

2025 Enrollment Request Form

☐ UHC Dual Complete PA-S3 (HMO-POS D-SNP) H3113-016-000

Last name Birth date Home phone number () □ I give consent for UnitedHealthca	First name	Sex □ Male □	l Female	Middle initial
Home phone number ()	–		l Female	e
. ,	—	Mobile phone n		
☐ I give consent for UnitedHealthca	are and its affili		umber () —
using an autodialer and/or prereco		•	one nur	mber(s) I have provided
Social Security number				
(Required for people who are enro	lling in D-SNP	plans):		
Medicare number				
Permanent residence street addres homelessness, a PO Box may be	•			
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)		L		
nrollee name				
gent name/ID number 0066 ERFMA 2025 C				 JHPA25HP0220834_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 automati 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-I	RMAA),		
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 Retirement Board (RRB) can bill you					
☐ I want to pay from my Social	Security check				
☐ I want to pay from my Railroad Retirement Board (RRB) check					
☐ I want to pay directly from a bank account					
Account type □ Checking □ Savings					
Account holder name:					
Bank routing number/					
Bank account 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 Large print Audi		•		
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C UHPA25HP0220834_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 number	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	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 nameAgent name/ID number		
V0066 EREMA 2025 C	ΙΙΗΡΔ25Η	DU33U834 UUU

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	rovider 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 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.	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, unled I understand that people with Medicare are go the country, except for limited coverage near urgent care outside of the U.S. See the Summary I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcare	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 numberY0066_ERFMA_2025_C	UHPA25HP0220834_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
apply for MA Private Fee-for-Service (PFFS),		
 Palease of information: By joining this Med will share my information with Medicare, who payments, and for other purposes allowed be information (see Privacy Act Statement below I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan. The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. However, plan. 	o may use it to track my ency Federal law that authorizw). my protected health informapplicable law as required best of my knowledge. I use form I will be disenrolled	rollment, to make e the collection of this nation with organizations I to administer my health understand that if I from the plan.
When I sign below, it means that I have read a		
understand that I will need to submit written proceed behalf of the member beyond this application. Af received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizat Signature of applicant/member/authorized rep	ter this application has been Customer Service at the nation information on file. Presentative Today	en approved and I have umber 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 applicar	t
Enrollee name		
Agent name/ID number		
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	elping enrollee with n if you're an individual (_	_	-
•	ird parties) helping an e	•	•		, , , , , , , , , , , , , , , , , , ,
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sale	es Representative/a	agei	ncy ι	ise only	
Licensed Sales representative/Writing ID				Initial receipt dat	re
Licensed Sales representative/agent name				Proposed effective date	
Employer group nam	e				
Employer group ID			E	Branch ID	
Agent must complet	te				
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)			P (MA-PD llees eligible for IFP)	☐ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible)	☐ SEP (Dual LIS change of status)	☐ SEI		EP (Change in lence)	☐ SEP (Loss of EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)	☐ AEP (Octobe December 7)		•	□ OEPI
☐ SEP (SEP reason)					
Envalle a reserve					
	 er				
Y0066_ERFMA_2025_C					UHPA25HP0220834_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 PA-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.

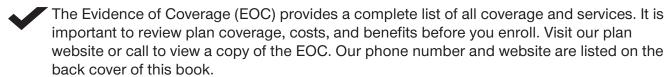
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

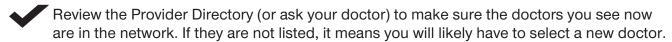
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

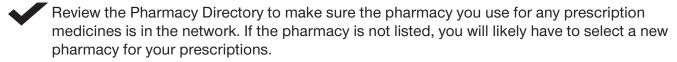
Enrollment checklist

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

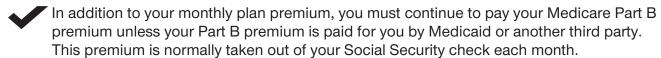




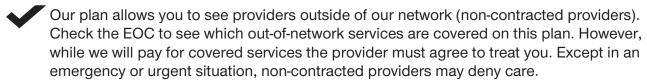




Understanding important rules







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.