

2025 Enrollment Request Form

☐ UHC Dual Complete CT-Q001 (PPO D-SNP) H2001-062-000

Information about you (Please	type or pri	nt in black or l	blue ink)		
Last name	First name			Middle initial		
Birth date	Birth date		Sex □ Male □ Female			
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 լ	olans):				
Medicare number						
Permanent residence street address homelessness, a PO Box may be co	-					
City	County State		State	Zip code		
Mailing address (Only if it's differen	t from above	e. You can give	a P.O. bo	ox.)		
City		State		Zip code		
Email address (optional)						
Enrollee nameAgent name/ID number						
Y0066_ERFMA_2025_C				UHCT25LP0221075_000		

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	elow, we'll send a bill each mo	onth to your mailir	ng address.
If you must pay a Part D-Incom	e Related Monthly Adjustment	Amount (Part D-I	RMAA),
Social Security (SS) will send y	ou a letter and ask you how yo	u 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		UHC	T25LP0221075_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	program?	☐ Yes ☐ No
If yes, please give us your Medicaid number:	:	
3. Are you Hispanic, Latino/a, or Spanish of No, not of Hispanic, Latino/a, or Spanish of Yes, Mexican, Mexican American, or Yes, Puerto Rican Yes, Cuban Yes, another Hispanic, Latino, or Spanic I choose not to answer	nish origin 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 I Lesbian or gay Straight, that is, not gay or lesbian Bisexual		
7. Do you or your spouse work?		☐ Yes ☐ No
Enrollee name Agent name/ID number Y0066_ERFMA_2025_C		P0221075_000

Do you or your spouse have other health insurance (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	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 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)	•
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 followin	g:
paying my Part B premium if I have one, unled I understand that people with Medicare are gother country, except for limited coverage near urgent care outside of the U.S. See the Summer of the U.S. See t	generally not covered under Medicare while out of r 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	

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•	nown as a member contract or subsc	,			
	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				
	for MA Private Fee-for-Service (PFFS),	MA Medicare Medical Sav	ings 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).				
•	9				
or pers plan.	or person(s) for permissible purposes under applicable law as required to administer my health				
•	formation on this form is correct to the	e best of my knowledge. I u	understand that if I		
intenti	onally provide false information on this	s form I will be disenrolled	from the plan.		
-	sponse to this form is voluntary. Howe	ver, failure to respond may	affect enrollment in the		
plan.					
When I sig	n below, it means that I have read a	nd understand the inform	ation on this form		
_	an authorized representative, it means				
•	en proof (power of attorney, guardians		•		
understand	d that I will need to submit written prod	of of this right, to the plan, i	f I wish to take action on		
	ne member beyond this application. A	• •	• •		
	ny UnitedHealthcare UCard®, I can cal Ithcare UCard to update my authoriza		umber on my		
			3- J-L-		
Signature	of applicant/member/authorized re	presentative Loday	<i>ı</i> 's date		
If you are	e the authorized representative	, please sign above ar	nd complete the		
_	ion below (*Not a Sales Agent)		•		
Last name	, , , , , , , , , , , , , , , , , , ,	First name			
Address					
City		State	Zip code		
Phone nun	nber () —	Relationship to applicar	nt		
	()				
Enrollee nar	me				
	e/ID number				

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

For individuals hel	ping enrollee with	n com	plet	ing this form o	nly		
Complete this section members, or other thir	-	. •			unselors, family		
Name		Relati	ions	hip to enrollee			
Signature		Natio	National Producer Number (Agents/Brokers only)				
For Licensed Sales Representative/ag				gency use only			
Licensed Sales representative/Writing ID				Initial receipt date)		
Licensed Sales representative/agent name			Proposed effective date		re date		
Employer group name							
Employer group ID			В	ranch ID			
Agent must complete ☐ IEP (MA-PD enrollees)	□ ICEP (MA enrolle	e		P (MA-PD lees eligible for	□ OEP (Jan 1 – Mar 31)		
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS ☐ S change of status) resid		□ SE eside □ 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							
Y0066_ERFMA_2025_C					UHCT25LP0221075_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 CT-Q001 (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.

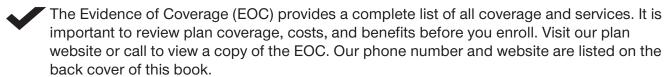
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

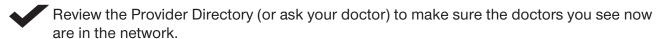
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

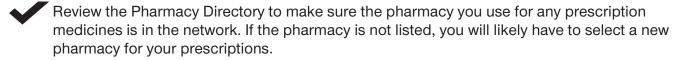
Enrollment checklist

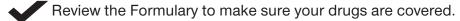
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

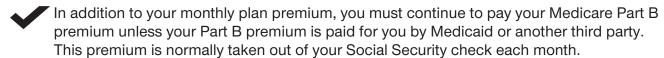








Understanding important rules



- 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.