

2025 Enrollment Request Form

☐ UHC Preferred Medicare Advantage FL-0001 (HMO) H1045-001-000

	rmation about you (Please type or print in black or blue in				
Last name	First name			Middle initial	
Birth date		Sex □ Male □	l Femal	e	
Home phone number ()	_	Mobile phone no	umber () –	
☐ I give consent for UnitedHealthcar using an autodialer and/or prerecord		•	ione nur	mber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be c	-				
City	County		State	Zip code	
Mailing address (Only if it's differer	nt from above	e. You can give a	P.O. bo	x.)	
City			State	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C				PCFL25HM0221220_	

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 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		•	
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C		PCFI	L25HM0221220_000	

If you don't see the language or format you want, please call us toll-free at **1-844-723-6470**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **myPreferredCare.com** for online help.

2. Are you Hispanic, Latino/a, or Spanish		
No, not of Hispanic, Latino/a, or Sp	•	
Yes, Mexican, Mexican American, c	or Chicano/a	
Yes, Puerto Rican		
Yes, Cuban		
Yes, another Hispanic, Latino, or Sp	oanish origin	
I choose not to answer		
3. What's your race? Select all that apply	•	
American Indian or Alaska Native	Black or African American	
Asian:	Native Hawaiian or Pacific Islander:	
Asian Indian	Guamanian or Chamorro	
Chinese	Native Hawaiian	
Filipino	Samoan	
Japanese	Other Pacific Islander	
Korean		
Vietnamese	White	
Other Asian	I choose not to answer	
Member/Citizen of a federal or state	e recognized Tribe (name of Tribe)	
4. What is your gender? Select one.		
Woman	I use a different term:	
Man		
Non-binary	I choose not to answer	
5. Which of the following best represents	s how you think of yourself? Select one.	
Lesbian or gay	I use a different term:	
Straight, that is, not gay or lesbian	I don't know	
Bisexual	I choose not to answer	
6. Do you or your spouse work?		☐ Yes ☐ No
Do you or your spouse have other health in	surance that will cover medical services?	
(Examples: Other employer group coverage		
auto liability, or Veterans benefits)		☐ Yes ☐ No
If yes, please complete the following:		_ 100 _ 110
Enrollee name		
Enrollee nameAgent name/ID number		
VOICE EREMA 2025 C	PCFL 25HM02	221220 000

Name of health insurance company				
Member number				
7. Please give us the name of your primary car	e provider (PCP), clinic or health center.			
You can find a list on the plan website or in the P	rovider Directory.			
Provider or PCP full name				
Provider/PCP number	(Please enter the number exactly as it appears on			
. To had, i or hamber	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 th	is provider? ☐ Yes ☐ No			
Please read and sign				
By completing this form, I agree to the following	ng:			
paying my Part B premium if I have one, unled the country, except for limited coverage neadurgent care outside of the U.S. See the Sum I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealth UnitedHealthcare and contained in my United (also known as a member contract or subscription UnitedHealthcare will pay for benefits or I understand that I can be enrolled in only or that enrollment in this plan will automatically	generally not covered under Medicare while out of at the U.S. border. This plan covers emergency and mary of Benefits for more information. Ecoverage begins, I must get all of my medical and neare. Benefits and services authorized by adHealthcare "Evidence of Coverage" document riber agreement) will be covered. Neither Medicare			
will share my information with Medicare, who payments, and for other purposes allowed b information (see Privacy Act Statement below	y Federal law that authorize the collection of this w).			
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 plan.				
 The information on this form is correct to the intentionally provide false information on this 	s form I will be disenrolled from the plan.			
My response to this form is voluntary. However plan.	ver, failure to respond may affect enrollment in the			
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C	PCFL25HM0221220_000			

Today's date

When I sign below, it means that I have read and understand the information on this form

Signature of applicant/member/authorized representative

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file.

information below (*Not a Sales A			
Last name	First	First name	
Address			
City	Stat	е	Zip code
Phone number () -	Rela	Relationship to applicant	
For individuals helping enrollee w	vith complet	ina this form onl	V
For individuals helping enrollee we Complete this section if you're an individ members, or other third parties) helping a	ual (i.e. agents an enrollee fill	out this form.	
Complete this section if you're an individ	ual (i.e. agents an enrollee fill	, brokers, SHIP cour	
Complete this section if you're an individ members, or other third parties) helping	ual (i.e. agents an enrollee fill Relationsh	out this form.	nselors, family
Complete this section if you're an individ members, or other third parties) helping a Name	ual (i.e. agents an enrollee fill Relationsh National F	e, brokers, SHIP cour out this form. hip to enrollee Producer Number (A	nselors, family
Complete this section if you're an individ members, or other third parties) helping a Name Signature	nal (i.e. agents an enrollee fill Relations! National F	e, brokers, SHIP cour out this form. hip to enrollee Producer Number (A	nselors, family

Employer group name					
Employer group ID			Branch ID		
Agent must complete					
☐ IEP (MA-PD	☐ ICEP (MA enrollees)		IEP (MA-PD	□ OEP (Jan 1 -	
enrollees)		enrollees eligible for		Mar 31)	
		2n	d IEP)		
☐ OEP (Newly	☐ SEP (Dual LIS		SEP (Change in	☐ SEP (Loss of	
eligible)	change of status)	` •		EGHP coverage)	
☐ SEP (Chronic)	☐ SEP (Dual LIS			□ OEPI	
	maintaining)	De	cember 7)		
☐ SEP (SEP reason) _					
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, 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 Medicare Advantage FL-0001 (HMO) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. 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. 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.

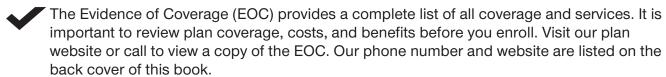
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

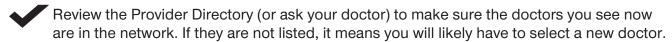
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

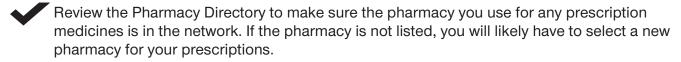
Enrollment checklist

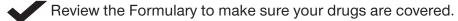
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





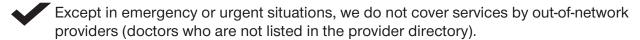




Understanding important rules







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.