

# **2025 Enrollment Request Form**

☐ UHC Dual Complete VA-Y4 (PPO D-SNP) H0421-001-000

Information about you (Please type or print in black or blue ink)					
Last name	First name			Middle initial	
Birth date		Sex □ Male	☐ Femal	e	
Home phone number ( )	_	Mobile phone	number ( ) -		
☐ 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	ng in D-SNP <sub>I</sub>	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		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					
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Do you have other insurance (Examples: Other private insurance 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 your choice. You can't be denied coverage because you don't fill them out.				
How do you want to pay?				
If you have a monthly plan prepay 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 below, we'll send a bill each month to your mailing 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	ou want to pay it:		
☐ You can pay it from your SS check				
□ Medicare can bill you				
☐ The Railroad Retiremer	nt 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		
$\square$ 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	ıs manage your plan			
1. Would you prefer plan info	rmation in another language	or an accessible	format?	
If you would prefer plan information in another language or accessible format, please check what you'd like: ☐ Spanish ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD ☐ Other				
Enrollee name				
Agent name/ID number H0421_ERF_2025_C			 'A25LP0221367_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 numbe	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	I use a different term:	
<ul><li>Non-binary</li><li>6. Which of the following best represents</li><li>Lesbian or gay</li><li>Straight, that is, not gay or lesbian</li><li>Bisexual</li></ul>	how you think of yourself? Select one l use a different term: l don't know l choose not to answer	
7. Do you or your spouse work?		□ Yes □ No
Enrollee nameAgent name/ID number		
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Do you or your spouse have other health insurance	ce that will cover medical services?		
(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 aren't limited to this list. You may go to any de	octor who accepts Medicare and the plan's		
payment terms.			
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)	e: Explanation of Benefits or the Annual Notice of		
computer, tablet or mobile phone.	ese communications through any device such as a		
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, unle  I understand that people with Medicare are g	generally not covered under Medicare while out of the U.S. border. This plan covers emergency and		
<ul> <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</li> </ul>			
Enrollee name			
Agent name/ID number			

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UnitedHealthcare and contained in my United (also known as a member contract or subscri		•			
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				
•	that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions				
apply for MA Private Fee-for-Service (PFFS), N	apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA)				
plans).					
☐ Release of information: By joining this Medic					
will share my information with Medicare, who may use it to track my enrollment, to make					
payments, and for other purposes allowed by	payments, and for other purposes allowed by Federal law that authorize the collection of this				
information (see Privacy Act Statement below	/).				
<ul> <li>I give UnitedHealthcare permission to share r</li> </ul>	- ·				
or person(s) for permissible purposes under a	applicable law as required	to administer my health			
plan.					
☐ The information on this form is correct to the	,				
intentionally provide false information on this		•			
<ul> <li>My response to this form is voluntary. However</li> </ul>	er, failure to respond may	affect enrollment in the			
plan.					
When I sign below, it means that I have read and understand the information on this form  If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file.  Signature of applicant/member/authorized representative  Today's date					
If you are the authorized representative,	nlogeo eign abovo an	d complete the			
information below (*Not a Sales Agent)	piease sign above an	a complete the			
Last name	First name				
Address					
City	State	Zip code			
Phone number ( ) —	Relationship to applicant				
Enrollee name					
Agent name/ID number					

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For individuals hal					
For individuals helping enrollee with completing this form only  Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family					
members, or other thin	•	•	_		disciolo, lariny
Name		Rela	ations	hip to enrollee	
Ciara atuma		NI-4:		Dua di . a a u Ni mala a u	(Asserts (Dualsons and s)
Signature		INati	onai	Producer Number	(Agents/Brokers only)
For Licensed Sale	s Representative/	ager	ncy u	se only	
Licensed Sales repres	entative/Writing ID			Initial receipt date	е
Licensed Sales repres	entative/agent name			Proposed effective date	
Employer group name	<b>;</b>				
Employer group ID			В	ranch ID	
Agent must complete	•				
☐ IEP (MA-PD	☐ ICEP (MA enrolle	es)		P (MA-PD	□ OEP (Jan 1 -
enrollees)				lees eligible for	Mar 31)
☐ OEP (Newly	☐ SEP (Dual LIS		2nd I	EP) EP (Change in	☐ SEP (Loss of
eligible)	change of status)			ence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS			P (October 15-	□ OEPI
	maintaining)	Decem		mber 7)	
☐ SEP (SEP reason) _					
Enrollee name					
Agent name/ID numbe					
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#### **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 VA-Y4 (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.

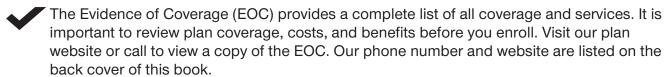
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

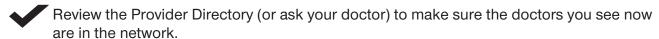
OMB No. 0938-1378 Expires: 6/30/2026 H0421\_ERF\_2025\_C

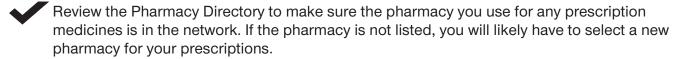
# **Enrollment checklist**

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

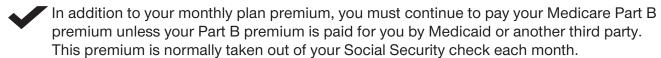


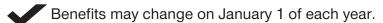


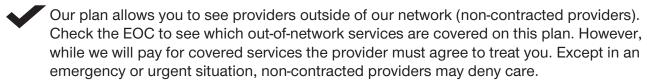




### **Understanding important rules**







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.