

# **2025 Enrollment Request Form**

☐ UHC Dual Complete WV-S2 (PPO D-SNP) H2001-082-000

	ormation about you (Please type or print in black or blue inletent to name)  First name			Middle initial	
Last name	First name			Middle initial	
Birth date		Sex □ Male □	] Femal	e	
Home phone number ( )	_	Mobile phone n	umber (	( ) –	
☐ I give consent for UnitedHealthcausing 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	plans):			
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 differe	ent from above	e. You can give a	P.O. bo	ox.)	
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 b	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 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 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		UHW	V25LP0221056_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	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, o  Yes, Puerto Rican  Yes, Cuban  Yes, another Hispanic, Latino, or Spanish	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 name		
Agent name/ID number Y0066_ERFMA_2025_C		 P0221056_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 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? ☐ Yes ☐ No
Providing your email address above automatications.	ally enrolls you in paperless delivery for some of
You will get many of your required plan communications (For example	-
an email when new communications (For example Changes) are available online. You can access the	ese communications through any device such as a
computer, tablet or mobile phone.	sec communications in ough any device such as a
If you would rather have hard copies of required	d materials mailed to you, please check here:
some communications are very large and may	ard copies of required materials. Please note that
preference for delivery at any time.	not lit ill all maliboxes. Tou 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 Medic	al (Part B) to stay in UnitedHealthcare. I must keep
paying my Part B premium if I have one, unle	
<ul> <li>I understand that people with Medicare are g</li> </ul>	enerally not covered under Medicare while out of
	the U.S. border. This plan covers emergency and
urgent care outside of the U.S. See the Sumr	
•	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	
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(also known as a member contract or sub						
nor UnitedHealthcare will pay for benefits  I understand that I can be enrolled in only						
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), MA Medicare Medical Savings Account (MSA)						
plans).	oj, ivii t ivicalcare ivica	iodi Gavingo / toocant (ivio/ t)				
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	•					
information (see Privacy Act Statement below).						
☐ I give UnitedHealthcare permission to sha	•	th information with organizations				
or person(s) for permissible purposes und	der applicable law as	required to administer my health				
plan.						
☐ The information on this form is correct to	the best of my knowle	edge. I understand that if I				
intentionally provide false information on t	this form I will be dise	nrolled from the plan.				
<ul> <li>My response to this form is voluntary. How</li> </ul>	wever, failure to respo	nd may affect enrollment in the				
plan.						
When I sign below, it means that I have read						
If I sign as an authorized representative, it mea						
show written proof (power of attorney, guardia	. ,					
understand that I will need to submit written p	-					
behalf of the member beyond this application.	• •					
received my UnitedHealthcare UCard®, I can o		-				
UnitedHealthcare UCard to update my authori	zation information on	file.				
Signature of applicant/member/authorized	representative	Today's date				
If you are the authorized representative	ve, please sign ab	ove and complete the				
information below (*Not a Sales Agent	)					
Last name	First name					
Address						
City	State	Zip code				
	Relationship to a	annlicant				
Phone number ( ) —	Tiolationomp to	~PPO				
Enrollee name						
Agent name/ID number						

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

For individuals hel	ning enrollee with	comr	امار	ing this form o	alv
Complete this section members, or other thir	if you're an individual	(i.e. age	ents	s, brokers, SHIP co	-
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sales	s Representative/	agenc	y u	se only	
Licensed Sales representative/Writing ID				Initial receipt date	)
Licensed Sales representative/agent name			Proposed effective date		re date
Employer group name	Employer group name				
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	□ ICEP (MA enrolle	er	rol	P (MA-PD lees eligible for EP)	☐ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	reside □ AE		EP (Change in ence) EP (October 15- mber 7)	☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason) _					
Enrollee name					
Agent name/ID number					LILINAN/OFL DOCALOFO COO
Y0066_ERFMA_2025_C					UHWV25LP0221056_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-S2 (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.

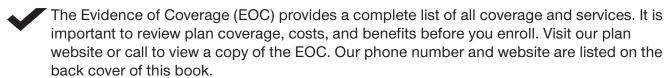
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

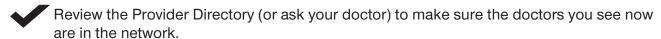
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

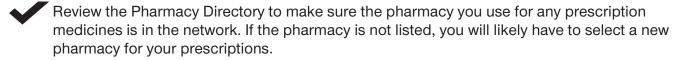
# **Enrollment checklist**

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**

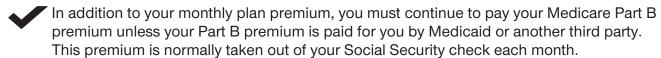


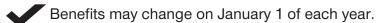


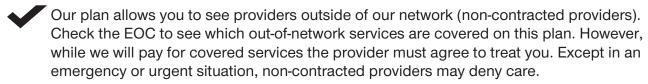


Review the Formulary to make sure your drugs are covered.

### **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.