

2025 Enrollment Request Form

☐ UHC Dual Complete WI-D001 (PPO D-SNP) H0294-027-000

| | ormation about you (Please type or print in black or blue in | | | | |
|--|--|---------------------|----------------|-------------------------|--|
| Last name | First name | | Middle initial | | |
| Birth date | | Sex □ Male □ Female | | | |
| Home phone number () | Mobile phone number | | | () — | |
| ☐ I give consent for UnitedHealthcal using an autodialer and/or prerecor | | | hone nur | mber(s) I have provided | |
| Social Security number | | | | | |
| (Required for people who are enroll | ing in D-SNP _I | olans): | | | |
| Medicare number | | | | | |
| Permanent residence street address homelessness, a PO Box may be o | - | | | | |
| City | County | County State | | Zip code | |
| Mailing address (Only if it's different | nt from above | e. You can give a | P.O. bo | x.) | |
| City | | | State | Zip code | |
| Email address (optional) | | | | | |
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| | | | | | |
| | | | | | |
| 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-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 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 | | | VI25LP0221382_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/Medicare** for online help.

| 2. Are you enrolled in your state Medicaid | d 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 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 | 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 | | |

| 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 fleatiff 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 d | octor who accepts Medicare and the plan's |
| payment terms. | |
| You can find a list on the plan website or in the P | 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 thi | s provider? ☐ Yes ☐ No |
| Duranidina varus amail addusaa abaya aytamatia | |
| your plan communications. | ally enrolls you in paperless delivery for some of |
| an email when new communications (For exampl | cations delivered electronically. We will send you e: Explanation of Benefits or the Annual Notice of 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 have 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: |
| | cal (Part B) to stay in UnitedHealthcare. I must keep |
| paying my Part B premium if I have one, unled | generally not covered under Medicare while out of |
| | r the U.S. border. This plan covers emergency and |
| urgent care outside of the U.S. See the Sum | mary 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 UnitedHealth | care. Benefits and services authorized by |
| Enrollee name | |
| Agent name/ID number | |
| Y0066 FREMA 2025 C | UHWI25LP0221382 000 |

| nor UnitedHealthcare will pay for benefits of | | | | | |
|--|--|--------------------------|--|--|--|
| I understand that I can be enrolled in only of that enrollment in this plan will automatical | • , | , · | | | |
| apply for MA Private Fee-for-Service (PFFS | • | . , . | | | |
| plans). | ,, | 907.10000 (07.1) | | | |
| □ Release of information: By joining this Me | Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan | | | | |
| will share my information with Medicare, w | ho may use it to track my er | rollment, to make | | | |
| payments, and for other purposes allowed | | e the collection of this | | | |
| information (see Privacy Act Statement bel | • | | | | |
| I give UnitedHealthcare permission to shar or person(s) for permissible purposes under | • • | • | | | |
| plan. | ci applicable law as required | a to administer my nearm | | | |
| ☐ The information on this form is correct to the | he best of my knowledge. Ι ι | understand that if I | | | |
| intentionally provide false information on the | nis form I will be disenrolled | from the plan. | | | |
| My response to this form is voluntary. How | ever, failure to respond may | affect enrollment in the | | | |
| plan. | | | | | |
| When I sign below it means that I have good | and understand the information | ection on this form | | | |
| When I sign below, it means that I have read | | | | | |
| If I sign as an authorized representative, it mean | | · · | | | |
| show written proof (power of attorney, guardian understand that I will need to submit written pro | . , , | | | | |
| behalf of the member beyond this application. | • | | | | |
| received my UnitedHealthcare UCard®, I can ca | • • | • • | | | |
| UnitedHealthcare UCard to update my authoriz | | , | | | |
| Signature of applicant/member/authorized r | enresentative Today | /'s date | | | |
| | oprocontain o | | | | |
| | | | | | |
| If you are the authorized representativ | e, please sign above ar | nd complete the | | | |
| information below (*Not a Sales Agent) | | | | | |
| Last name | First name | | | | |
| | | | | | |
| Address | | | | | |
| | | | | | |
| City | State | Zip code | | | |
| · | | | | | |
| Dhana murahay (| Relationship to applicar | nt | | | |
| Phone number () — | | | | | |
| Enrollee name | | | | | |
| Agent name/ID number | | | | | |
| Y0066 ERFMA 2025 C | | UHWI25LP0221382 000 | | | |

UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (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 | • | • | _ | | unselors, family | |
| members, or other third parties) helping an e | | T . | Relationship to enrollee | | | |
| Signature | | National Producer Number (Agents/Brokers only) | | | | |
| | | | | | | |
| For Licensed Sales Representative/agency use only Licensed Sales representative/Writing ID Initial receipt date | | | | 2 | | |
| Liberiaed Gales repres | ontative, writing ib | | | mila receipt date | | |
| Licensed Sales representative/agent name | | | | Proposed effective date | | |
| Employer group name | | | | | | |
| Employer group ID | | | В | ranch ID | | |
| Agent must complete ☐ IEP (MA-PD enrollees) | □ ICEP (MA enrolle | , | | P (MA-PD lees eligible for EP) | ☐ OEP (Jan 1 – Mar 31) | |
| ☐ OEP (Newly | ☐ SEP (Dual LIS | 1 | □ SE | P (Change in | ☐ SEP (Loss of | |
| eligible) □ SEP (Chronic) | change of status) ☐ SEP (Dual LIS | | | ence) EP (October 15- | EGHP coverage) □ OEPI | |
| | maintaining) | | | mber 7) | | |
| ☐ SEP (SEP reason) _ | | | | | | |
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| | | | | | | |
| Enrollee name | | | | | | |
| Agent name/ID number Y0066_ERFMA_2025_C | · | | | | UHWI25LP0221382_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 WI-D001 (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.

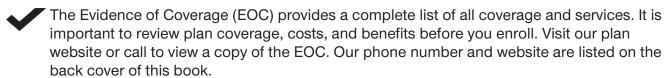
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

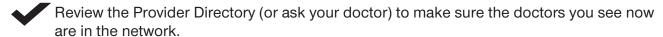
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

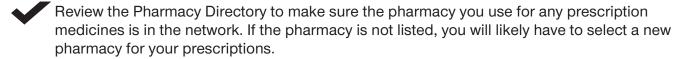
Enrollment checklist

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

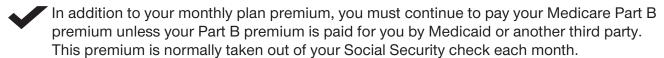








Understanding important rules



- 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.