

# **2025 Enrollment Request Form**

☐ UHC Dual Complete NY-S4 (HMO-POS D-SNP) H3387-017-000

Last name  Birth date  Home phone number ( )	First name	Carr Cl Mala Cl		Middle initial		
		Cov. C. Mala C		Middle initial		
Homo phono numbor (		Sex Li Male Li	Sex □ Male □ Female			
Home phone number ( )	_	Mobile phone nur	mber (	) –		
☐ I give consent for UnitedHealthcausing an autodialer and/or prerect		•	ne num	nber(s) I have provided		
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	St	tate	Zip code		
Mailing address (Only if it's different	ent from above	e. You can give a P	O. box	c.)		
City		St	tate	Zip code		
Email address (optional)		l .				
nrollee name						
gent name/ID number 0066 ERFMA 2025 C				HNY25HP0220811_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 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 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 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		UHN	Y25HP0220811_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		P0220811_000

ce that will cover medical services?					
O coverage, Workers' Compensation,					
☐ Yes ☐ No					
If yes, please complete the following:  Name of health insurance company					
re provider (PCP), clinic or health center.					
Provider Directory.					
(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.)					
is provider? ☐ Yes ☐ No					
cally enrolls you in paperless delivery for some of nications delivered electronically. We will send you le: Explanation of Benefits or the Annual Notice of nese communications through any device such as a					
ed materials mailed to you, please check here:					
hard copies of required materials. Please note that not fit in all mailboxes. You can change your					
ng:					
<ul> <li>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.</li> <li>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.</li> <li>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</li> </ul>					

If y inf Las	ceived my UnitedHealthcare UCard®, I can itedHealthcare UCard to update my authorized gnature of applicant/member/authorized you are the authorized representate formation below (* Not a Sales Agentst name dress  y  one number ( ) —	rization information on file d representative  tive, please sign about)  First name  State  Relationship to ap	Today's date  ve and complete the  Zip code  plicant					
Un Sig	gnature of applicant/member/authorized  you are the authorized representate formation below (* Not a Sales Agents and stress  dress	tive, please sign about  First name  State	Today's date  ve and complete the  Zip code					
Un Sig If y inf Las	gnature of applicant/member/authorized  you are the authorized representate formation below (* Not a Sales Agents  st name	tive, please sign about	roday's date  ve and complete the					
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Un <b>Sig</b>	itedHealthcare UCard to update my authorized	rization information on fi	e. Today's date					
Un	itedHealthcare UCard to update my author	rization information on fi	e.					
	-		•					
bel	half of the member beyond this application	n. After this application h	as been approved and I have					
	ow written proof (power of attorney, guardi derstand that I will need to submit written p			1				
	sign as an authorized representative, it me							
\ <b>\</b> /}	nen I sign below, it means that I have rea	nd and understand the i	oformation on this form					
	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.							
	plan.							
	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							
	information (see Privacy Act Statement b	pelow).						
	will share my information with Medicare, payments, and for other purposes allowed	•	-					
	Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan							
_	plans).		al Savings Account (MSA)					
	apply for MA Private Fee-for-Service (PFF plans).	•	understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time - and hat enrollment in this plan will automatically end my enrollment in another MA plan (exceptions					
	that enrollment in this plan will automatic apply for MA Private Fee-for-Service (PFF	cally end my enrollment i	n another MA plan (exception					

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

For individuals he			_	_	_
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/	age	ncy	use only	
Licensed Sales repres	sentative/Writing ID			Initial receipt da	ate
Licensed Sales repres	sentative/agent name		Proposed effective date		tive date
Employer group name	;				
Employer group ID				Branch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	e ☐ ICEP (MA enrolle	es)		ollees eligible for	□ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)			dence) EP (October 15-	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _				,	
Enrollee name					
Agent name/ID numbe Y0066_ERFMA_2025_C	r				UHNY25HP0220811_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 NY-S4 (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.

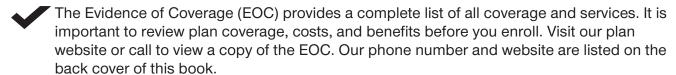
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

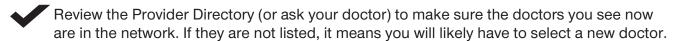
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

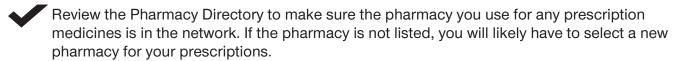
# **Enrollment checklist**

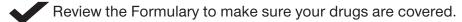
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## **Understanding the benefits**









## **Understanding important rules**

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medicaid or another third party. This premium is normally taken out of your Social Security check each month.
- 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.