

# **2025 Enrollment Request Form**

☐ UHC Dual Complete MI-S002 (HMO-POS D-SNP) H2247-001-000

Information about you (Please	type or pri	nt in black or	blue ink	)	
Last name	First name			Middle initial	
Birth date		Sex □ Male	□ Femal	е	
Home phone number ( )	<ul> <li>Mobile phone number (</li> </ul>			( ) –	
☐ 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				UHMI25HP0221002_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)	nium (including any late enroll 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	elow, we'll send a bill each mo	onth to your mailir	ng address.
If you must pay a Part D-Incom	e Related Monthly Adjustment	Amount (Part D-I	RMAA),
Social Security (SS) will send you a letter and ask you how you want to pay it:			
☐ You can pay it from your 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/_			
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			
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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 Spanish  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:	
<ul><li>Non-binary</li><li>6. Which of the following best represents</li><li>Lesbian or gay</li><li>Straight, that is, not gay or lesbian</li><li>Bisexual</li></ul>	how you think of yourself? Select one l use a different term: l don't know l choose not to answer	
7. Do you or your spouse work?		□ Yes □ No
Enrollee nameAgent name/ID number		
Y0066_ERFMA_2025_C	UHMI25H	P0221002_000

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.	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 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	UHMI25HP0221002_000
	<del>-</del>

<ul> <li>(also known as a member contract or subscinor UnitedHealthcare will pay for benefits or</li> <li>□ I understand that I can be enrolled in only or that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS),</li> </ul>	services that are not cover ne Medicare Advantage (M end my enrollment in and	red. A) plan at a time – and ther MA plan (exceptions	
plans).  Release of information: By joining this Med will share my information with Medicare, who	licare Advantage Plan, I ac	knowledge that the plan	
payments, and for other purposes allowed be information (see Privacy Act Statement below	y Federal law that authoriz		
<ul> <li>I give UnitedHealthcare permission to share or person(s) for permissible purposes under</li> </ul>	my protected health inform	<u> </u>	
<ul> <li>plan.</li> <li>The information on this form is correct to the intentionally provide false information on this</li> <li>My response to this form is voluntary. However plan.</li> </ul>	s form I will be disenrolled	from the plan.	
When I sign below, it means that I have read a	nd understand the inform	ation on this form	
understand that I will need to submit written proceed behalf of the member beyond this application. At received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizate Signature of applicant/member/authorized repositions.	ter this application has been customer Service at the nation information on file.  presentative Today	en approved and I have number on my	
If you are the authorized representative information below (*Not a Sales Agent)	, piease sign above ar	id complete the	
Last name	First name		
Address			
City	State	Zip code	
Phone number ( ) —	Relationship to applicar	nt	
Enrollee name			
Agent name/ID number			
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Complete this section	n if you're an individual (	i.e. ag	ents	, brokers, SHIP co	ounselors, family
members, or other th	ird parties) helping an e	nrolle	e fill	out this form.	· •
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sale	es Representative/a	igenc	cy u	se only	
Licensed Sales representative/Writing ID				Initial receipt dat	е
Licensed Sales representative/agent name				Proposed effective date	
Employer group nam	е				
Employer group ID			В	ranch ID	
Agent must complet ☐ IEP (MA-PD enrollees)	e ☐ ICEP (MA enrollee	lees)     IEP (MA-PD enrollees eligible for 2nd IEP)     SEP (Change in residence)     AEP (October 18 December 7)		lees eligible for	□ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)			ence) P (October 15-	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason)					
Enrollee name					
Agent name/ID numbe					
Y0066_ERFMA_2025_C					UHMI25HP0221002_00

#### **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 MI-S002 (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.

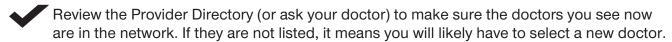
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

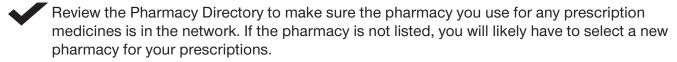
# **Enrollment checklist**

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

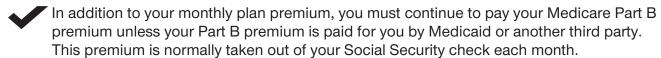


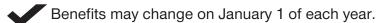


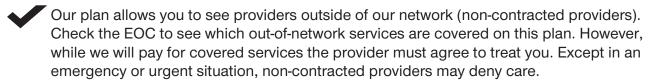




### **Understanding important rules**







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.