

# **2025 Enrollment Request Form**

☐ UHC Preferred Medicare Advantage FL-0002 (HMO) H1045-005-000

Information about you (Places	type or pri	nt in black or b	luo ink)		
Information about you (Please		III III DIACK OF D	iue irik)		
Last name	First name			Middle initial	
Birth date	Sex ☐ Male ☐ Femal		e 		
Home phone number ( )	_	Mobile phone 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.					
Medicare number	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 differen	t from above	e. You can give a	P.O. bo	x.)	
City		;	State	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number				DOEL 05UM0001010 000	
Y0066_ERFMA_2025_C				PCFL25HM0221219_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.	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	L25HM0221219_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		
·	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:	_ 755 _ 716	
Farallas assas		
Agent name/ID number	PCEL 25HM0221210 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 of 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 the	s provider? ☐ Yes ☐ No		
Please read and sign			
By completing this form, I agree to the following	ıg:		
paying my Part B premium if I have one, unled I understand that people with Medicare are go 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 UnitedHealthcare and contract or subscription UnitedHealthcare will pay for benefits or I understand that I can be enrolled in only on that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS), plans).  Release of information: By joining this Medwill share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below	generally not covered under Medicare while out of r 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 locare. Benefits and services authorized by dHealthcare "Evidence of Coverage" document riber agreement) will be covered. Neither Medicare services that are not covered.  The Medicare Advantage (MA) plan at a time – and end my enrollment in another MA plan (exceptions MA Medicare Medical Savings Account (MSA)  The icare Advantage Plan, I acknowledge that the plan of may use it to track my enrollment, to make by Federal law that authorize the collection of this		
·	applicable law as required to administer my health		
intentionally provide false information on this  My response to this form is voluntary. However, plan.	form I will be disenrolled from the plan. ver, failure to respond may affect enrollment in the		
Enrollee name			
Agent name/ID number Y0066_ERFMA_2025_C	PCFL25HM0221219_000		
	. 55522 12.15_500		

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.

<b>information below</b> (*Not a Sales A			
Last name	First n	First name	
Address			
City	State		Zip code
Phone number ( ) —	Relation	Relationship to applicant	
For individuals helping enrollee v Complete this section if you're an individ	lual (i.e. agents, b	orokers, SHIP cour	
	lual (i.e. agents, b an enrollee fill ou	orokers, SHIP cour	
Complete this section if you're an indivice members, or other third parties) helping	lual (i.e. agents, b an enrollee fill ou Relationship	orokers, SHIP cour ut this form. o to enrollee	
Complete this section if you're an individual members, or other third parties) helping Name	lual (i.e. agents, b an enrollee fill ou Relationship National Pro	orokers, SHIP cour ut this form. o to enrollee oducer Number (A	nselors, family
Complete this section if you're an individual members, or other third parties) helping Name Signature	National Prove/agency use	orokers, SHIP cour ut this form. o to enrollee oducer Number (A	nselors, family

		Branch ID			
☐ ICEP (MA enrollees)		IEP (MA-PD	□ OEP (Jan 1 -		
		•	Mar 31)		
☐ SEP (Dual LIS	,		☐ SEP (Loss of		
change of status)	residence)		EGHP coverage)		
☐ SEP (Dual LIS	☐ AEP (October 15-		□ OEPI		
maintaining)	December 7)				
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					
	☐ ICEP (MA enrollees)  ☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)  Sentative signature (option of the property of the pro	ICEP (MA enrollees)  en  2n  SEP (Dual LIS  change of status)  SEP (Dual LIS  maintaining)  Desertative signature (optional  Please mail or fax this co  UnitedHealth  P.O. Box 303  Salt Lake City, UT 8  Fax: 1-888-950	□ ICEP (MA enrollees) □ IEP (MA-PD enrollees eligible for 2nd IEP) □ SEP (Dual LIS □ SEP (Change in residence) □ SEP (Dual LIS □ AEP (October 15-maintaining) □ December 7)  Sentative signature (optional)  Please mail or fax this completed form to:		

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-0002 (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.

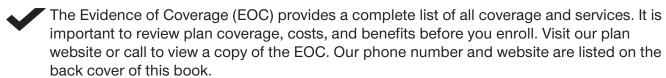
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

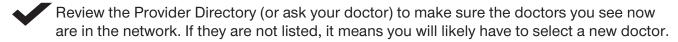
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

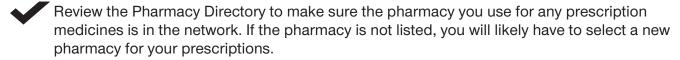
## **Enrollment checklist**

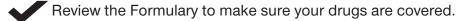
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the benefits









### **Understanding important rules**





