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A UnitedHealthcare Company

Y0066 ERFMA 2025 C

2025 Enrollment Request Form

☐ Peoples Health Secure Health (HMO-POS D-SNP) H1961-003-000 Information about you (Please type or print in black or blue ink) Middle initial Last name First name Birth date Sex ☐ Male ☐ Female Home phone number () Mobile phone number () ☐ 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. Medicare number 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 Parish Zip code State Mailing address (Only if it's different from above. You can give a P.O. box.) Zip code City State Email address (optional) Enrollee name ___ Agent name/ID number _

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 below, we'll send a bill each month to your mailing address.					
If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA),					
Social Security (SS) will send you a letter and ask you how you want to pay it:					
☐ You can pay it from you	☐ 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 I	□ Savings				
Account holder name:					
Bank routing number/	/_/_/_/_				
Bank account number/////					
A few questions to help u					
1. Would you prefer plan info					
	rmation in another language or Braille □ Large print □ Audi		•		
Enrollee name					
Agent name/ID number					
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If you don't see the language or format you want, please call us toll-free at **1-855-269-0778**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **peopleshealth.com** for online help.

2. Are you enrolled in your state Medicaid	d program?	⊔ Yes ⊔ No
If yes, please give us your Medicaid numbe	r:	
3. Are you Hispanic, Latino/a, or Spanish No, not of Hispanic, Latino/a, or Sp Yes, Mexican, Mexican American, o Yes, Puerto Rican Yes, Cuban Yes, another Hispanic, Latino, or Sp I choose not to answer	anish origin or 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	I use a different term:	
7. Do you or your spouse work?		☐ Yes ☐ No
Enrollee name		
Agent name/ID number		
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Do you or your spouse have other health insuran	
(Examples: Other employer group coverage, LTE	
auto liability, or Veterans benefits) If yes, please complete the following:	☐ Yes ☐ No
Name of health insurance company	
,	
Member number	
8. Please give us the name of your primary car	re provider (PCP), clinic or health center.
You can find a list on the plan website or in the P	rovider 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 th	is provider? ☐ Yes ☐ No
your plan communications. You will get many of your required plan commun an email when new communications (For examp	ications delivered electronically. We will send you le: Explanation of Benefits or the Annual Notice of nese communications through any device such as a
If you would rather have hard copies of require	ed materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you some communications are very large and may preference for delivery at any time.	hard 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	ng:
paying my Part B premium if I have one, unled I understand that people with Medicare are the country, except for limited coverage near urgent care outside of the U.S. See the Sum I understand that when my Peoples Health or prescription drug benefits from Peoples Health	generally not covered under Medicare while out of ir the U.S. border. This plan covers emergency and
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	PHLA25HP0221128_000
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	Health will pay for benefits or services that a lunderstand that I can be enrolled in only o	ne Medicare Advantage (M				
	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 Medicare Advantage Plan, I acknowledge that the plan 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).					
	The information on this form is correct to th	e best of my knowledge. I u	inderstand that if I			
	intentionally provide false information on the		•			
	My response to this form is voluntary. Howe plan.	ever, fallure to respond may	affect enrollment in the			
	•					
	en I sign below, it means that I have read a					
	sign as an authorized representative, it mean	0 0	•			
	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 on					
	nalf of the member beyond this application. A	• •	• •			
	eived my UnitedHealthcare UCard®, I can ca		umber on my			
	tedHealthcare UCard to update my authoriza					
Sig	nature of applicant/member/authorized re	presentative Today	's date			
If y	ou are the authorized representative	e, please sign above ar	nd complete the			
info	ormation below (*Not a Sales Agent)	I				
Las	t name	First name				
Add	dress					
City	/	State	Zip code			
Pho	one number () —	Relationship to applicar	ıt			
	,					
	ollee name					
Ager	ollee name nt name/ID number 6_ERFMA_2025_C		PHLA25HP0221128_000			

member contract or subscriber agreement) will be covered. Neither Medicare nor Peoples

For individuals he	lping enrollee with	ı co	mple	etina this form	only
Complete this section	if you're an individual	(i.e.	agen	ts, brokers, SHIP	-
members, or other thi	rd parties) helping an e			Il out this form. ship to enrollee	
Name		110	iation	Ship to enionee	
Signature		Na	tiona	Producer Numbe	er (Agents/Brokers only)
For Licensed Sale	es Representative/	age	ncy	use only	
Licensed Sales repres	sentative/Writing ID			Initial receipt da	ate
Licensed Sales repres	sentative/agent name		Proposed effective		tive date
Employer group name	Э				
Employer group ID				Branch ID	
Agent must completed ☐ IEP (MA-PD enrollees)	e □ ICEP (MA enrolle	es)	enrollees eligible for Mar 31)		□ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)			☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ SEP (SEP reason)					
Enrollee name					
Agent name/ID number					
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Licensed Sales representative signature (optional) Please fax this completed form to: 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.

Peoples Health Secure Health (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.

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

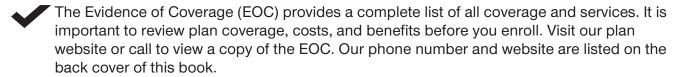
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

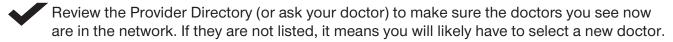
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

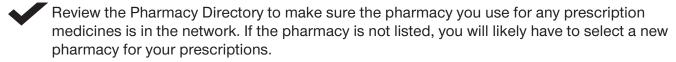
Enrollment checklist

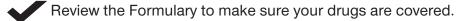
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

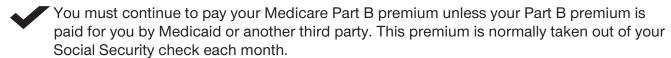


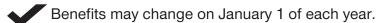


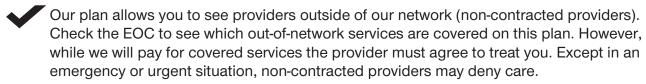




Understanding important rules







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 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.