

2025 Enrollment Request Form

 \square UHC Preferred Dual Complete FL-D001 (HMO D-SNP) H1045-012-000

Information about you (Please type or print in black or blue ink)				
Last name	First name		Middle initial	
Birth date		Sex ☐ Male	☐ Femal	e
Home phone number ()	 Mobile phone number 		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 բ	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	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)			l	
Enrollee nameAgent name/ID numberY0066_ERFMA_2025_C				PCFL25HM0221218 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 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 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 Railroad Retirement Board (RRB) check			
☐ 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			 L25HM0221218_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	d 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	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 6. 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		

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 fleath 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 Pro	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
Are you now easing or hove you recently each this	10 to 12 digits. Don't include dashes.) sprovider? ☐ Yes ☐ No
Are you now seeing or have you recently seen this Please read and sign	provider? Lifes Lino
By completing this form, I agree to the following	3 :
paying my Part B premium if I have one, unless I understand that people with Medicare are gother the country, except for limited coverage near urgent care outside of the U.S. See the Summ I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcare unitedHealthcare and contained in my United (also known as a member contract or subscribe nor UnitedHealthcare will pay for benefits or see 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), New plans). Release of information: By joining this Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below I give UnitedHealthcare permission to share means.)	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and nary of Benefits for more information. coverage begins, I must get all of my medical and care. Benefits and services authorized by linealthcare "Evidence of Coverage" document ber agreement) will be covered. Neither Medicare services that are not covered. Experiment in another MA plan (exceptions of MA Medicare Medical Savings Account (MSA) Care Advantage Plan, I acknowledge that the plan may use it to track my enrollment, to make Federal law that authorize the collection of this
Enrollee nameAgent name/ID number	
Y0066_ERFMA_2025_C	PCFL25HM0221218_000

 The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan. My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. 				
When I sign below, it means that I have read 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 Signature of applicant/member/authorized If you are the authorized representation.	eans I havianship, e proof of the n. After the call Custerization in d represe	re the legal right under tc.) of this right if Med his right, to the plan, it is application has been omer Service at the number of the formation on file.	r state law to sign. I can dicare asks for it. I f I wish to take action on en approved and I have umber on my	
information below (*Not a Sales Ager	nt)	-	-	
Last name	Fir	First name		
Address	l			
City	Sta	ate	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 environment	(i.e. agent enrollee fil	s, brokers, SHIP cour		
Signature	National Producer Number (Agents/Brokers only)			
For Licensed Sales Representative/a	agency	1		
Licensed Sales representative/Writing ID		Initial receipt date		
Licensed Sales representative/agent name		Proposed effective date		
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C			CFL25HM0221218_000	

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Employer group name		,	
Employer group ID		Branch ID	
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PD enrollees eligible for 2nd IEP)	□ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic) ☐ SEP (SEP reason)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	☐ SEP (Change in residence) ☐ AEP (October 15-December 7)	☐ SEP (Loss of EGHP coverage) ☐ OEPI
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			

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-D001 (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.

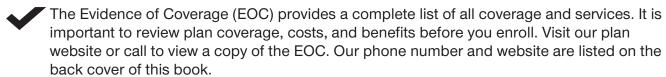
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

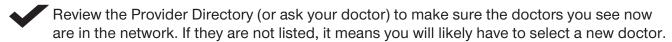
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

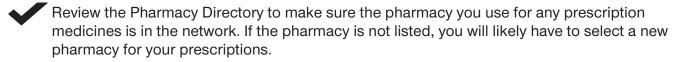
Enrollment checklist

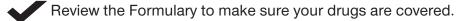
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

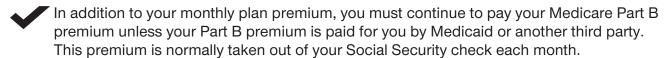








Understanding important rules



- Benefits may change on January 1 of each year.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- 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.