

# **2025** Enrollment Request Form

☐ UHC Sharp Medicare Advantage CA-001P (HMO-POS) H0543-145-000

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	blue ink	)
Last name	First name		Middle initial	
Birth date		Sex ☐ Male	□ Femal	е
Home phone number ( )	_	Mobile phone	number	( ) —
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	ohone 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 nameAgent name/ID number				
Y0066_ERFMA_2025_C				UHCA25HP0221352_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 automation 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 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 Retiremen	t 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 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 UHCA25HP0221352_000			

If you don't see the language or format you want, please call us toll-free at **1-844-723-6473**, 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	<b>'•</b>		
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)	, , , , , , , , , , , , , , , , , , , ,	☐ Yes ☐ No	
If yes, please complete the following:			
Enrollee name			
Agent name/ID number			
V0066 EREMA 2025 C	IHCA25HPO	221352 000	

	Page 4 of 8
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	UHCA25HP0221352_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 (plans).	PFFS), MA Medicare Medi	cal Savings Account (MSA)	
Release of information: By joining the will share my information with Medical payments, and for other purposes all information (see Privacy Act Statements).	are, who may use it to track owed by Federal law that a	my enrollment, to make	
<ul> <li>I give UnitedHealthcare permission to or person(s) for permissible purposes plan.</li> </ul>	share my protected health	<u> </u>	
<ul> <li>The information on this form is correct intentionally provide false information</li> <li>My response to this form is voluntary plan.</li> </ul>	n on this form I will be diser	rolled from the plan.	
When I sign below, it means that I have	read and understand the	information on this form	
show written proof (power of attorney, guanderstand that I will need to submit writte behalf of the member beyond this applicate received my UnitedHealthcare UCard®, I contedHealthcare UCard to update my autiside applicant/member/authorically.	en proof of this right, to the ation. After this application can call Customer Service a thorization information on f	plan, if I wish to take action on has been approved and I have at the number on my	
If you are the authorized represent information below (*Not a Sales Agents Agen	•	ove and complete the	
Last name	First name		
Address			
City	State	Zip code	
Phone number ( ) —	Relationship to a	pplicant	
For individuals helping enrollee w	ith completing this for	m only	
Complete this section if you're an individumembers, or other third parties) helping a		•	
Enrollee name			
Agent name/ID number			

Name Re		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sale	s Representative/a	agency	y u	se only	
Licensed Sales representative/Writing ID			Initial receipt date		
Licensed Sales representative/agent name			Proposed effective date		
Employer group name	<del>)</del>				
Employer group ID			Ві	ranch ID	
Agent must complete	e		1		
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollee	es) ☐ IEP (MA-PD enrollees eligible for 2nd IEP)		ees eligible for	☐ OEP (Jan 1 – Mar 31)
☐ OEP (Newly	☐ SEP (Dual LIS	☐ SEP (Change in residence)		,	☐ SEP (Loss of
eligible)	change of status)			•	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS	☐ AEP (October 15-		-	□ OEPI
☐ SEP (SEP reason) _	maintaining)	December 7)			
Licensed Sales repre	esentative signature (o	ptional	l)	Da	ate
	Please mail or fax	this co			
		Box 30			
Enrollee name					
Agent name/ID numbe					
Y0066_ERFMA_2025_C					UHCA25HP0221352_000

## 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 Sharp Medicare Advantage CA-001P (HMO-POS) 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.

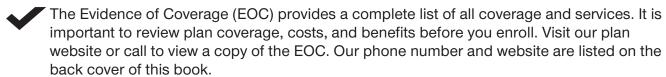
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

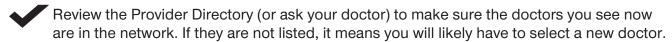
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

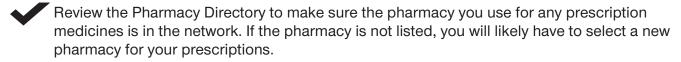
## **Enrollment checklist**

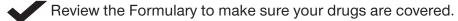
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

#### Understanding the benefits





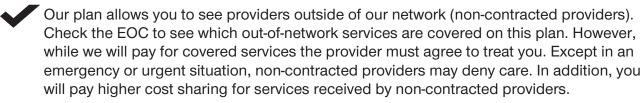




### **Understanding important rules**







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.