

2025 Enrollment Request Form

☐ UHC Dual Complete OH-S3 (HMO-POS D-SNP) H1285-002-000

	you (Please type or print in black or blue ink			N A * 1 11 * * * 1 * 1	
Last name	First name			Middle initial	
Birth date	,	Sex □ Male □ Female			
Home phone number ()	_	Mobile phone n	umber (() –	
☐ I give consent for UnitedHealthcausing an autodialer and/or prereco		•	none nur	mber(s) I have provided	
Social Security number					
(Required for people who are enrol	ling 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	Zip code	
Mailing address (Only if it's different	ent from above	e. You can give a	P.O. bo)x.)	
City			State	Zip code	
Email address (optional)				- I	
Enrollee name					
Agent name/ID number					

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-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 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	ieck		
\square 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	• • •			
1. Would you prefer plan info				
	rmation in another language or Braille		•	
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C		UHUI	H25HP0221159_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 or 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		 P0221159_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	e 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?			
Providing your email address above automatications. You will get many of your required plan communications an email when new communications (For example)	-			
	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 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:			
 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 number				
Y0066_ERFMA_2025_C	UHOH25HP0221159_000			

 (also known as a member contract or subscrinor UnitedHealthcare will pay for benefits or solutions.) I understand that I can be enrolled in only one that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS), No. 	services that are not cover e Medicare Advantage (M. end my enrollment in anot	red. A) plan at a time – and ther MA plan (exceptions			
plans). Release of information: By joining this Mediwill share my information with Medicare, who	care Advantage Plan, I ac	knowledge that the plan			
payments, and for other purposes allowed by information (see Privacy Act Statement below	Federal law that authorize	•			
·	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				
 The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. However plan. 	form I will be disenrolled	from the plan.			
When I sign below, it means that I have read an	d understand the inform	ation on this form			
behalf of the member beyond this application. Aft received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizati Signature of applicant/member/authorized rep	Customer Service at the non information on file. resentative Today	umber on my			
If you are the authorized representative, information below (*Not a Sales Agent)	please sign above ar	id 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		HOH25HP0221159_000			

For individuals he	lping enrollee with	ı co	mple	etina this form	only
Complete this section	if you're an individual	(i.e.	agen	ts, brokers, SHIP	_
members, or other third parties) helping an e				ship to enrollee	
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sale	es Representative/	age	ncy	use only	
Licensed Sales representative/Writing ID			Initial receipt date		ate
Licensed Sales representative/agent name				Proposed effective date	
Employer group name	9				
Employer group ID				Branch ID	
Agent must completed ☐ IEP (MA-PD enrollees)	e □ ICEP (MA enrolle	enrollees eligible for Mar 31 2nd IEP) ☐ SEP (Change in ☐ SEP residence) EGHP of		ollees eligible for	□ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)			☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ SEP (SEP reason)					
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C	er				UHOH25HP0221159_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 OH-S3 (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.

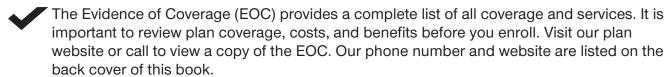
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

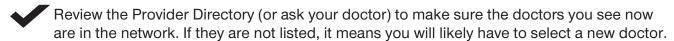
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

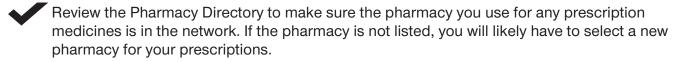
Enrollment checklist

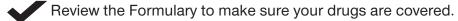
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

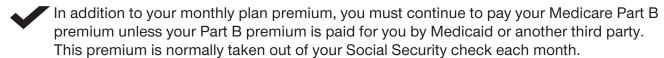








Understanding important rules



- 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.