

# **2025 Enrollment Request Form**

☐ UHC Dual Complete MS-S3 (PPO D-SNP) H1889-032-000

Information about you (Please	type or pri	nt in black or t	olue ink		
Last name	First name			Middle initial	
Birth date	Sex ☐ Male ☐ Femal		e		
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 բ	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		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					
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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 your choice. You can't be denied coverage because you don't fill them out.				
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 you	r 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 I	☐ 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	program?	☐ Yes ☐ No
If yes, please give us your Medicaid number:		
3. Are you Hispanic, Latino/a, or Spanish of No, not of Hispanic, Latino/a, or Spanish of Yes, Mexican, Mexican American, or Yes, Puerto Rican Yes, Cuban Yes, another Hispanic, Latino, or Spanish of	nish origin 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 r	ecognized Tribe (name of Tribe)	
5. What is your gender? Select one Woman Man	I use a different term:	
<ul> <li>Non-binary</li> <li>Which of the following best represents he Lesbian or gay</li> <li>Straight, that is, not gay or lesbian</li> <li>Bisexual</li> </ul>	I choose not to answer  now 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 nameAgent name/ID numberY0066_ERFMA_2025_C		

Do you or your spouse have other health insurance	e that will cover medical services?
(Examples: Other employer group coverage, LTD	coverage, Workers' Compensation,
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	e provider (PCP), clinic or health center.
You aren't limited to this list. You may go to any do	octor who accepts Medicare and the plan's
payment terms.	
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?
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.	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 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	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and mary of Benefits for more information. coverage begins, I must get all of my medical and
Enrollee name	
Agent name/ID number	
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•	lso known as a member contract or subsc or UnitedHealthcare will pay for benefits or	,				
tha	I understand that I can be enrolled in only one Medicare Advantage (MA) 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).					
□ <b>R</b> €	<b>Release of information:</b> 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).					
or	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.					
•	<ul> <li>My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.</li> </ul>					
When	I sign below, it means that I have read a	nd understand the inforn	nation on this form			
•	n as an authorized representative, it means	• •	•			
	vritten proof (power of attorney, guardians stand that I will need to submit written proc	. ,				
	of the member beyond this application. A					
	ed my UnitedHealthcare UCard®, I can cal		number on my			
	Healthcare UCard to update my authoriza ure of applicant/member/authorized re		y's date			
	ure of applicant/member/authorized re	presentative	y 5 uale			
If you	are the authorized representative	, please sign above a	nd complete the			
_	nation below (*Not a Sales Agent)	, ·	·			
Last na	ame	First name				
Addres	SS					
City		State	Zip code			
Phone	one number ( ) — Relationship to applicant					
Enrolles	e name					
	ame/ID number					

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UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document

For individuals hel	ning enrollee with	con	nnlat	ting this form o	nlv
Complete this section			-	_	•
members, or other thir	d parties) helping an	enroll	ee fill	out this form.	
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sales	s Representative/	ager	ncy u	se only	
Licensed Sales repres	entative/Writing ID			Initial receipt dat	е
Licensed Sales representative/agent name			Proposed effective date		
Employer group name					
Employer group ID			В	ranch ID	
Agent must complete	•				
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrolle	es)		P (MA-PD lees eligible for EP)	☐ OEP (Jan 1 – Mar 31)
☐ OEP (Newly	☐ SEP (Dual LIS			EP (Change in	☐ SEP (Loss of
eligible)	change of status)			ence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)			EP (October 15- ember 7)	□ OEPI
☐ SEP (SEP reason) _					
Enrollee name					
Agent name/ID number					
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### **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 MS-S3 (PPO 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.

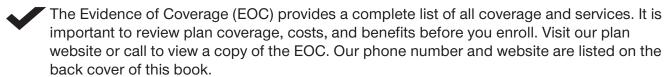
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

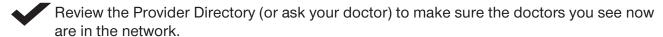
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

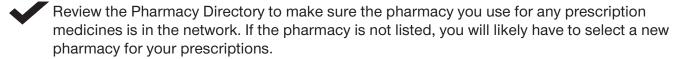
# **Enrollment checklist**

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**

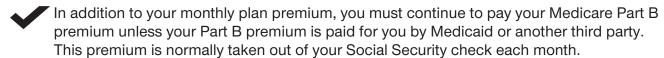








### **Understanding important rules**



- Benefits may change on January 1 of each year.
- Our plan allows you to see providers outside of our network (non-contracted providers). Check the EOC to see which out-of-network services are covered on this plan. However, while we will pay for covered services the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care.
- 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.