

# **2025 Enrollment Request Form**

☐ UHC Dual Complete NM-S1 (PPO D-SNP) H0294-050-000

Last name	e type or print in black or blue ink				
Last Hame	riistiiaille		Middle initial		
Birth date		Sex □ Male □ Female			
Home phone number ( )	<ul> <li>Mobile phone number</li> </ul>		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 ı	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		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 name					
Agent name/ID number					
Agent name/ID number Y0066 ERFMA 2025 C				 UHNM25l	

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 y	ou a letter and ask you how yo	u 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		
☐ 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   Large print   Audi			
Enrollee name				
Agent name/ID number Y0066_ERFMA_2025_C			M25LP0221371_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	program?	☐ Yes ☐ No
If yes, please give us your Medicaid number	:	
3. Are you Hispanic, Latino/a, or Spanish  No, not of Hispanic, Latino/a, or Spanish  Yes, Mexican, Mexican American, or  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 Vietnamese Other Asian	Native Hawaiian or Pacific Islander: Guamanian or Chamorro Native Hawaiian Samoan Other Pacific Islander White I choose not to answer	
Member/Citizen of a federal or state  5. Do you or your spouse work?	recognized Tribe (name of Tribe)	□ Yes □ No
Do you or your spouse have other health ins (Examples: Other employer group coverage auto liability, or Veterans benefits)  If yes, please complete the following:  Name of health insurance company		?
Member number		
Enrollee name		
Agent name/ID number Y0066_ERFMA_2025_C		 P0221371_001

## 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.

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?
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.	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 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 or UnitedHealthcare will pay for benefits or so I understand that I can be enrolled in only one that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS), Neplans).	renerally 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 d'Healthcare "Evidence of Coverage" document ber agreement) will be covered. Neither Medicare services that are not covered.  e Medicare Advantage (MA) plan at a time – and end my enrollment in another MA plan (exceptions MA Medicare Medical Savings Account (MSA)
Enrollee nameAgent name/ID number	
Y0066_ERFMA_2025_C	UHNM25LP0221371_001

payments, and for other purposes allow information (see Privacy Act Statement  I give UnitedHealthcare permission to s or person(s) for permissible purposes uplan.	below hare n	). ny protected health inform	nation with organizations	
<ul> <li>The information on this form is correct to intentionally provide false information or My response to this form is voluntary. He plan.</li> </ul>	n this	form I will be disenrolled t	rom the plan.	
When I sign below, it means that I have re	ad and	d understand the inform	ation on this form	
If I sign as an authorized representative, it meshow 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 on. Afte n call (	ip, etc.) of this right if Med of this right, to the plan, i 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 rep	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 Name	(i.e. a	gents, brokers, SHIP cour		
Signature		National Producer Number (Agents/Brokers only)		
Enrollee name				
Agent name/ID number			 HNM25I P0221371 001	
DUDU LATIVIA 7070 C		l I	LIMINIZOFLASZ 19/ L AAL	

For Licensed Sales Representative/agency use only					
Licensed Sales representative/Writing ID			Initial receipt date		
Licensed Sales representative/agent name			Proposed effective date		
Employer group name					
Employer group ID		ı	Branch ID		
Agent must complete					
☐ IEP (MA-PD	☐ ICEP (MA enrollees)	☐ IEP (MA-PD		□ OEP (Jan 1 -	
enrollees)			ollees eligible for IEP)	Mar 31)	
☐ OEP (Newly	☐ SEP (Dual LIS	□S	EP (Change in	☐ SEP (Loss of	
eligible)	change of status)	resid	dence)	EGHP coverage)	
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)		EP (October 15- ember 7)	□ OEPI	
☐ SEP (SEP reason) _					
Licensed Sales representative signature (optional)  Date					
	Please mail or fax this	s com	pleted form to:		
	UnitedHe	althca	are		
	P.O. Box	x 3076	69		
	Salt Lake City,	UT 84	130-0769		
	Fax: 1-888	-950-1	1169		
	Fax the front and b	oack c	of each page		
Enrollee name					
Agent name/ID number					

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-S1 (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.

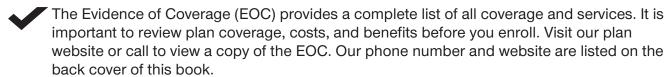
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

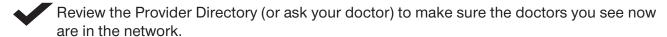
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

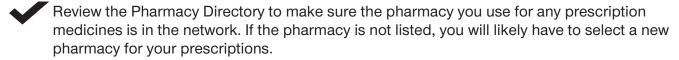
## **Enrollment checklist**

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**

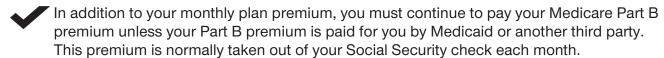






Review the Formulary to make sure your drugs are covered.

### **Understanding important rules**



- 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.