

2025 Enrollment Request Form

☐ UHC Preferred Medicare Advantage FL-002P (HMO) H1045-037-000

Information about you (Please	type or pri	nt in black or b	lue ink		
Last name	First name			Middle initial	
		T			
Birth date		Sex □ Male □] Femal	е	
Home phone number ()	_	Mobile phone n	umber () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	none nur	mber(s) I have provided	
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 different from above. You can give a P.O. box.)					
City			State	Zip code	
Email address (optional)		,			
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C				PCFL25HM0221208_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 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 you a letter and ask you how you 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 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 or Braille		•	
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C		PCFI	L25HM0221208_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 Spa	•	
Yes, Mexican, Mexican American, o	r Chicano/a	
Yes, Puerto Rican		
Yes, Cuban		
Yes, another Hispanic, Latino, or Sp	panish origin	
I choose not to answer		
0. W/s-sN		
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	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	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
		<u> </u>
Do you or your spouse have other health ins		
(Examples: Other employer group coverage	e, LID coverage, workers' Compensation,	
auto liability, or Veterans benefits)		☐ Yes ☐ No
If yes, please complete the following:		
Enrollee name		
Agent name/ID number		
Y0066_ERFMA_2025_C	PCFL25HM0	221208_000

Name of health insurance company	
Member number	
7. Please give us the name of your primary ca	re provider (PCP), clinic or health center.
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 t	his provider? ☐ Yes ☐ No
Please read and sign	
By completing this form, I agree to the follow	ing:
paying my Part B premium if I have one, understand that people with Medicare are the country, except for limited coverage neurgent care outside of the U.S. See the Sur I understand that when my UnitedHealthcar prescription drug benefits from UnitedHealthcare understand that ontained in my UnitedHealthcare and contained in my UnitedHealthcare will pay for benefits on UnitedHealthcare will pay for benefits of I understand that I can be enrolled in only of that enrollment in this plan will automatically	e generally not covered under Medicare while out of ar the U.S. border. This plan covers emergency and mmary of Benefits for more information. re coverage begins, I must get all of my medical and thcare. Benefits and services authorized by edHealthcare "Evidence of Coverage" document criber agreement) will be covered. Neither Medicare
will share my information with Medicare, who payments, and for other purposes allowed information (see Privacy Act Statement below I give UnitedHealthcare permission to share	my protected health information with organizations
or person(s) for permissible purposes under plan.	er applicable law as required to administer my health
intentionally provide false information on th	ie best of my knowledge. I understand that if I is form I will be disenrolled from the plan. ever, failure to respond may affect enrollment in the
Enrollee name	
Agent name/ID number	
Y0066_ERFMA_2025_C	PCFL25HM0221208_000

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

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.

Signature of applicant/member/authorize	d represer	ntative Today	's date	
If you are the authorized representa	tive, plea	se sign above an	d complete the	
information below (*Not a Sales Age	nt)			
Last name	Firs	First name		
Address	I			
City	Stat	te	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 and Name	(i.e. agents enrollee fill	s, brokers, SHIP cour		
Signature	National F	nal Producer Number (Agents/Brokers only)		
For Licensed Sales Representative/	agency u	se only		
Licensed Sales representative/Writing ID		Initial receipt date		
Licensed Sales representative/agent name		Proposed effective date		
Enrollee nameAgent name/ID number			CFL25HM0221208 000	

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)	res	sidence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS		AEP (October 15-	☐ 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-002P (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.

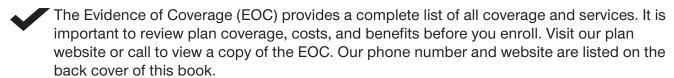
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

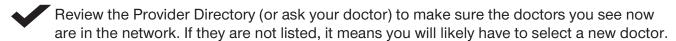
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

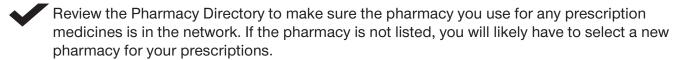
Enrollment checklist

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





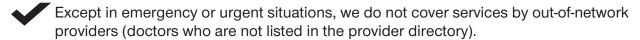


Review the Formulary to make sure your drugs are covered.

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.