

## 2026 Enrollment Request Form

 $\square$  UHC Dual Complete TN-S001 (HMO-POS D-SNP) H0251-002-000

Information about you (Please	e type or pri	nt in black or blue i	nk)	
Last name	First name	1		ddle initial
Birth date		Sex ☐ Male ☐ Femal		
Home phone number ( )	_	Mobile phone number	er (	) –
You can stay on top of your plan and Check here to consent to receive technology. You can change your p	calls using au	to dialer/artificial or pr	erecor	ded voice
Social Security number				
(Required for people who are enroll	ing in D-SNP	plans):		
Medicare number				
Permanent residence street address experiencing homelessness, a P.C address)  City	-			
Mailing address (Only if it's different	nt from above	e. You can give a P.O.	Box.)	
City		State		Zip code
Email address		l l		
You will receive some plan informat Changes, electronically (quicker that review online.  □ Check here if you prefer to receive preference at any time.	ın mail). We'll	email you when new d	ocume	ents are ready to
Enrollee name				
Agent name/ID number				N26HP0320266 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	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	pelow, we'll send a bill each mo	onth to your mailin	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	r SS check		
☐ Medicare can bill you			
<ul> <li>The Railroad Retirement</li> </ul>	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	
$\square$ I want to pay directly from a	bank account		
Account type ☐ Checking I	☐ Savings		
Account holder name:			
Bank routing number/	/_/_/_/_		
Bank account number/_	/_/_/_/_		
*Members enrolled in the EFT Insurance Company the new cl current retroactive charges plu tell both UHC and my bank. I u	narges from my bank Account s monthly premium amount. If	which may includ I choose to stop p	le up to \$200.00 of baying by EFT, I will
A few questions to help u	s manage your plan		
1. Which language or accessi	ble format do you prefer for t	future plan inforn	nation?
Enrollee name			
Agent name/ID number			
Y0066_EFMA_2026_C		CSTI	N26HP0320266_000

☐ English ☐ Spanish	
☐ Braille ☐ Large print ☐ Audio CD ☐ Da	ta CD
	nt, please call us toll-free at <b>1-844-560-4944</b> , TTY visit <b>UHC.com/CommunityPlan</b> for online help. <b>If</b> formation in English.
2. Are you enrolled in your state Medicaid prog	ram? □ Yes □ No
If yes, please give us your Medicaid number:	
3. Do you or your spouse work?	☐ Yes ☐ No
Do you or your spouse have other health insurance (Examples: Other employer group coverage, LTD auto liability, or Veterans benefits)  If yes, please complete the following:	
Name of health insurance company	
Member number	
4. 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 Pr	ovider 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	s provider? ☐ Yes ☐ No
Please read and sign	
By completing this form, I agree to the following	g:
paying my Part B premium if I have one, unle I understand that people with Medicare are g the country, except for limited coverage near urgent care outside of the U.S. See the Sumr I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcare UnitedHealthcare and contained in my United (also known as a member contract or subscri nor UnitedHealthcare will pay for benefits or s	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and nary of Benefits for more information. coverage begins, I must get all of my medical and care. Benefits and services authorized by Healthcare "Evidence of Coverage" document ber agreement) will be covered. Neither Medicare services that are not covered.
Enrollee name	
/0066_EFMA_2026_C	CSTN26HP0320266_000

	I understand that I can be enrolled in only one that enrollment in this plan will automatically e apply for MA Private Fee-for-Service (PFFS), N plans).	end my enrollment in anot	her MA plan (exceptions
	Release of information: By joining this Medic will share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below	may use it to track my end Federal law that authorize	rollment, to make
	I give UnitedHealthcare permission to share mor person(s) for permissible purposes under a plan.	• •	•
	The information on this form is correct to the lintentionally provide false information on this	form I will be disenrolled f	rom the plan.
	My response to this form is voluntary. However plan.	er, railure to respond may	anect enrollment in the
Whe	en I sign below, it means that I have read and	d understand the informa	ation on this form
beha rece Unite	erstand that I will need to submit written proof alf of the member beyond this application. After ived my UnitedHealthcare UCard®, I can call content of the	er this application has been customer Service at the noting information on file.	en approved and I have
_	ou are the authorized representative, prmation below (*Not a Sales Agent)	please sign above an	d complete the
Last	name	First name	
Add	ress		
City		State	Zip code
Phor	ne number ( ) —	Relationship to applican	t
For	individuals helping enrollee with com	pleting this form onl	y
	lee name		
_	t name/ID number EFMA 2026 C		 STN26HP0320266_000

-	n if you're an individual ( ird parties) helping an e	_			
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sale	es Representative/a	agency	use only		
Licensed Sales repre	sentative/Writing ID		Initial receipt da	ate	
Licensed Sales representative/agent name			Proposed effect	Proposed effective date	
Employer group nam	е				
Employer group ID			Branch ID		
Agent must complet		` _	JED (14: 55		
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollee	en	IEP (MA-PD rollees eligible for d IEP)	□ OEP (Jan 1 – Mar 31)	
☐ OEP (Newly	☐ SEP (Dual LIS	☐ SEP (Change in		☐ SEP (Loss of	
eligible) ☐ SEP (Chronic)	change of status) ☐ SEP (Dual LIS maintaining)	residence)  ☐ AEP (October <sup>-</sup> December 7)		EGHP coverage) □ OEPI	
☐ SEP (SEP reason)	<del>-</del> ·				
Licensed Sales repr	esentative signature (o	ptional	) D	Date	
		dHealth Box 30 ty, UT 8 388-950	care 769 4130-0769 -1169		
Enrollee name Agent name/ID numbe Y0066_EFMA_2026_C	er				

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 Dual Complete TN-S001 (HMO-POS D-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare.

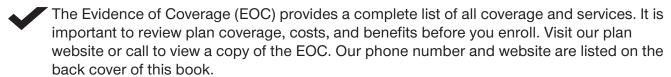
Notice: TennCare is not responsible for payment for these benefits, except for appropriate cost sharing amounts. TennCare is not responsible for guaranteeing the availability or quality of these benefits. Any additional Medicare benefit mentioned in this communication above Original Medicare is applicable to the Medicare benefit only and does not indicate increased Medicaid benefits.

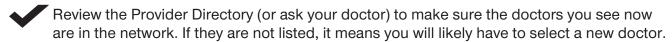
OMB No. 0938-1378 Expires: 12/31/2026 Y0066\_EFMA\_2026\_C

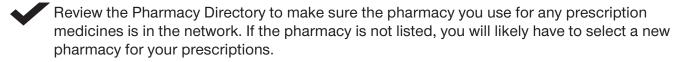
## **Enrollment checklist**

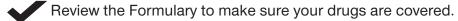
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## **Understanding the benefits**

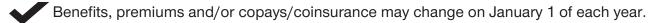


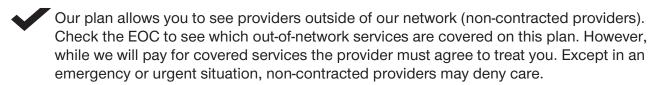


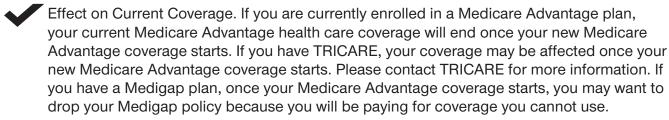




## **Understanding important rules**







This plan is a Dual Eligible Special Needs Plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.