

# **2025** Enrollment Request Form

☐ UHC Dual Complete SD-S2 (PPO D-SNP) H2001-077-000

Information about you (Please	type or pri	nt in black or b	olue ink		
Last name	First name			Middle initial	
Birth date	Sex ☐ Male ☐ Femal		] Femal	e	
Home phone number ( )	<ul> <li>Mobile phone number</li> </ul>		· · · · · ·		
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	hone nur	mber(s) I have provided	
Social Security number					
(Required for people who are enrolling in D-SNP plans):					
Medicare number					
Permanent residence street address homelessness, a PO Box may be co	•				
City	County State		State	Zip code	
Mailing address (Only if it's differen	t from above	e. You can give a	P.O. bo	x.)	
City		State		Zip code	
Email address (optional)				1	
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 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 y	ou a letter and ask you how yo	u 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	ieck		
☐ 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				
1. Would you prefer plan info				
	rmation in another language or Braille		•	
Enrollee name				
Agent name/ID number			<del></del>	
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If you don't see the language or format you want, please call us toll-free at **1-855-545-9340**, 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, o  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 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 name		
Agent name/ID number		P0221061_000
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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:	_ 100 _ 110
Name of health insurance company	
Member number	
8. Please give us the name of your primary care	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 Sumn	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	
Y0066_ERFMA_2025_C	UHSD25LP0221061_000

UnitedHealthcare and contained in my Uni (also known as a member contract or subs		•			
nor UnitedHealthcare will pay for benefits	nor UnitedHealthcare will pay for benefits or services that are not covered.				
☐ I understand that I can be enrolled in only	• •	, ·			
that enrollment in this plan will automatica	•	. , .			
apply for MA Private Fee-for-Service (PFFS	o), IMA IMEGICARE IMEGICAI Sav	vings account (MSA)			
•	plans).  Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan				
will share my information with Medicare, w					
payments, and for other purposes allowed	,	·			
information (see Privacy Act Statement be	low).				
<ul> <li>I give UnitedHealthcare permission to share</li> </ul>	re my protected health infor	mation with organizations			
	or person(s) for permissible purposes under applicable law as required to administer my health				
plan.	·				
	, , , , , , , , , , , , , , , , , , , ,				
intentionally provide false information on this form I will be disenrolled from the plan.  My response to this form is voluntary. However, failure to respond may affect enrollment in the					
My response to this form is voluntary. How plan.	rever, randre to respond may	aneot emoliment in the			
Piani					
When I sign below, it means that I have read	and understand the inform	nation on this form			
If I sign as an authorized representative, it mea	ns I have the legal right und	er state law to sign. I can			
show written proof (power of attorney, guardian		_			
understand that I will need to submit written pro	· · · · · · · · · · · · · · · · · · ·				
behalf of the member beyond this application.	After this application has be	en approved and I have			
received my UnitedHealthcare UCard®, I can ca	all Customer Service at the r	number on my			
UnitedHealthcare UCard to update my authorize	zation information on file.				
Signature of applicant/member/authorized r	representative Today	y's date			
If you are the authorized representative		nd complete the			
information below (*Not a Sales Agent)					
Last name	First name				
Address					
City	State	Zip code			
Phone number ( ) —	Relationship to applicant				
Phone number ( ) —					
Enrolled name					
Enrollee nameAgent name/ID number					
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For individuals hel		_		_	-
Complete this section	•	. •			unselors, family
members, or other third parties) helping an e				hip to enrollee	
ivaille		riolati	0110		
Signature		Natio	nal F	Producer Number	(Agents/Brokers only)
<b>-</b>	<b>5</b> /				
For Licensed Sales	•	agend	y u	-	
Licensed Sales representative/Writing ID				Initial receipt date	9
Licensed Sales representative/agent name				Proposed effective date	
Employer group name					
Employer group ID			В	ranch ID	
Agent must complete			1		
☐ IEP (MA-PD	☐ ICEP (MA enrolle	,		P (MA-PD	□ OEP (Jan 1 -
enrollees)			nrol nd l	lees eligible for EP)	Mar 31)
☐ OEP (Newly				P (Change in	☐ SEP (Loss of
eligible)	change of status)			ence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS		☐ AEP (October 15- ☐ OEPI		
☐ SEP (SEP reason) _	maintaining)	Decem		mber /)	
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C					UHSD25LP0221061_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 SD-S2 (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.

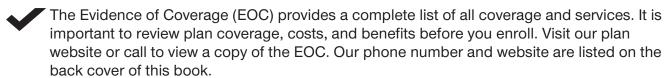
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

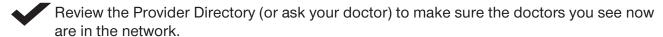
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

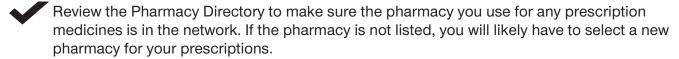
# **Enrollment checklist**

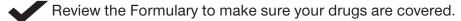
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## **Understanding the benefits**

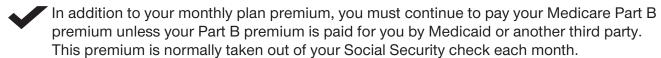


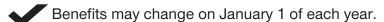


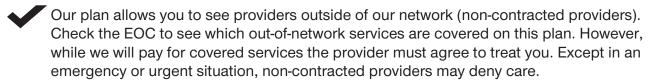




### **Understanding important rules**







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.