

2025 Enrollment Request Form

☐ UHC Dual Complete TX-D003 (HMO-POS D-SNP) H4527-015-000

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 n	umber () —		
☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology.						
Social Security number						
(Required for people who are enrolling in D-SNP plans):						
Medicare number	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)		I				
Enrollee nameAgent name/ID number						
Y0066_ERFMA_2025_C				UHTX25HP0220769_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 below, we'll send a bill each month to your mailing 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 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	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	X25HP0220769_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	☐ 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 Sp Yes, Mexican, Mexican American, or Sp Yes, Puerto Rican Yes, Cuban Yes, another Hispanic, Latino, or Sp I choose not to answer	eanish 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	s 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	UHTX25H	

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	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.	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	UHTX25HP0220769_000				

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bel	half of the member beyond this application.	After this application has be	en approved and I have				
	derstand that I will need to submit written pr	oor or this right, to the plan,	i i wish to take action on				
	ow written proof (power of attorney, guardia						
	nen I sign below, it means that I have read sign as an authorized representative, it mea						
\ \/		and understand the inform	ation on this form				
	intentionally provide false information on t	this form I will be disenrolled	from the plan.				
	plan. The information on this form is correct to the best of my knowledge. I understand that if I						
	or person(s) for permissible purposes under applicable law as required to administer my health						
	information (see Privacy Act Statement below). I give UnitedHealthcare permission to share my protected health information with organization						
	payments, and for other purposes allowed	d by Federal law that authoriz					
	Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make						
	plans).	o, MA Medicale Medical Gav	ings Account (MoA)				
	that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA)						
	•	ally end my enrollment in ano	nor UnitedHealthcare will pay for benefits or services that are not covered. I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and				
	I understand that I can be enrolled in only that enrollment in this plan will automatical	one Medicare Advantage (M					

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

For individuals helping enrollee with completing this form only						
Complete this section members, or other thin	•	•	_	•	counselors, family	
Name		Relationship to enrollee				
Signature		National Producer Number (Agents/Brokers only)				
For Licensed Sale	s Representative/	age	ncy	use only		
Licensed Sales representative/Writing ID				Initial receipt da	ate	
Licensed Sales representative/agent name				Proposed effect	tive date	
Employer group name	;					
Employer group ID				Branch ID		
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrolle	eı		EP (MA-PD ollees eligible for	□ OEP (Jan 1 – Mar 31)	
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)		2nd IEP) ☐ SEP (Change in residence) ☐ AEP (October 15-December 7)		☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ SEP (SEP reason) _						
Enrollee name						
Agent name/ID numbe Y0066_ERFMA_2025_C					UHTX25HP0220769_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-D003 (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.

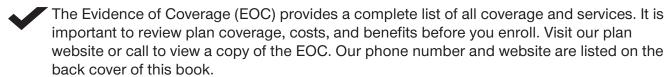
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

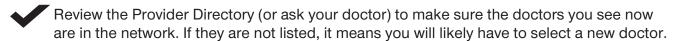
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

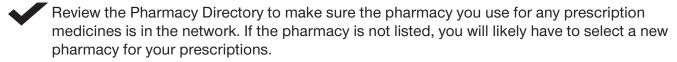
Enrollment checklist

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

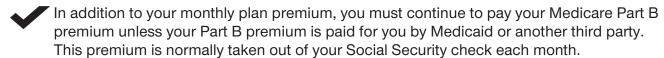








Understanding important rules



- 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.