

2025 Enrollment Request Form

☐ UHC Dual Complete MI-S3 (HMO D-SNP) H2247-004-000

| Information about you (Please type or print in black or blue ink) | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--|---------------------|---------------------|--|
| Last name | First name | | Middle initial | | |
| Birth date | h 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. | | | | | |
| Social Security number (Required for people who are enrolling in D-SNP plans): | | | | | |
| 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 | | 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 name | | | | | |
| Agent name/ID number | | | | | |
| Y0066_ERFMA_2025_C | | | | UHMI25HM0221000_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 | 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-II | RMAA), |
| Social Security (SS) will send you a letter and ask you how you want to pay it: | | | |
| ☐ You can pay it from you | r 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 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 | | | |
| Y0066_ERFMA_2025_C | | UHM | I25HM0221000_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 numbe | 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: | |
| 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 numberY0066_ERFMA_2025_C | | И0221000_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 | | | | |
| 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 | 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? ☐ 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: | | | |
| 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 | UHMI25HM0221000_000 | | | |
| _ _ _ _ | = | | | |

| (also known as a member contract or subscinor UnitedHealthcare will pay for benefits or □ I understand that I can be enrolled in only or that enrollment in this plan will automatically | services that are not cover ne Medicare Advantage (M | red. A) plan at a time – and | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--|--|
| 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). | | | | |
| 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). I give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health plan. The information on this form is correct to the best of my knowledge. I understand that if I | | | | |
| intentionally provide false information on this form I will be disenrolled from the plan. My response to this form is voluntary. However, failure to respond may affect enrollment in 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 reports of the cartes are the cartes of the cartes and the cartes of t | fter this application has been clear the name of the n | en approved and I have number on my | | |
| If you are the authorized representative information below (*Not a Sales Agent) | , piease sign above ar | ia complete the | | |
| Last name | First name | | | |
| Address | | | | |
| City | State | Zip code | | |
| Phone number () — | Relationship to applicant | | | |
| Enrollee name | | | | |
| Agent name/ID number | | | | |
| Y0066_ERFMA_2025_C | L | JHMI25HM0221000_000 | | |

| For individuals he | Ining enrollee with | cor | nnl | eting this form | only |
|-------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|------------------------------------------------|--------|------------------------------------------------------------------------------------|--------------------------------------------------------------|
| Complete this section | if you're an individual | (i.e. a | agen | ts, brokers, SHIP | |
| members, or other thin | rd parties) helping an | 1 | | | |
| Name | | Rela | ation | ship to enrollee | |
| Signature | | National Producer Number (Agents/Brokers only) | | | |
| For Licensed Sale | s Representative/ | ager | псу | use only | |
| Licensed Sales representative/Writing ID | | | | Initial receipt d | ate |
| Licensed Sales representative/agent name | | | | Proposed effect | ctive date |
| Employer group name |) | | | | |
| Employer group ID | | | | Branch ID | |
| Agent must complete ☐ IEP (MA-PD enrollees) ☐ OEP (Newly eligible) ☐ SEP (Chronic) ☐ SEP (SEP reason) | □ ICEP (MA enrolle □ SEP (Dual LIS change of status) □ SEP (Dual LIS maintaining) | | enresi | EP (MA-PD ollees eligible for IEP) SEP (Change in dence) AEP (October 15-cember 7) | ☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI |
| Enrollee name Agent name/ID numbe Y0066_ERFMA_2025_C | | | | | UHMI25HM0221000_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 MI-S3 (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.

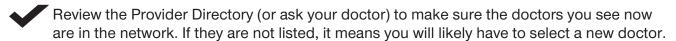
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

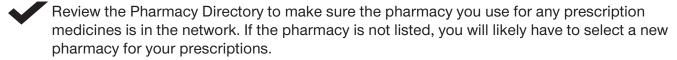
Enrollment checklist

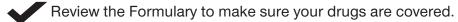
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

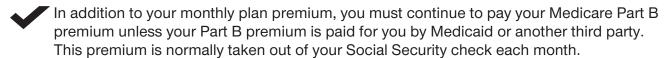








Understanding important rules



- 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.