

2025 Enrollment Request Form

☐ UHC Dual Complete OH-D001 (HMO-POS D-SNP) H5253-059-000

First name		ľ	Viidale initial			
-			Middle initial			
Sex □ Male						
 Mobile phone number) –			
e and its affilided voice tec	•	ne num	ber(s) I have provided			
ng in D-SNP բ	olans):	-				
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)						
County	St	tate	Zip code			
t from above	e. You can give a P	O. box	.)			
	St	tate	Zip code			
		U				
			State			

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		UHO	H25HP0220708_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	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 Non-binary	I use a different term: I choose not to answer	
6. Which of the following best represents Lesbian or gay Straight, that is, not gay or lesbian Bisexual		
7. Do you or your spouse work?		☐ Yes ☐ No
Enrollee nameAgent name/ID numberY0066_ERFMA_2025_C		
10000_ENFIVIA_2020_C	UHUH25H	P0220708_000

Do you or your spouse have other health insurance					
(Examples: Other employer group coverage, LTD	coverage, Workers' Compensation, ☐ Yes ☐ No				
,					
If yes, please complete the following: Name of health insurance company					
Name of fleath 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					
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.	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 numberY0066_ERFMA_2025_C	UHOH25HP0220708_000				

Unit Signary If you information Lass Add	itedHealthcare UCard to update my au inature of applicant/member/author you are the authorized represer formation below (* Not a Sales A st name	ntative, please sign above an gent) First name State Relationship to applican	's date d complete the Zip code				
Unit Sig	nature of applicant/member/author you are the authorized represer formation below (* Not a Sales A st name dress	ithorization information on file. ized representative Today ntative, please sign above an gent) First name State	's date d complete the Zip code				
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Uni	itedHealthcare UCard to update my au	uthorization information on file.	•				
			umber on my				
beł	nalf of the member beyond this applica						
sho	sign as an authorized representative, i ow written proof (power of attorney, gu derstand that I will need to submit writ	ardianship, etc.) of this right if Med	dicare asks for it. I				
	nen I sign below, it means that I have						
	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.						
	or person(s) for permissible purposes under applicable law as required to administer my health 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).						
_	plans). Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan						
	plans).		3 ()				
	. ,	natically end my enrollment in anot (PFFS), MA Medicare Medical Savi	ther MA plan (exceptions				

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

	lping enrollee with		-	_	-	
•	if you're an individual	•	_		ounselors, family	
members, or other third parties) helping an						
Ivaille	Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)				
	es Representative/	ager	псу і	_		
Licensed Sales repres	sentative/Writing ID			Initial receipt dat	te	
Licensed Sales representative/agent name			Proposed effective date		ive date	
Employer group name	Э					
Employer group ID			E	Branch ID		
Agent must complete	e					
☐ IEP (MA-PD	☐ ICEP (MA enrolle	lees) □ IEF		EP (MA-PD	□ OEP (Jan 1 –	
enrollees)	·		enrollees eligible for Mar 31)		Mar 31)	
☐ OEP (Newly	☐ SEP (Dual LIS	residence) EGH		☐ SEP (Loss of		
eligible)	change of status)			,	EGHP coverage)	
☐ SEP (Chronic)	☐ SEP (Dual LIS			,		
,	maintaining)			•		
☐ SEP (SEP reason)						
Enrollee name						
Enrollee nameAgent name/ID number						
Y0066_ERFMA_2025_C					UHOH25HP0220708_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-D001 (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.

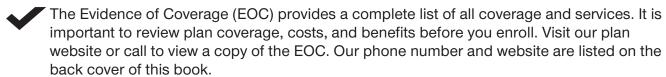
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

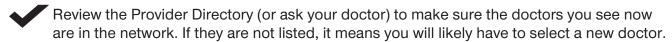
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

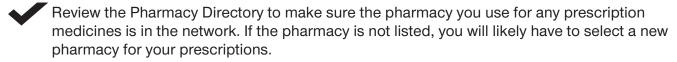
Enrollment checklist

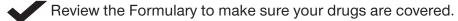
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

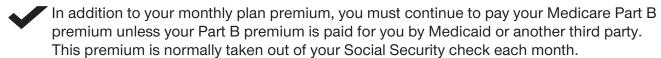


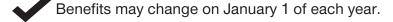


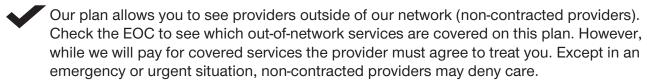




Understanding important rules







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.