

2025 Enrollment Request Form

 \square UHC Preferred Dual Complete FL-V2 (HMO D-SNP) H1045-064-000

| 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 using an autodialer and/or prerecord | | • | hone nui | mber(s) I have provided | |
| 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 name | | | | | |
| Agent name/ID number Y0066_ERFMA_2025_C | | | | PCFL25HM0221189_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-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 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 ☐ 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? |
| | mation in another language or Braille □ Large print □ Audi | | |
| Enrollee name | | | |
| Agent name/ID number Y0066_ERFMA_2025_C | | | L25HM0221189_000 |

If you don't see the language or format you want, please call us toll-free at **1-855-874-6282**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **myPreferredCare.com** for online help.

| 2. Are you enrolled in your state Medicaid | l 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 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 nameAgent name/ID number | | |
| Y0066_ERFMA_2025_C | PCFL25HI | M0221189_000 |

| Do you or your spouse have other health insurance | e that will cover medical services? |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (Examples: Other employer group coverage, LTD | |
| auto liability, or Veterans benefits) | ☐ Yes ☐ No |
| If yes, please complete the following: Name of health insurance company | |
| Name of health insurance company | |
| 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 |
| A | 10 to 12 digits. Don't include dashes.) |
| Are you now seeing or have you recently seen this Please read and sign | s provider? |
| By completing this form, I agree to the following | n· |
| | |
| 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 prescription drug benefits from 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), Normalism (PFF | 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 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) care Advantage Plan, I acknowledge that the plan may use it to track my enrollment, to make rederal law that authorize the collection of this |
| Enrollee name | |
| Agent name/ID number | PCFL25HM0221189_000 |
| Y0066_ERFMA_2025_C | FOFLZONIVIUZZ I 109_000 |

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|-----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|
| | The information on this form is correct to intentionally provide false information of My response to this form is voluntary. H | n this | form | I will be disenrolled | from the plan. | |
| | plan. | | , iai | iaro to rospona may | | |
| Who | en I sign below, it means that I have re | ad and | d und | derstand the inform | ation on this form | |
| sho und beh rece Unit | sign as an authorized representative, it m w written proof (power of attorney, guard lerstand that I will need to submit written alf of the member beyond this application eived my UnitedHealthcare UCard®, I can tedHealthcare UCard to update my authorize mature of applicant/member/authorize | diansh proof on. Aften orizatio | ip, et of th er this Custo on inf | c.) of this right if Medis right, to the plan, is application has becomer Service at the normation on file. | dicare asks for it. I if I wish to take action on en approved and I have | |
| _ | ou are the authorized representa ormation below (*Not a Sales Age | | plea | se sign above ar | nd complete the | |
| Last name | | , | Firs | First name | | |
| Add | dress | | | | | |
| City | , | | Stat | e | Zip code | |
| Pho | Phone number () — | | Relationship to applicant | | | |
| For | r individuals helping enrollee with | n com | plet | ting this form onl | ly | |
| | nplete this section if you're an individual | • | _ | | nselors, family | |
| | mbers, or other third parties) helping an e | 1 | | | | |
| Nan | ne | Rela | tions | hip to enrollee | | |
| Signature Natio | | onal I | Producer Number (A | gents/Brokers only) | | |
| For | Licensed Sales Representative/ | agen | cy u | se only | | |
| Lice | ensed Sales representative/Writing ID | | | Initial receipt date | | |
| Lice | ensed Sales representative/agent name | | | Proposed effective date | | |
| nro | llee name | | | | | |
| \ger | nt name/ID number | | | | | |
| ุกกลด | S EREMA 2025 C | | | | OCEL 25HM0221189 000 | |

| | | | | Page 6 0 | 11 (|
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-----------|----------------------------------------------------|---------------------------|------|
| Employer group name | | | | | |
| Employer group ID | | | Branch ID | | |
| Agent must complete ☐ IEP (MA-PD enrollees) | ☐ ICEP (MA enrollees) | en | IEP (MA-PD rollees eligible for d IEP) | □ OEP (Jan 1 – Mar 31) | |
| ☐ OEP (Newly eligible) ☐ SEP (Chronic) ☐ SEP (SEP reason) | ☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining) | res De | SEP (Change in sidence) AEP (October 15-ecember 7) | EGHP coverage) | |
| Licensed Sales representative signature (optional) Date | | | | | |
| Please mail or fax this completed form to: UnitedHealthcare P.O. Box 30769 Salt Lake City, UT 84130-0769 Fax: 1-888-950-1169 Fax the front and back 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 Preferred Dual Complete FL-V2 (HMO 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.

Preferred Care Partners 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 plan is available to anyone who has both Medical Assistance from the State and Medicare.

This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

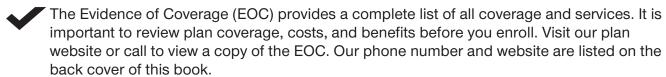
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

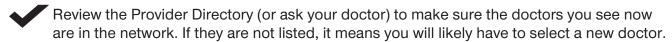
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

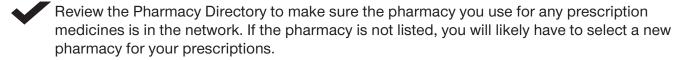
Enrollment checklist

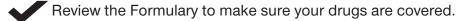
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

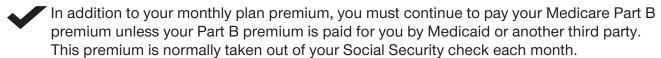




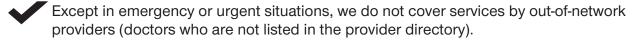


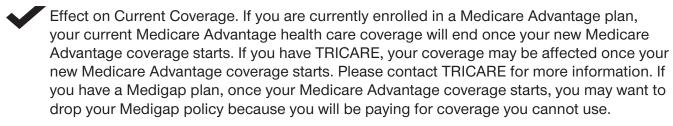


Understanding important rules









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.