

2025 Enrollment Request Form

☐ UHC Dual Complete NM-Y1 (PPO D-SNP) H0294-049-000

Information about you (Please	type or prii	nt in black or l	blue ink)	
Last name	First name			Middle initial	
Birth date		Sex □ Male	□ Femal	е	
Home phone number ()	_	Mobile phone number () —			
\Box 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	g in D-SNP բ	olans):			
Medicare number					
Permanent residence street address (homelessness, a PO Box may be co	-				
City	County		State	Zip code	
Mailing address (Only if it's different	from above	e. You can give	a P.O. bo	ox.)	
City			State	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C				 JHNM25LP0221372_001	

Do you have other insurance (Examples: Other private insura programs.) If yes, what is it?		_	☐ Yes ☐ No benefits or state
Name of other insurance			
		I	T
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	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	ou want to pay it:	
☐ You can pay it from you	r 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	
\square 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 o Braille □ Large print □ Aud		•
Enrollee name			
Agent name/ID number Y0066_ERFMA_2025_C			 M25LP0221372_001

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	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, 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	White	
Other Asian	I choose not to answer	
Member/Citizen of a federal or state	recognized Tribe (name of Tribe)	
5. Do you or your spouse work?Do you or your spouse have other health ins	surance that will cover medical services?	☐ Yes ☐ No
(Examples: Other employer group coverage auto liability, or Veterans benefits) If yes, please complete the following:	e, LTD coverage, Workers' Compensatio	n, □ Yes □ No
Name of health insurance company		
Member number		
Enrollee name		
Agent name/ID number		70001270 001
Y0066_ERFMA_2025_C	UHNM25LI	P0221372_001

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6. 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 doctor who accepts Medicare and the plan's payment terms.

You can find a list on the plan website or in the Provider Directory.

Y0066_ERFMA_2025_C

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 Changes) are available online. You can access the computer, tablet or mobile phone.	·
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:
paying my Part B premium if I have one, unled I understand that people with Medicare are go the country, except for limited coverage near urgent care outside of the U.S. See the Summare I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcare unitedHealthcare and contained in my United (also known as a member contract or subscription UnitedHealthcare will pay for benefits or so I understand that I can be enrolled in only one that enrollment in this plan will automatically eapply for MA Private Fee-for-Service (PFFS), Neplans).	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 care. Benefits and services authorized by dHealthcare "Evidence of Coverage" document ber agreement) will be covered. Neither Medicare services that are not covered. Medicare Advantage (MA) plan at a time – and end my enrollment in another MA plan (exceptions MA Medicare Medical Savings Account (MSA)
 Release of information: By joining this Medic will share my information with Medicare, who 	care Advantage Plan, I acknowledge that the plan may use it to track my enrollment, to make
Enrollee nameAgent name/ID number	

payments, and for other purposes allow information (see Privacy Act Statement I give UnitedHealthcare permission to sl or person(s) for permissible purposes u plan.	below hare m). ny protected health inform	nation with organizations	
 The information on this form is correct t intentionally provide false information or My response to this form is voluntary. H plan. 	n this	form I will be disenrolled f	rom the plan.	
When I sign below, it means that I have rea	ad and	d understand the informa	ation on this form	
If I sign as an authorized representative, it m show written proof (power of attorney, guard understand that I will need to submit written behalf of the member beyond this application received my UnitedHealthcare UCard®, I can UnitedHealthcare UCard to update my authorized.	diansh proof n. Aften call (ip, etc.) of this right if Med of this right, to the plan, it er this application has bee Customer Service at the n	dicare asks for it. If I wish to take action on en approved and I have	
Signature of applicant/member/authorize	d repi	resentative Today	's date	
If you are the authorized representation below (*Not a Sales Age		please sign above an	d complete the	
Last name		First name		
Address				
City		State	Zip code	
Phone number () —		Relationship to applicant		
For individuals helping enrollee with Complete this section if you're an individual members, or other third parties) helping an en	(i.e. ag	gents, brokers, SHIP cour		
Signature		National Producer Number (Agents/Brokers only)		
Enrollee name				
Agent name/ID number			 HNM25I P0221372 001	
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For Licenseu Sales	s Representative/age	ency u	ise only			
Licensed Sales representative/Writing ID			Initial receipt date			
Licensed Sales representative/agent name			Proposed effective date			
Employer group name						
Employer group ID		В	ranch ID			
Agent must complete		•				
☐ IEP (MA-PD	☐ ICEP (MA enrollees)		P (MA-PD	□ OEP (Jan 1 -		
enrollees)		enrol 2nd I	lees eligible for EP)	Mar 31)		
☐ OEP (Newly	☐ SEP (Dual LIS		EP (Change in	☐ SEP (Loss of		
eligible)	change of status)		ence)	EGHP coverage)		
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)		EP (October 15- ember 7)	□ OEPI		
☐ SEP (SEP reason) _			•			
Licensed Sales repres	sentative signature (option	onal)	Da	ite		
	Please mail or fax this	s comp	oleted form to:			
	UnitedHe	althca	re			
	P.O. Box					
	Salt Lake City , UT 84130-0769					
Fax: 1-888-950-1169						
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	Fax: 1-888- Fax the front and b		169			
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Enrollee name		pack of	169			

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 NM-Y1 (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.

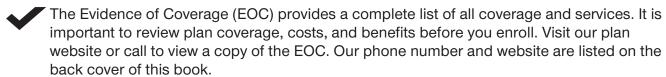
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

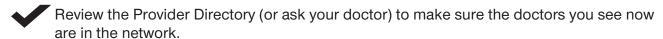
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

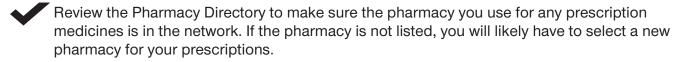
Enrollment checklist

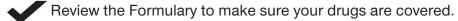
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

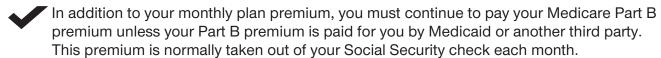


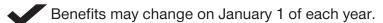


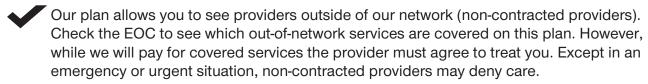




Understanding important rules







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.