

# **2025** Enrollment Request Form

☐ UHC Dual Complete MD-S002 (HMO D-SNP) H7464-008-001

Information about you (Please type or print in black or blue ink)					
Last name	First name		Middle initial		
Birth date		Sex □ Male I	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.					
Social Security number (Required for people who are enrolling	ng in D-SNP լ	olans):			
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	County State		Zip code		
Mailing address (Only if it's different from above. You can give a P.O. box.)					
City			State	Zip code	
Email address (optional)					
Enrollee nameAgent name/ID number					
Y0066_ERFMA_2025_C				HMD25HM0220560 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 the street of the street	nium (including any late enroll c deduction from your Social S ch month. You can also pay fro	Security or Railroa	d Retirement		
Electronic Funds Transfer (EFT If you don't choose an option be	•	onth to vour mailir	ng address		
If you must pay a Part D-Incom		•			
Social Security (SS) will send y	•	•	itivii o cy,		
☐ You can pay it from you		d want to pay it.			
	1 33 CHECK				
☐ Medicare can bill you	+ D (DDD)  -				
	t Board (RRB) can bill you				
☐ I want to pay from my Social	•				
☐ I want to pay from my Railro	,	ieck			
☐ I want to pay directly from a bank account					
Account type ☐ Checking ☐ Savings					
Bank routing number/					
Bank account number/_					
A few questions to help u	s manage your plan				
1. Would you prefer plan info	• • •	or an accessible	format?		
	rmation in another language or Braille   Large print  Audi		•		
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C					

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	☐ 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, o  Yes, Puerto Rican  Yes, Cuban  Yes, another Hispanic, Latino, or Spanish  I choose not to answer	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		

Do you or your spouse have other health insurance	
(Examples: Other employer group coverage, LTD	
auto liability, or Veterans benefits)	☐ Yes ☐ No
If yes, please complete the following:  Name of health insurance company	
Name of fleath findulation company	
Member number	
8. 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	
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
your plan communications.  You will get many of your required plan communications (For example)	•
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.	
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	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
Enrollee name	
Agent name/ID numberY0066_ERFMA_2025_C	UHMD25HM0220560_000

an authorized representation proof (power of attorned that I will need to submit the member beyond this any UnitedHealthcare UCard Ithcare UCard to update of applicant/member/authorized representation below (*Not a Salimber ( ) —	resentative, please sign abo	t under state law to sign. I can if Medicare asks for it. I plan, if I wish to take action on as been approved and I have it the number on my le.  Today's date  ve and complete the  Zip code	n			
an authorized representation proof (power of attorned that I will need to submit the member beyond this any UnitedHealthcare UCard Ithcare UCard to update of applicant/member/authorized representation below (*Not a Sali	ative, it means I have the legal right ey, guardianship, etc.) of this right it written proof of this right, to the application. After this application hard®, I can call Customer Service at my authorization information on finathorized representative  resentative, please sign about les Agent)  First name  State	t under state law to sign. I can if Medicare asks for it. I plan, if I wish to take action or has been approved and I have it the number on my le.  Today's date  Eve and complete the  Zip code	n			
an authorized representaten proof (power of attorned that I will need to submit the member beyond this a large UnitedHealthcare UCard to update of applicant/member/are the authorized representations.	ative, it means I have the legal right ey, guardianship, etc.) of this right it written proof of this right, to the application. After this application had a call Customer Service at my authorization information on final authorized representative resentative, please sign about 18 Agent)  First name	t under state law to sign. I can if Medicare asks for it. I plan, if I wish to take action on as been approved and I have it the number on my le.  Today's date	n			
an authorized representaten proof (power of attorned that I will need to submit the member beyond this a large UnitedHealthcare UCard to update of applicant/member/are the authorized representations.	ative, it means I have the legal right ey, guardianship, etc.) of this right it written proof of this right, to the application. After this application had a call Customer Service at my authorization information on finanthorized representative  resentative, please sign about 18 Agent	It under state law to sign. I can tif Medicare asks for it. I plan, if I wish to take action or has been approved and I have t the number on my le.  Today's date	n			
an authorized representaten proof (power of attorned that I will need to submit the member beyond this a large UnitedHealthcare UCard to update of applicant/member/are the authorized representations.	ative, it means I have the legal right ey, guardianship, etc.) of this right it written proof of this right, to the application. After this application had a call Customer Service at my authorization information on finanthorized representative  resentative, please sign about 18 Agent	It under state law to sign. I can tif Medicare asks for it. I plan, if I wish to take action or has been approved and I have t the number on my le.  Today's date	n			
an authorized representaten proof (power of attorned that I will need to submit the member beyond this a large UnitedHealthcare UCard to update of applicant/member/are the authorized representations.	ative, it means I have the legal right ey, guardianship, etc.) of this right it written proof of this right, to the application. After this application had a call Customer Service at my authorization information on finanthorized representative  resentative, please sign about 18 Agent	It under state law to sign. I can tif Medicare asks for it. I plan, if I wish to take action or has been approved and I have t the number on my le.  Today's date	n			
an authorized representaten proof (power of attorned that I will need to submit the member beyond this a large UnitedHealthcare UCard to update of applicant/member/are the authorized representations.	ative, it means I have the legal right ey, guardianship, etc.) of this right it written proof of this right, to the application. After this application had a call Customer Service at my authorization information on finanthorized representative	It under state law to sign. I can tif Medicare asks for it. I plan, if I wish to take action or has been approved and I have t the number on my le.  Today's date	n			
an authorized representaten proof (power of attorned that I will need to submit the member beyond this a large UnitedHealthcare UCard to update it of applicant/member/au	ative, it means I have the legal right ey, guardianship, etc.) of this right it written proof of this right, to the application. After this application h rd®, I can call Customer Service at my authorization information on finanthorized representative	It under state law to sign. I can tif Medicare asks for it. I plan, if I wish to take action or has been approved and I have t the number on my le.  Today's date	n			
an authorized representaten proof (power of attorned that I will need to submine member beyond this a by UnitedHealthcare UCard to update a	ative, it means I have the legal right ey, guardianship, etc.) of this right it written proof of this right, to the application. After this application h rd <sup>®</sup> , I can call Customer Service a my authorization information on fi	It under state law to sign. I can t if Medicare asks for it. I plan, if I wish to take action or has been approved and I have t the number on my le.	n			
an authorized representaten proof (power of attorned that I will need to submine member beyond this a by UnitedHealthcare UCard to update a	ative, it means I have the legal right ey, guardianship, etc.) of this right it written proof of this right, to the application. After this application h rd <sup>®</sup> , I can call Customer Service a my authorization information on fi	It under state law to sign. I can t if Medicare asks for it. I plan, if I wish to take action or has been approved and I have t the number on my le.	n			
an authorized representa en proof (power of attorne d that I will need to submi ne member beyond this a	ative, it means I have the legal right ey, guardianship, etc.) of this right it written proof of this right, to the application. After this application h	t under state law to sign. I car t if Medicare asks for it. I plan, if I wish to take action on has been approved and I have	n			
an authorized representa en proof (power of attorne	ative, it means I have the legal righ ey, guardianship, etc.) of this right	t under state law to sign. I car t if Medicare asks for it. I				
an authorized representa	ative, it means I have the legal righ	t under state law to sign. I car	1			
n below, it means that I	have read and understand the i	nformation on this form				
☐ My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.						
onally provide false inforr	mation on this form I will be disen	rolled from the plan.				
plan.  The information on this form is correct to the best of my knowledge. I understand that if I						
or person(s) for permissible purposes under applicable law as required to administer my health						
information (see Privacy Act Statement below).						
•	•					
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						
tor MA Private Fee-tor-Sei	rvice (PFFS), MA Medicare Medic	al Savings Account (MSA)				
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.  I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and						
1 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	rollment in this plan will or MA Private Fee-for-Se  e of information: By join are my information with I are, and for other purposation (see Privacy Act St UnitedHealthcare permis	rollment in this plan will automatically end my enrollment for MA Private Fee-for-Service (PFFS), MA Medicare Medicare Medicare of information: By joining this Medicare Advantage Place my information with Medicare, who may use it to track ints, and for other purposes allowed by Federal law that aution (see Privacy Act Statement below). UnitedHealthcare permission to share my protected health	stand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and rollment in this plan will automatically end my enrollment in another MA plan (exception or MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA) see of information: By joining this Medicare Advantage Plan, I acknowledge that the planare my information with Medicare, who may use it to track my enrollment, to make into another purposes allowed by Federal law that authorize the collection of this ation (see Privacy Act Statement below).  UnitedHealthcare permission to share my protected health information with organization			

(also known as a member contract or subscriber agreement) will be covered. Neither Medicare

For individuals helping enrollee with completing this form only					
Complete this section members, or other thin	•	•	_	· ·	counselors, family
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sale	s Representative/	ager	псу	use only	
Licensed Sales repres	Licensed Sales representative/Writing ID			Initial receipt da	ate
Licensed Sales representative/agent name				Proposed effect	tive date
Employer group name					
Employer group ID				Branch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees) ☐ e 2 ☐ SEP (Dual LIS ☐ change of status) re ☐ SEP (Dual LIS ☐		s) ☐ IEP (MA-PD enrollees eligible for 2nd IEP) ☐ SEP (Change in residence) ☐ AEP (October 15-December 7)		☐ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic) ☐ SEP (SEP reason) _					☐ SEP (Loss of EGHP coverage) ☐ OEPI
Enrollee nameAgent name/ID numbe					
Y0066_ERFMA_2025_C					UHMD25HM0220560_000

### **Licensed Sales representative signature (optional)**

**Date** 

#### Please mail or fax this completed form to:

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 Dual Complete MD-S002 (HMO 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.

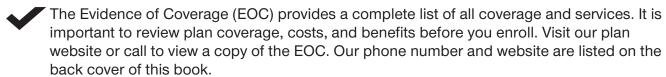
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

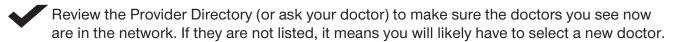
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

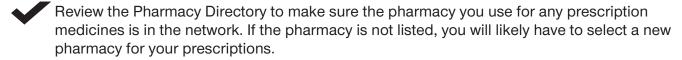
# **Enrollment checklist**

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**

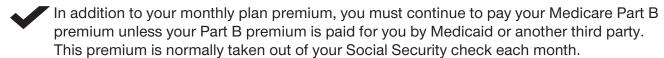








### **Understanding important rules**



- Benefits may change on January 1 of each year.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- 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.