

2025 Enrollment Request Form

☐ UHC Dual Complete TX-V002 (HMO-POS D-SNP) H4527-003-000

Information about you (Please	type or pri	nt in black or b	lue ink		
Last name	First name			Middle initial	
Birth date	Sex □ Male □ Femal		e		
Home phone number ()	 Mobile phone number) —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	none nur	mber(s) I have provided	
Social Security number					
(Required for people who are enrolling	ng in D-SNP բ	olans):	- _		
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 from above. You can give a P.O. box.)					
City		State		Zip code	
Email address (optional)					
Enrollee nameAgent name/ID number					
Y0066_ERFMA_2025_C				UHTX25HP0220772_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 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	□ 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		UHT	X25HP0220772_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, o 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	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 number Y0066_ERFMA_2025_C		P0220772_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	
Name of fleath insurance company	
Member number	
8. Please give us the name of your primary care	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? ☐ Yes ☐ No
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.	
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 Sumr 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 nary of Benefits for more information. coverage begins, I must get all of my medical and
Enrollee name	
Agent name/ID numberY0066_ERFMA_2025_C	UHTX25HP0220772_000

 (also known as a member contract or subsonor UnitedHealthcare will pay for benefits on I understand that I can be enrolled in only on that enrollment in this plan will automatically apply for MA Private Foe for Service (PEES) 	r services that are not cove ne Medicare Advantage (M y end my enrollment in ano	red. A) plan at a time – and ther MA plan (exceptions	
apply for MA Private Fee-for-Service (PFFS). plans).	, IVIA Medicare Medicai Sav	ings Account (MSA)	
 □ Release of information: By joining this Medwill share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below) □ I give UnitedHealthcare permission to share 	no may use it to track my er by Federal law that authoriz bw).	rollment, to make te the collection of this	
or person(s) for permissible purposes unde		<u> </u>	
 plan. The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. Howen plan. 	is form I will be disenrolled	from the plan.	
When I sign below, it means that I have read a	and understand the inform	ation on this form	
understand that I will need to submit written probehalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorization. Signature of applicant/member/authorized received my authorized my authorized received my authorized received my authorized received my authorized received my authorized my authorized received my authorized my author	After this application has be all Customer Service at the relation information on file. Perpresentative Today	en approved and I have number on my y's date	
If you are the authorized representative information below (*Not a Sales Agent)	e, piease sign above ar	na complete the	
Last name	First name		
Address			
City	State	Zip code	
Phone number () —	Relationship to applicant		
	ı		
Enrollee name			
Agent name/ID numberY0066_ERFMA_2025_C		 UHTX25HP0220772_000	

For individuals he	lping enrollee with	COL	mnl	eti	ing this form o	nlv
	if you're an individual		-		_	-
members, or other thi	rd parties) helping an	enrol	llee fi	ill c	out this form.	
Name		Rel	lation	ısh	nip to enrollee	
Signature		Nat	National Producer Number (Agents/Brokers only)			
For Licensed Sale	es Representative/	age	ncy	us	se only	
Licensed Sales representative/Writing ID			Initial receipt date		Initial receipt date	9
Licensed Sales repres	sentative/agent name			Proposed effective		ve date
Employer group name	9					
Employer group ID				Br	anch ID	
Agent must complete ☐ IEP (MA-PD enrollees) ☐ OEP (Newly eligible) ☐ SEP (Chronic) ☐ SEP (SEP reason)	□ ICEP (MA enrolled □ SEP (Dual LIS change of status) □ SEP (Dual LIS maintaining)	es)	enre 2nc 1 S resi	olle SEI ide	P (MA-PD ees eligible for EP) P (Change in ence) P (October 15- mber 7)	☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI
Enrollee name Agent name/ID numbe Y0066_ERFMA_2025_C						UHTX25HP0220772_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 TX-V002 (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.

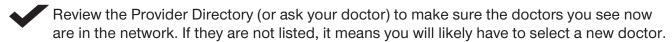
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

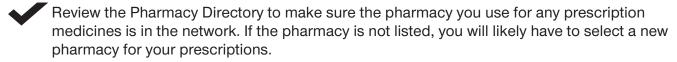
Enrollment checklist

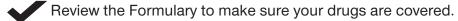
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

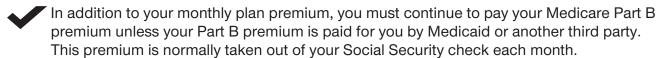


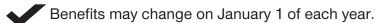


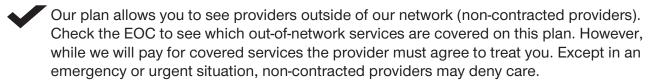




Understanding important rules







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.