0543-224-000

Select optional supplemental benefits in addition to what is included with your plan

You can add the following benefit rider for an extra cost. You can purchase the rider now while you are enrolling, or within 3 months after your effective date. See the Summary of Benefits for more information, including costs.

☐ Platinum Dental Rider					
Information about you (Please	type or pri	nt in black or l	olue ink		
Last name	First name			Middle initial	
Birth date	Sex ☐ Male ☐ Femal		□ Femal	e	
Home phone number ()	_	Mobile phone	number (() –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			hone nur	mber(s) I have provided	
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 nameAgent name/ID number					
Y0066_ERFMA_2025_C				JHCA25HP0221325_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?					
pay your premium by automatic Board (RRB) benefit check each	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 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	□ You can pay it from your SS check				
☐ Medicare can bill you	□ 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 I	□ Savings				
Account holder name:					
Bank routing number/	Bank routing number////				
Bank account number/_	Bank account number/////				
A few questions to help u					
1. Would you prefer plan info					
	rmation in another language or Braille □ Large print □ Audi		•		
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C			 A25HP0221325_000		
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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)	o,	☐ Yes ☐ No		
If yes, please complete the following:				
Enrollee name				
Agent name/ID number				
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Na	Name of health insurance company	
M	Member number	
7. I	. Please give us the name of your primary care p	rovider (PCP), clinic or health center.
Υοι	ou can find a list on the plan website or in the Provi	der Directory.
Pro	Provider or PCP full name	
Pro	ti	Please enter the number exactly as it appears or he website or in the Provider Directory. It will be 0 to 12 digits. Don't include dashes.)
Are	Are you now seeing or have you recently seen this p	rovider? ☐ Yes ☐ No
	Providing your email address above automatically our plan communications.	enrolls you in paperless delivery for some of
an Cha	ou will get many of your required plan communicat on email when new communications (For example: E Changes) are available online. You can access these computer, tablet or mobile phone.	Explanation of Benefits or the Annual Notice of
lf y	f you would rather have hard copies of required n	naterials mailed to you, please check here:
5	Instead of paperless delivery, we will mail you hard some communications are very large and may not preference for delivery at any time.	·
Ple	Please read and sign	
Ву	By completing this form, I agree to the following:	
	paying my Part B premium if I have one, unless	erally not covered under Medicare while out of e U.S. border. This plan covers emergency and

	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
Enro	ollee name

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

☐ 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

Agent name/ID number ___

	apply for MA Private Fee-for-Service (PFFS plans).	S), MA Medicare Medic	al Savings Account (MSA)		
	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).				
	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.				
Wh	en I sign below, it means that I have read	and understand the in	nformation on this form		
und beh rece Unit	w written proof (power of attorney, guardian derstand that I will need to submit written properly of the member beyond this application. The eived my UnitedHealthcare UCard®, I can catedHealthcare UCard to update my authorized nature of applicant/member/authorized nature of applicant nature	roof of this right, to the After this application heall Customer Service a zation information on firepresentative	plan, if I wish to take action on as been approved and I have t the number on my le. Today's date		
_	ormation below (*Not a Sales Agent)		·		
Las	t name	First name			
Add	dress				
City	1	State	Zip code		
Pho	one number () —	Relationship to ap	pplicant		
	r individuals helping enrollee with c		-		
Enro	lla a mana a				
	llee name nt name/ID number				

•	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	agen	cy u	se only	
Licensed Sales repres	entative/Writing ID		Initial receipt date		te
Licensed Sales repres	sentative/agent name			Proposed effective date	
Employer group name)				
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	e ☐ ICEP (MA enrollee			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)	☐ SEP (Chang residence)		P (Change in ence) P (October 15-	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _					
Licensed Sales repre	esentative signature (c	ption	al)		Date
	Please mail or fax	this	comp	oleted form to:	
Enrollee name Agent name/ID numbe					
Y0066_ERFMA_2025_C	I				UHCA25HP0221325_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 CA-25P (HMO-POS 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.

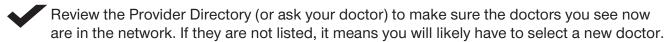
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

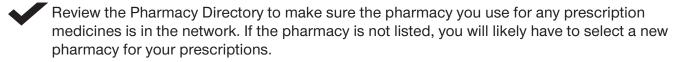
Enrollment checklist

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

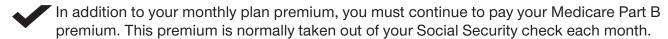




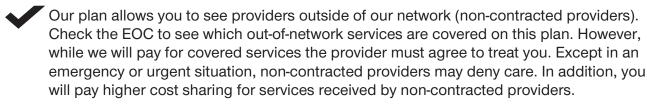




Understanding important rules







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.