

# **2025 Enrollment Request Form**

☐ UHC Dual Complete DE-S001 (HMO-POS D-SNP) H3113-011-000

Last name  Birth date  Home phone number ( )  I give consent for UnitedHealthcausing an autodialer and/or prereco  Social Security number  (Required for people who are enrol	First name  — are and its affili	Sex ☐ Male ☐ Fema			
Home phone number ( )  I give consent for UnitedHealthcausing an autodialer and/or prereco	– are and its affili				
□ I give consent for UnitedHealthcausing an autodialer and/or prereco	– are and its affili	Mobile phone number	( ) –		
using an autodialer and/or prereco	are and its affili		, –		
·		· ·	umber(s) I have provided		
(Required for people who are enrol					
	ا lling in D-SNP	olans):			
Medicare number					
Permanent residence street addres homelessness, a PO Box may be	-				
City	County	State	Zip code		
Mailing address (Only if it's differe	ent from above	e. You can give a P.O. b	ox.)		
City		State	Zip code		
Email address (optional)					
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 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 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 Railroad Retirement Board (RRB) check						
☐ I want to pay directly from a bank account						
Account type ☐ Checking ☐ Savings						
Account type in Checking in Savings  Account holder name:						
Bank routing number////						
Bank account number/////						
Dank 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?			
If you would prefer plan information in another language or accessible format, please check what you'd like: $\Box$ Spanish $\Box$ Braille $\Box$ Large print $\Box$ Audio CD $\Box$ Data CD						
Enrollee name						
Agent name/ID number Y0066_ERFMA_2025_C						

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/CommunityPlan** for online help.

2. Are you enrolled in your state Medicaid	☐ 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 Non-binary	I use a different term:I choose not to answer	
6. Which of the following best represents Lesbian or gay Straight, that is, not gay or lesbian Bisexual		
7. Do you or your spouse work?		☐ Yes ☐ No
Enrollee nameAgent name/ID numberY0066_ERFMA_2025_C		
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Do you or your spouse have other health insurance				
(Examples: Other employer group coverage, LTD				
auto liability, or Veterans benefits)  If yes, please complete the following:  Name of health insurance company  □ Yes □ No				
Member number				
8. Please give us the name of your primary care	provider (PCP), clinic or health center.			
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			
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.				
Please read and sign				
By completing this form, I agree to the following	g:			
<ul> <li>I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.</li> <li>I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information.</li> <li>I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document</li> </ul>				
Enrollee name				
Agent name/ID numberY0066_ERFMA_2025_C	UHDE25HP0220838_000			

If y inf Las	ceived my UnitedHealthcare UCard®, I can ditedHealthcare UCard to update my authorized gnature of applicant/member/authorized you are the authorized representative formation below (*Not a Sales Agent st name dress  y  one number ( ) —	representative Tod  ve, please sign above (a)  First name  State  Relationship to applic	and complete the				
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bel	half of the member beyond this application.	. After this application has b	peen approved and I have				
	ow written proof (power of attorney, guardia derstand that I will need to submit written p	. ,					
	nen I sign below, it means that I have read sign as an authorized representative, it mea						
\ <b>\/</b>		d and understand the infer	rmation on this form				
	The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan.						
	plan.						
	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						
	information (see Privacy Act Statement below).						
	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						
	apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA) plans).						
	apply for MA Private Fee-for-Service (PFF	•	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 (exception)				
	that enrollment in this plan will automatical apply for MA Private Fee-for-Service (PFF)	ally end my enrollment in ar	· , •				

(also known as a member contract or subscriber agreement) will be covered. Neither Medicare

For individuals he	lping enrollee with	ı co	mple	eting this form	only
Complete this section	if you're an individual	(i.e.	agent	s, brokers, SHIP o	-
members, or other thin	rd parties) helping an	1			
Name		Re	lations	ship to enrollee	
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sale	s Representative/	age	ncy	use only	
Licensed Sales representative/Writing ID			Initial receipt date		ate
Licensed Sales representative/agent name			Proposed effective date		tive date
Employer group name	)				
Employer group ID			E	Branch ID	
Agent must complete ☐ IEP (MA-PD enrollees) ☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ ICEP (MA enrollees ☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)		enrollees eligible for 2nd IEP)  SEP (Change in residence)  AEP (October 15-December 7)		☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI
Enrollee name Agent name/ID numbe					
Y0066_ERFMA_2025_C	1				UHDE25HP0220838_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 DE-S001 (HMO-POS 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.

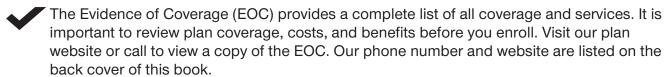
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

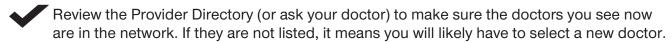
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

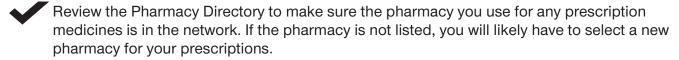
# **Enrollment checklist**

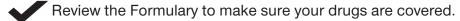
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the benefits

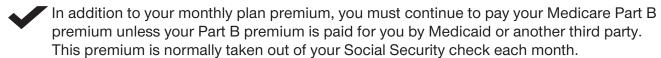


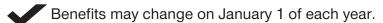


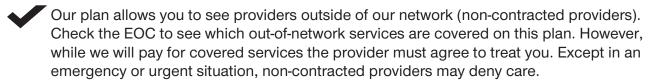




### **Understanding important rules**







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.