

# **2025 Enrollment Request Form**

☐ UHC Dual Complete TX-S5 (HMO-POS D-SNP) H5322-046-000

The state of the s	bout you (Please type or print in black or blue ink			İ	
Last name	First name			Middle initial	
Birth date		Sex □ Male □ Female			
Home phone number ( )	_	Mobile phone n	umber (	( ) —	
☐ I give consent for UnitedHealthca using an autodialer and/or prereco		•	none nur	mber(s) I have provided	
Social Security number					
(Required for people who are enrol	ling in D-SNP	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	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 name					
Agent name/ID number					

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 I	☐ 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	X25HP0220579_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  I choose not to answer	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 number		
Y0066_ERFMA_2025_C	UHTX25H	P0220579_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.	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:			
<ul> <li>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.</li> <li>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.</li> <li>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</li> </ul>				
Enrollee name				
Agent name/ID numberY0066_ERFMA_2025_C	UHTX25HP0220579_000			

<ul> <li>(also known as a member contract or subset nor UnitedHealthcare will pay for benefits of I understand that I can be enrolled in only of that enrollment in this plan will automaticall apply for MA Private Fee-for-Service (PFFS)</li> </ul>	or services that are not cove one Medicare Advantage (M ly end my enrollment in ano	red. IA) plan at a time – and ther MA plan (exceptions	
plans).			
<ul> <li>Release of information: By joining this Me will share my information with Medicare, wh payments, and for other purposes allowed information (see Privacy Act Statement below I give UnitedHealthcare permission to share or person(s) for permissible purposes under the purposes under the purposes of the purpose of the purposes of the purpose of the pur</li></ul>	no may use it to track my er by Federal law that authoriz ow). e my protected health inforr	rollment, to make the collection of this mation with organizations	
<ul> <li>plan.</li> <li>The information on this form is correct to the intentionally provide false information on the My response to this form is voluntary. Howen plan.</li> </ul>	ne best of my knowledge. I units form I will be disenrolled	understand that if I from the plan.	
When I sign below, it means that I have read a	and understand the inform	nation 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 cau UnitedHealthcare UCard to update my authorized Signature of applicant/member/authorized received.	After this application has be all Customer Service at the relation information on file.  Pepresentative 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 ai	na complete the	
Last name	First name		
Address			
City	State	Zip code	
Phone number ( ) —	Relationship to applicant		
Enrollee name			
Agent name/ID numberY0066_ERFMA_2025_C		 UHTX25HP0220579_000	

For individuals he	lping enrollee with	ı co	mple	eting this form	only
Complete this section	if you're an individual	(i.e.	agent	ts, brokers, SHIP o	-
members, or other third parties) helping an e				ship to enrollee	
	Name		- Lation		
Signature		Na	tional	Producer Numbe	r (Agents/Brokers only)
For Licensed Sale	s Representative/	age	ncy	use only	
Licensed Sales representative/Writing ID			Initial receipt date		ate
Licensed Sales repres	entative/agent name			Proposed effective date	
Employer group name	)				
Employer group ID			ı	Branch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	□ ICEP (MA enrolle	es)	es) ☐ IEP (MA-PD enrollees eligible 2nd IEP)		□ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	☐ SEP (Change in ☐ SEP residence)		☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ SEP (SEP reason) _					
Enrollee name					
Agent name/ID numbe Y0066_ERFMA_2025_C					UHTX25HP0220579_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-S5 (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.

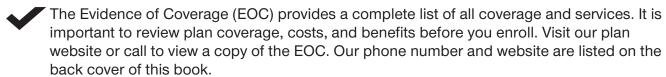
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

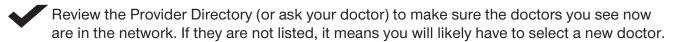
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

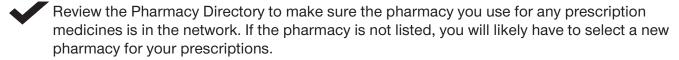
# **Enrollment checklist**

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

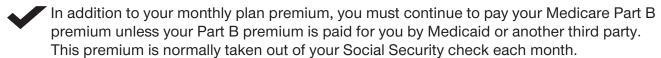


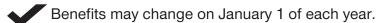


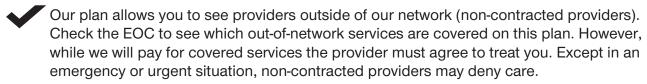




### **Understanding important rules**







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.