

2025 Enrollment Request Form

☐ UHC Dual Complete MD-S002 (HMO D-SNP) H7464-008-002

First name — re and its affilited voice tec	Sex Male Mobile phone		Middle initial
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		number () —
		hone nur	mber(s) I have provided
ing in D-SNP إ	olans):		
•	a P.O. box. No our permanent i		dividuals experiencing e address)
County		State	Zip code
nt from above	e. You can give	a P.O. bo	x.)
		State	Zip code
		•	nt from above. You can give a P.O. bo

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		
If you have a monthly plan prer pay your premium by automatic	How do you want to pay? If you have a monthly plan premium (including any late enrollment penalty you may owe), you can pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT).				
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 y You can pay it from you Medicare can bill you The Railroad Retiremen		ou want to pay it:			
☐ I want to pay from my Social	, ,				
☐ I want to pay from my Railro	•	neck			
☐ I want to pay directly from a	,	·oon			
Account type ☐ Checking I					
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		•		
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	I 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, 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		

Oo you or your spouse have other health insurance that will cover medical services? Examples: Other employer group coverage, LTD coverage, Workers' Compensation,			
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 care	e provider (PCP), clinic or health center.		
You can find a list on the plan website or in the Pr	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 this	s provider? ☐ Yes ☐ No		
Providing your email address above automatications.	ally enrolls you in paperless delivery for some of		
·	cations delivered electronically. We will send you e: Explanation of Benefits or the Annual Notice of ese communications through any device such as a		
If you would rather have hard copies of require	d materials mailed to you, please check here:		
☐ Instead of paperless delivery, we will mail you have some communications are very large and may preference for delivery at any time.	nard 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 followin	g:		
 I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it. I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary 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 UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document 			
Enrollee name			
Agent name/ID numberY0066_ERFMA_2025_C	UHMD25HM0220559_000		

If y inf Las	ceived my UnitedHealthcare UCard®, I can ditedHealthcare UCard to update my authorized gnature of applicant/member/authorized you are the authorized representative formation below (*Not a Sales Agent at name) dress y one number () —	representative Today ve, please sign above are First name State Relationship to applicare	y's date nd complete the Zip code		
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Un	itedHealthcare UCard to update my authori	zation information on file.	·		
			number on my		
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	•	ed to submit written proof of this right, to the plan, if I wish to take action on eyond this application. After this application has been approved and I have			
sho	ow written proof (power of attorney, guardia	anship, etc.) of this right if Me	dicare asks for it. I		
	nen I sign below, it means that I have read sign as an authorized representative, it mea				
	plan.				
	My response to this form is voluntary. How		•		
	The information on this form is correct to intentionally provide false information on the correct to intentional provide false information of the correct to intentional provide false in the correct to intentional provide fal				
	or person(s) for permissible purposes und plan.	der applicable law as required	to administer my nealth		
	I give UnitedHealthcare permission to sha	are my protected health inforr	•		
	payments, and for other purposes allowed information (see Privacy Act Statement be		e the collection of this		
	will share my information with Medicare, v	who may use it to track my er	rollment, to make		
	plans). Release of information: By joining this M	ledicare Advantage Plan I ac	knowledge that the plan		
	apply for the trace is do for doi trice (i. i. i.	•			
	apply for MA Private Fee-for-Service (PFF)		, ·		
	nor UnitedHealthcare will pay for benefits I understand that I can be enrolled in only that enrollment in this plan will automatica apply for MA Private Fee-for-Service (PFF)	one Medicare Advantage (M			

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

	lping enrollee with		-	_	-	
•	if you're an individual	•	_		ounselors, family	
members, or other third parties) helping an Name		Relationship to enrollee				
		·				
Signature	Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sale	es Representative/	agen	cy u	se only		
Licensed Sales repres	sentative/Writing ID		-	Initial receipt dat	е	
Licensed Sales representative/agent name			Proposed effective date		ve date	
Employer group name	9			<u> </u>		
Employer group ID			В	ranch ID		
Agent must complet ☐ IEP (MA-PD enrollees) ☐ OEP (Newly eligible) ☐ SEP (Chronic) ☐ SEP (SEP reason)	□ ICEP (MA enrolled SEP (Dual LIS change of status) □ SEP (Dual LIS maintaining)	2 1	enrol 2nd I □ SE resid □ AE	P (MA-PD lees eligible for EP) EP (Change in ence) EP (October 15- ember 7)	☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI	
Enrollee name Agent name/ID number Y0066_ERFMA_2025_C					UHMD25HM0220559_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.

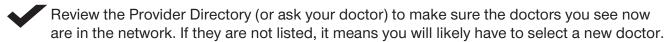
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

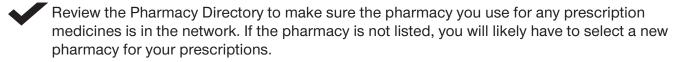
Enrollment checklist

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

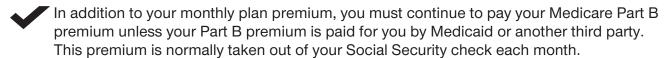








Understanding important rules



- 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.