

# **2025 Enrollment Request Form**

 $\square$  UHC Preferred Complete Care FL-0003 (HMO C-SNP) H1045-018-000

Information about you (Please	type or pri	nt in black or	blue ink	)	
Last name	First name			Middle initial	
Birth date		Sex □ Male	□ Femal	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					
Permanent residence street address homelessness, a PO Box may be co	-			-	
City	County	County 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					
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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-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				
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If you don't see the language or format you want, please call us toll-free at **1-855-548-1564**, 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)	s, Erb coverage, workers compensation,	☐ Yes ☐ No			
If yes, please complete the following:					
Enrollee name					
Enrollee nameAgent name/ID number	·				
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Name of health insurance company	
Member number	
7. Please give us the name of your primary care	e provider (PCP), clinic or health center.
You can find a list on the plan website or in the Pr	
D	
Provider or PCP full name Provider/PCP number	(Please enter the number exactly as it appears on
Trovidely For Humber	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 this	s provider?
Please read and sign	
By completing this form, I agree to the followin	g:
paying my Part B premium if I have one, unlead 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 UnitedHealth UnitedHealthcare and contained in my United (also known as a member contract or subscription of 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), I plans).  Release of information: By joining this Medi will share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below I give UnitedHealthcare permission to share reor person(s) for permissible purposes under plan.  The information on this form is correct to the intentionally provide false information on this	generally 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 d'Healthcare "Evidence of Coverage" document diber 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 a Federal law that authorize the collection of this who my protected health information with organizations applicable law as required to administer my health best of my knowledge. I understand that if I
Enrollee nameAgent name/ID number	
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Todav's date

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

Signature of applicant/member/authorized representative

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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.

If you are the authorized represe	entative, please sign a	above and complete the		
information below (*Not a Sales a	Agent)			
Last name	First name	irst name		
Address	I			
City	State	Zip code		
Phone number ( ) —	Relationship t	lationship to applicant		
For individuals helping enrollee	with completing this	form only		
For individuals helping enrollee		-		
Complete this section if you're an indivimembers, or other third parties) helping	dual (i.e. agents, brokers, g an enrollee fill out this fo	SHIP counselors, family rm.		
Complete this section if you're an indivi	dual (i.e. agents, brokers,	SHIP counselors, family rm.		
Complete this section if you're an indivimembers, or other third parties) helping	dual (i.e. agents, brokers, g an enrollee fill out this fo Relationship to enro	SHIP counselors, family rm. ollee		
Complete this section if you're an indivimembers, or other third parties) helping Name	dual (i.e. agents, brokers, g an enrollee fill out this fo Relationship to enro	SHIP counselors, family rm.		
Complete this section if you're an indivimembers, or other third parties) helping Name  Signature	dual (i.e. agents, brokers, g an enrollee fill out this fo Relationship to enrollee National Producer Nive/agency use only	SHIP counselors, family rm. ollee Number (Agents/Brokers only)		
Complete this section if you're an indiving members, or other third parties) helping Name  Signature  For Licensed Sales Representation	dual (i.e. agents, brokers, g an enrollee fill out this fo Relationship to enrollee National Producer Notes agency use only Description Initial recommendation of the Production of the Producti	SHIP counselors, family rm. ollee Number (Agents/Brokers only)		

Employer group name				
Employer group ID			Branch ID	
Agent must complete				
☐ IEP (MA-PD	☐ ICEP (MA enrollees)		IEP (MA-PD	□ OEP (Jan 1 -
enrollees)		en	rollees 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	ecember 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, 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 Complete Care FL-0003 (HMO C-SNP) 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 plan is available to anyone having a qualifying chronic care condition.

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

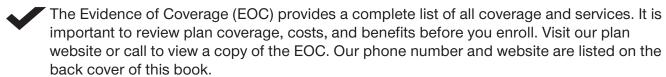
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

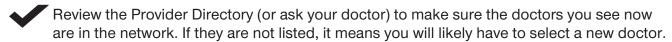
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

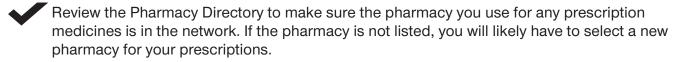
## **Enrollment checklist**

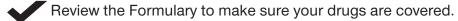
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the benefits





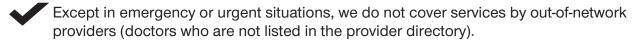




### **Understanding important rules**







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.

This plan is a Chronic Condition Special Needs Plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.