

2025 Enrollment Request Form

☐ UHC Dual Complete WV-S001 (PPO D-SNP) H2001-030-000

Last name Birth date Home phone number () □ I give consent for UnitedHealthca	First name	Sex □ Male □ F		ddle initial
Home phone number ()	_		emale	
. ,	_	Malaila valaavaa varvusa		
☐ I give consent for UnitedHealthc		Mobile phone num	ıber () —
using an autodialer and/or prereco		•	ie numbe	r(s) I have provided
Social Security number				
(Required for people who are enro	lling in D-SNP	plans):		- — —
Medicare number				
Permanent residence street addre homelessness, a PO Box may be	-			
City	County	County Sta		Zip code
Mailing address (Only if it's different	ent from above	e. You can give a P.	O. box.)	
City		Sta	ite	Zip code
Email address (optional)		I		
nrollee name				
gent name/ID number 0066 ERFMA 2025 C				

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 you a letter and ask you how you want to pay it:			
☐ You can pay it from your SS check			
☐ Medicare can bill you			
☐ The Railroad Retirement 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		UHW	V25LP0221107_000

If you don't see the language or format you want, please call us toll-free at **1-855-545-9340**, 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	I 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	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 nameAgent name/ID number		
Y0066_ERFMA_2025_C	UHWV25L	P0221107_000

Do you or your spouse have other health insurance	e that will cover medical services?
(Examples: Other employer group coverage, LTD	coverage, Workers' Compensation,
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	provider (PCP), clinic or health center.
You aren't limited to this list. You may go to any do	octor who accepts Medicare and the plan's
payment terms.	
You can find a list on the plan website or in the Pr	ovider 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)	-
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:
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	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and mary of Benefits for more information. coverage begins, I must get all of my medical and
Enrollee name	
Agent name/ID number	
Y0066_ERFMA_2025_C	UHWV25LP0221107_000

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(also known as a member contract or substant or UnitedHealthcare will pay for benefits	,					
☐ I understand that I can be enrolled in only						
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)						
plans).						
,, ,	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						
payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).						
	I give UnitedHealthcare permission to share my protected health information with organizations					
	or person(s) for permissible purposes under applicable law as required to administer my health					
plan.						
☐ The information on this form is correct to t	•	S				
intentionally provide false information on t		•				
 My response to this form is voluntary. How 	ever, failure to respo	nd 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 mea						
show written proof (power of attorney, guardian		· ·				
understand that I will need to submit written pr	. , ,					
behalf of the member beyond this application. After this application has been approved and I have						
received my UnitedHealthcare UCard®, I can c	all Customer Service	at the number on my				
UnitedHealthcare UCard to update my authorize	zation information on	file.				
Signature of applicant/member/authorized i	representative	Today's date				
If you are the authorized representative		ove and complete the				
information below (*Not a Sales Agent)						
Last name	First name					
Address						
City	State	Zip code				
Phone number () —	Relationship to a	pplicant				
Enrollee name						
Agent name/ID number						

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UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document

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 third parties) helping an enrollee fill out this form.					
Name		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	9
Licensed Sales repres	entative/agent name		Proposed effective date		ve date
Employer group name					
Employer group ID			В	ranch ID	
Agent must complete)		•		
☐ IEP (MA-PD	☐ ICEP (MA enrolle	-	•		☐ OEP (Jan 1 –
enrollees)	rollees)		enrollees eligible for 2nd IEP)		Mar 31)
☐ OEP (Newly	☐ SEP (Dual LIS		☐ SEP (Change in		☐ SEP (Loss of
eligible)	change of status)		residence)		EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)		☐ AEP (October 15- ☐ December 7)		□ OEPI
☐ SEP (SEP reason) _	.			,	
Enrollee nameAgent name/ID number					
Y0066_ERFMA_2025_C	·				UHWV25LP0221107_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 WV-S001 (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.

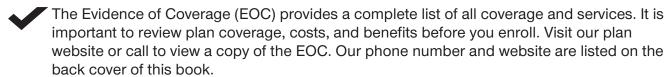
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

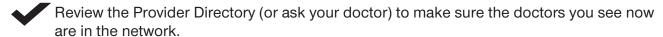
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

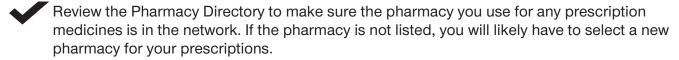
Enrollment checklist

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

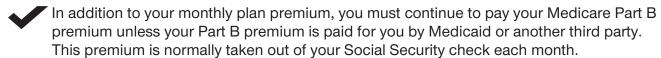


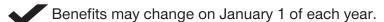


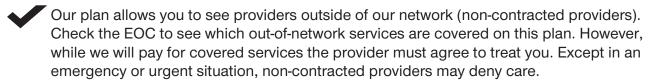




Understanding important rules







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.