

2025 Enrollment Request Form

☐ UHC Dual Complete HI-S001 (PPO D-SNP) H2406-051-000

Last name First name Middle initial	Information about you (Please	type or prii	nt in black or l	blue ink)	
Home phone number () — Mobile phone number () — I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have providusing an autodialer and/or prerecorded voice technology. Social Security number (Required for people who are enrolling in D-SNP plans):						
□ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have providusing an autodialer and/or prerecorded voice technology. Social Security number (Required for people who are enrolling in D-SNP plans):	Birth date Sex ☐ Male [е	
using an autodialer and/or prerecorded voice technology. Social Security number (Required for people who are enrolling in D-SNP plans):	Home phone number ()	ome phone number () — Mobile phone number () —				
(Required for people who are enrolling in D-SNP plans):	☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology.					
Permanent residence street address (Don't enter a P.O. box. Note: For individuals experience 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	·	ng in D-SNP բ	olans):			
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	Medicare number					
Mailing address (Only if it's different from above. You can give a P.O. box.) City State Zip code	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 State Zip code	City County State Zip code				Zip code	
	Mailing address (Only if it's different from above. You can give a P.O. box.)					
Email address (optional)	City			State	Zip code	
	Email address (optional)					
Enrollee name						
Agent name/ID number	Agent name/ID number				 UHHI25LP0220966_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	nium (including any late enroll c deduction from your Social S	Security or Railroa	d Retirement	
Electronic Funds Transfer (EFT	•			
If you don't choose an option b		-		
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				
☐ 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_/_/_/_/_/_/				
Dank doodant namber				
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			 HI25LP0220966_000	

If you don't see the language or format you want, please call us toll-free at **1-844-560-4944**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **UHC.com/CommunityPlan** for online help.

2. Are you enrolled in your state Medicaid	l program?	☐ Yes ☐ No
If yes, please give us your Medicaid number	r:	
3. Are you Hispanic, Latino/a, or Spanish No, not of Hispanic, Latino/a, or Spanish Yes, Mexican, Mexican American, or Yes, Puerto Rican Yes, Cuban Yes, another Hispanic, Latino, or Spanish	anish origin r Chicano/a	
4. What's your race? Select all that apply.		
American Indian or Alaska Native	Black or African American	
Asian: Asian Indian Chinese Filipino Japanese Korean	Native Hawaiian or Pacific Islander: Guamanian or Chamorro Native Hawaiian Samoan Other Pacific Islander	
Vietnamese Other Asian	White I choose not to answer	
Member/Citizen of a federal or state	recognized Tribe (name of Tribe)	
5. What is your gender? Select one Woman Man	I use a different term:	
Non-binary	I choose not to answer	
6. Which of the following best represents Lesbian or gay Straight, that is, not gay or lesbian Bisexual	how you think of yourself? Select one I use a different term: I don't know I choose not to answer	
7. Do you or your spouse work?		□ Yes □ No
Enrollee name		
Agent name/ID number Y0066_ERFMA_2025_C		P0220966_000

Do you or your spouse have other health insurance	e that will cover medical services?			
(Examples: Other employer group coverage, LTD				
auto liability, or Veterans benefits)	☐ Yes ☐ No			
If yes, please complete the following:				
Name of health insurance company				
Member number				
8. Please give us the name of your primary care	provider (PCP), clinic or health center.			
You aren't limited to this list. You may go to any do	octor who accepts Medicare and the plan's			
payment terms.				
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?			
your plan communications. You will get many of your required plan communications (For example)	-			
computer, tablet or mobile phone.	any device each ac a			
If you would rather have hard copies of required	d materials mailed to you, please check here:			
☐ Instead of paperless delivery, we will mail you h some communications are very large and may preference for delivery at any time.	ard copies of required materials. Please note that not fit in all mailboxes. You can change your			
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 Sumn	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and nary of Benefits for more information.			
 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 				
Enrollee name				
Agent name/ID number				
VILLION FREIGHT STUDE (ロロロウム ロロクカロはん ハイハ			

UHHI25LP0220966_000

(also known as a member contract or substant or UnitedHealthcare will pay for benefits	,				
☐ I understand that I can be enrolled in only					
•	that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions				
apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA)					
plans).					
□ Release of information: By joining this Mo	•				
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).					
☐ I give UnitedHealthcare permission to share	•	h information with organizations			
or person(s) for permissible purposes und	• •	<u> </u>			
plan.					
☐ The information on this form is correct to t	•	S			
intentionally provide false information on t		•			
 My response to this form is voluntary. How 	ever, failure to respo	nd 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 mea					
show written proof (power of attorney, guardian		· ·			
understand that I will need to submit written pr	. , ,				
behalf of the member beyond this application.		•			
received my UnitedHealthcare UCard®, I can c	all Customer Service	at the number on my			
UnitedHealthcare UCard to update my authorize	zation information on	file.			
Signature of applicant/member/authorized i	representative	Today's date			
If you are the authorized representative		ove and complete the			
information below (*Not a Sales Agent)					
Last name	First name				
Address					
City	State	Zip code			
Phone number () —	Relationship to a	pplicant			
Enrollee name					
Agent name/ID number					

Y0066_ERFMA_2025_C

UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document

For individuals hel	ning enrollee with	con	nnlat	ting this form o	nlv
Complete this section			-	_	•
members, or other thir	d parties) helping an	T			
Name		Rela	ations	hip to enrollee	
Signature		Nati	ional F	Producer Number	(Agents/Brokers only)
For Licensed Sale	s Representative/	ager	ncy u	se only	
Licensed Sales repres	entative/Writing ID			Initial receipt date	e
Licensed Sales repres	entative/agent name		Proposed effective date		
Employer group name					
Employer group ID			В	ranch ID	
Agent must complete)				
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrolle	es)		P (MA-PD lees eligible for EP)	☐ OEP (Jan 1 – Mar 31)
☐ OEP (Newly	☐ SEP (Dual LIS			EP (Change in	☐ SEP (Loss of
eligible)	change of status)			ence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)			EP (October 15- ember 7)	□ OEPI
☐ SEP (SEP reason) _					
Enrollee name					
Agent name/ID number	r				
Y0066_ERFMA_2025_C					UHHI25LP0220966_000

Licensed Sales representative signature (optional)

Date

Please mail or fax this completed form to:

UnitedHealthcare P.O. Box 30769 Salt Lake City, UT 84130-0769

Fax: 1-888-950-1169
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 Dual Complete HI-S001 (PPO 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.

This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

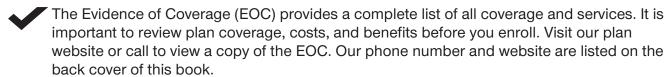
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

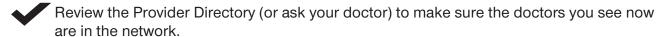
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

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

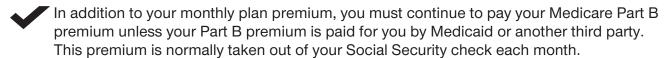






Review the Formulary to make sure your drugs are covered.

Understanding important rules



- Benefits may change on January 1 of each year.
- Our plan allows you to see providers outside of our network (non-contracted providers). Check the EOC to see which out-of-network services are covered on this plan. However, while we will pay for covered services the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care.
- 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 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.