

2025 Enrollment Request Form

☐ UHC Medicare Advantage CT-0002 (HMO-POS) H0755-031-000

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 prii	nt in black or blue i	nk)		
Last name	First name		М	Middle initial	
Birth date		Sex □ Male □ Fer	nale	e	
Home phone number ()	_	Mobile phone number	er () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	numbe	er(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 different	t from above	e. You can give a P.O.	box.)		
City		State		Zip code	
Email address (optional)		 			
Enrollee name					
Agent name/ID number					
Y0066 ERFMA 2025 C UHCT25HP0221229 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 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	
☐ 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 Large print Audi		•
Enrollee name			
Agent name/ID number			
Y0066_ERFMA_2025_C		UHC	T25HP0221229_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	·•	
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		
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Name of health insurance company	
Member number	
7. Please give us the name of your primar	y 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 se	en this provider? ☐ Yes ☐ No
your plan communications. You will get many of your required plan com an email when new communications (For ex	nmunications delivered electronically. We will send you cample: Explanation of Benefits or the Annual Notice of ess these communications through any device such as a
lf you would rather have hard copies of re	quired materials mailed to you, please check here:
	you hard copies of required materials. Please note that I may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the fol	lowing:
paying my Part B premium if I have one I understand that people with Medicare the country, except for limited coverage urgent care outside of the U.S. See the	Medical (Part B) to stay in UnitedHealthcare. I must keep e, unless Medicaid or someone else pays for it. e are generally not covered under Medicare while out of e near the U.S. border. This plan covers emergency and Summary of Benefits for more information. hcare coverage begins, I must get all of my medical and
•	Healthcare. Benefits and services authorized by

Enrollee name	
Agent name/ID number	
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nor UnitedHealthcare will pay for benefits or services that are not covered.

UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare

□ 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

apply for MA Private Fee-for-Service (PF plans).	FS), MA Medicare Med	dical Savings Account (MSA)	
Release of information: By joining this will share my information with Medicare payments, and for other purposes allow information (see Privacy Act Statement I	, who may use it to trac red by Federal law that	ck my enrollment, to make	
 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 healt plan. 			
 The information on this form is correct to intentionally provide false information or My response to this form is voluntary. He plan. 	n this form I will be dise	enrolled from the plan.	
When I sign below, it means that I have rea	ad and understand the	information on this form	
If I sign as an authorized representative, it meshow written proof (power of attorney, guard understand that I will need to submit written behalf of the member beyond this application received my UnitedHealthcare UCard®, I can UnitedHealthcare UCard to update my authorized Signature of applicant/member/authorized	dianship, etc.) of this rig proof of this right, to the on. After this application on call Customer Service prization information or	pht if Medicare asks for it. I ne plan, if I wish to take action on n has been approved and I have e at the number on my	
If you are the authorized representation below (*Not a Sales Ager		oove and complete the	
Last name	First name		
Address	 		
City	State	Zip code	
Phone number () —	Relationship to	applicant	
For individuals helping enrollee with	completing this fo	orm only	
Enrollee name			
Agent 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	agenc	y u	se only		
Licensed Sales representative/Writing ID				Initial receipt date		
Licensed Sales representative/agent name				Proposed effective date		
Employer group name)					
Employer group ID			В	ranch ID		
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)		☐ IEP (MA-PD enrollees eligible for 2nd IEP) ☐ SEP (Change in residence) ☐ AEP (October 15-December 7)		☐ OEP (Jan 1 – Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ OEP (Newly eligible) ☐ SEP (Chronic)	□ SEP (Dual LIS □ change of status) re □ SEP (Dual LIS □					
☐ SEP (SEP reason) _	maintaining)					
Licensed Sales repre	esentative signature (o	ptiona	ıl)		Date	
	Please mail or fax	this co	omp	oleted form to:		
Enrolled						
Enrollee nameAgent name/ID numbe						
Y0066_ERFMA_2025_C					UHCT25HP0221229_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 Medicare Advantage CT-0002 (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.

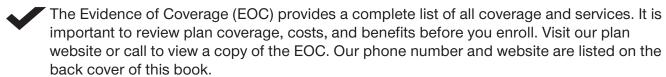
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

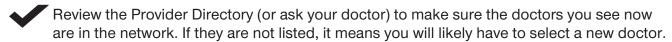
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

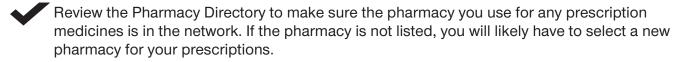
Enrollment checklist

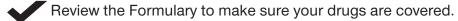
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

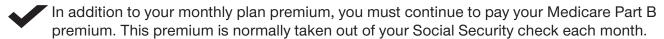


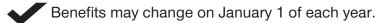


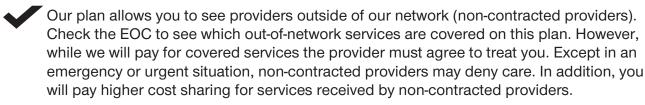




Understanding important rules







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.