

2025 Enrollment Request Form

☐ UHC Complete Care CA-18P (HMO-POS C-SNP) H0543-217-000

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 r	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 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	a P.O. bo	ex.)
City			State	Zip code
Email address (optional)		ı		
Enrollee name				
Agent name/ID number				
V0066 EREMA 2025 C			1	HHC∆25HD0221332 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 Retirement 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		UHC	A25HP0221332_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	surance that will cover medical services?	
(Examples: Other employer group coverage		
auto liability, or Veterans benefits)	s, 2.2 coverage, memore compensation,	☐ Yes ☐ No
If yes, please complete the following:		
Enrollee name		
Agent name/ID number		
V0066 EREMA 2025 C	IHCA25HP0	221332 000

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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	UHCA25HP0221332_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.

□ Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plar 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). □ Igive UnitedHealthcare permission to share my protected health information with organization or person(s) for permissible purposes under applicable law as required to administer my healt 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. □ Wy 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 car 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 of 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	apply for MA Private Fee-for-Service (PFFS) plans).	, MA Medicare Medi	ical Savings Account (MSA)	
□ I give UnitedHealthcare permission to share my protected health information with organization or person(s) for permissible purposes under applicable law as required to administer my healting 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 of 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	Release of information: By joining this Med will share my information with Medicare, wh payments, and for other purposes allowed by	no may use it to tracl by Federal law that a	k my enrollment, to make	ı
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information below (*Not a Sales Agent) Last name First name Address City State Zip code	show written proof (power of attorney, guardians understand that I will need to submit written probehalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can ca UnitedHealthcare UCard to update my authorization.	ship, etc.) of this right of of this right, to the after this application Il Customer Service ation information on	ht if Medicare asks for it. I e plan, if I wish to take action or has been approved and I have at the number on my file.	า
Address City State Zip code		e, please sign ab	ove and complete the	
City State Zip code	Last name	First name		
	Address			
Delationality to configurat	City	State	Zip code	
Phone number () — Relationship to applicant	Phone number () —	Relationship to a	applicant	
For individuals helping enrollee with completing this form only	For individuals helping enrollee with co	empleting this fo	rm only	
Enrollee name				
Agent name/ID number	nrollee 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	s Representative/a	agenc	y u	se only		
Licensed Sales repres	sentative/Writing ID			Initial receipt dat	re	
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)	te ☐ ICEP (MA enrollees)		□ IEP (MA-PD enrollees eligible for end IEP)		☐ OEP (Jan 1 – Mar 31)	
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS		☐ SEP (Change in residence) ☐ AEP (October 15-December 7)		☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ SEP (SEP reason) _	maintaining)		ece			
Licensed Sales repre	esentative signature (o	ptiona	ıl)		Date	
	Please mail or fax	this co	omp	oleted form to:		
Enrollee name Agent name/ID numbe						
Agent name/1D numbe Y0066_ERFMA_2025_C	·				UHCA25HP0221332_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-18P (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.

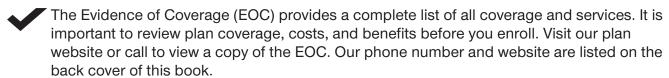
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

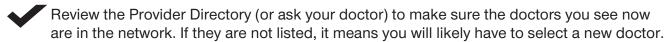
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

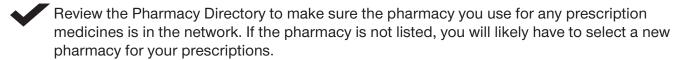
Enrollment checklist

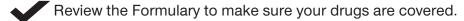
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





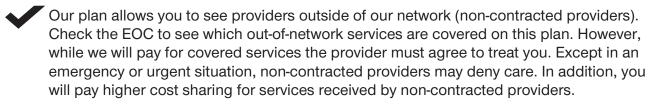




Understanding important rules







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.