

2025 Enrollment Request Form

☐ UHC Dual Complete CT-S2 (PPO D-SNP) H2001-066-000

Information about you (Please	type or pri	nt in black or	blue ink)	
Last name	First name			Middle initial	
Birth date		Sex □ Male	□ Femal	е	
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 (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		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 nameAgent name/ID number					
Y0066_ERFMA_2025_C				UHCT25LP0221070_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 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 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 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 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 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		UHC	T25LP0221070_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	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 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 numberY0066_ERFMA_2025_C		P0221070_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	
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 Sumn	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	UHCT25LP0221070_000

	nitedHealthcare and contained in my l Iso known as a member contract or su		G			
no	nor UnitedHealthcare will pay for benefits or services that are not covered.					
□ lu	ınderstand that I can be enrolled in on	ly one Medicare Advant	tage (MA) plan at a time - and			
tha	that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions					
ар	apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA)					
pla	plans).					
□ Re	Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan					
wi	will share my information with Medicare, who may use it to track my enrollment, to make					
ра	payments, and for other purposes allowed by Federal law that authorize the collection of this					
inf	formation (see Privacy Act Statement	below).				
□ Ig	ive UnitedHealthcare permission to sl	nare my protected healt	h information with organizations			
or	person(s) for permissible purposes u	nder applicable law as r	equired to administer my health			
pla	an.					
□ Th	ne information on this form is correct t	o the best of my knowle	dge. I understand that if I			
int	tentionally provide false information o	n this form I will be dise	nrolled from the plan.			
	y response to this form is voluntary. H	owever, failure to respo	nd may affect enrollment in the			
pla	an.					
When	I sign below, it means that I have rea	ad and understand the	information on this form			
If I sigr	n as an authorized representative, it m	eans I have the legal rig	ht under state law to sign. I can			
show v	vritten proof (power of attorney, guard	lianship, etc.) of this rigl	nt if Medicare asks for it. I			
unders	stand that I will need to submit written	proof of this right, to the	e plan, if I wish to take action on			
	of the member beyond this applicatio		•			
	ed my UnitedHealthcare UCard®, I car	• •	• •			
	Healthcare UCard to update my author		_			
Signat	ture of applicant/member/authorize	u representative	Today's date			
If you	are the cutherized represented	tivo places sign ch	ave and complete the			
_	are the authorized representa		ove and complete the			
	nation below (*Not a Sales Age	,				
Last na	ame	First name				
Addres	SS					
City		State	Zip code			
Oity		Otato	210 0000			
Phone	number () —	Relationship to a	ipplicant			
Fnrolles	e name					
	ame/ID number					
•	RFMA_2025_C		UHCT25LP0221070_000			

Ear individuals hal	ning oprolled with		امامه	ing this form s	mh.
For individuals hel Complete this section			-	_	
members, or other thir	•	•	_		ansciors, rarring
Name		Relat	tions	hip to enrollee	
Ciaract		NIatia	I F	Dun ali i a a u Ni i ua la a u	(Asserts /Dustraus and v)
Signature		INatio	onai i	Producer Number	(Agents/Brokers only)
For Licensed Sales	s Representative/	agen	cy u	se only	
Licensed Sales represe	entative/Writing ID			Initial receipt date	Э
Licensed Sales represe	entative/agent name			Proposed effective	/e date
Employer group name					
Employer group ID			В	ranch ID	
Agent must complete			ı		
☐ IEP (MA-PD	☐ ICEP (MA enrolle	,		P (MA-PD	☐ OEP (Jan 1 –
enrollees)			enrol 2nd l	lees eligible for	Mar 31)
☐ OEP (Newly	☐ SEP (Dual LIS			P (Change in	☐ SEP (Loss of
eligible)	change of status)			ence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS			EP (October 15-	□ OEPI
☐ SEP (SEP reason) _	maintaining) December 7)				
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C					UHCT25LP0221070_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-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.

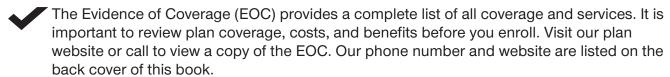
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

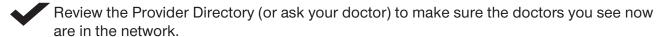
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

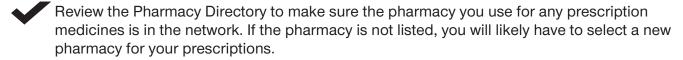
Enrollment checklist

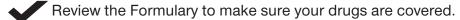
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

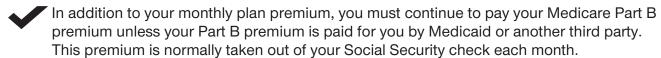


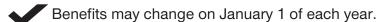


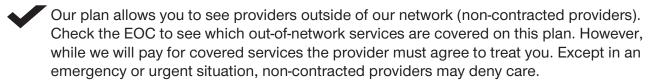




Understanding important rules







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.