

2025 Enrollment Request Form

☐ UHC Preferred Dual Complete FL-Y3 (HMO-POS D-SNP) H1045-065-000

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 nu		number	() –	
\Box 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 ı	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 Sta		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					
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Do you have other insurance (Examples: Other private insura programs.) If yes, what is it?		_	☐ Yes ☐ No a 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 eac Electronic Funds Transfer (EFT	c deduction from your Social S ch month. You can also pay fro	Security or Railroa	ad 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 you a letter and ask you how you want to pay it:				
☐ You can pay it from your SS check				
□ Medicare can bill you				
☐ The Railroad Retirement 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	ıs manage vour plan			
1. Would you prefer plan info	• • •	or an accessible	format?	
	rmation in another language o Braille □ Large print □ Aud		•	
Enrollee name				
Agent name/ID number Y0066_ERFMA_2025_C			 FL25HP0221188_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	l 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 or 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	I choose not to answer	
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 that will cover medical services?			
(Examples: Other employer group coverage, LTD coverage, Workers' Compensation,			
auto liability, or Veterans benefits)	☐ Yes ☐ No		
If yes, please complete the following: Name of health insurance company			
Name of health 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 10 to 12 digits. Don't include dashes.)		
Are you now socing or have you recently soon this	,		
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	<u>ı</u> :		
paying my Part B premium if I have one, unless I understand that people with Medicare are go 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 prescription drug benefits from UnitedHealthcare understand in my United (also known as a member contract or subscription or UnitedHealthcare will pay for benefits or so I understand that I can be enrolled in only one that enrollment in this plan will automatically exapply for MA Private Fee-for-Service (PFFS), No 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 no or person(s) for permissible purposes under a plan.	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 IHealthcare "Evidence of Coverage" document ber 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 Federal law that authorize the collection of this of). In protected health information with organizations applicable law as required to administer my health		
Enrollee nameAgent name/ID number			
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 The information on this form is correct to intentionally provide false information or My response to this form is voluntary. He plan. 	n this for	m I will be disenrolled	from the plan.	
When I sign below, it means that I have re				
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	ed repres	entative Today	y's date	
If you are the authorized representation below (*Not a Sales Age		ease sign above ar	nd complete the	
Last name		First name		
Address				
City	St	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	(i.e. ager enrollee f	nts, brokers, SHIP cou ill out this form.		
Name	Relationship to enrollee			
Signature National Producer Number (Agents/Bro		agents/Brokers only)		
For Licensed Sales Representative/	agency	use only		
Licensed Sales representative/Writing ID		Initial receipt date		
Licensed Sales representative/agent name		Proposed effective date		
Enrollee name				
Agent name/ID number			DOEL OF LIDOUS 4 4 5 5 5 5 5	
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Employer group name					
Employer group ID			Branch ID		
Agent must complete ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	en	IEP (MA-PD rollees eligible for d IEP)	□ OEP (Jan 1 – Mar 31)	
☐ OEP (Newly eligible) ☐ SEP (Chronic) ☐ SEP (SEP reason)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	res De	SEP (Change in sidence) AEP (October 15-cember 7)	EGHP coverage)	
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					

Enrollee name	
Agent name/ID number	
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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-Y3 (HMO-POS 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.

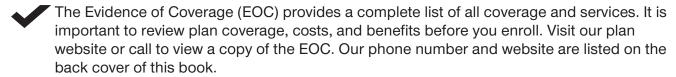
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

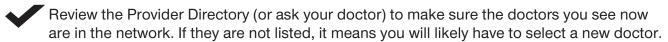
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

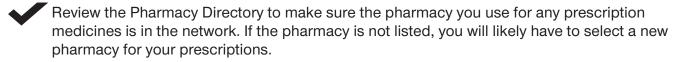
Enrollment checklist

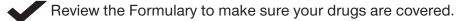
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

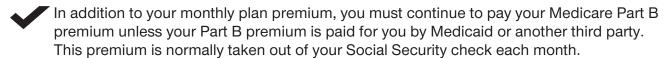








Understanding important rules



- Benefits may change on January 1 of each year.
- Our plan allows you to see providers outside of our network (non-contracted providers). Check the EOC to see which out-of-network services are covered on this plan. However, while we will pay for covered services the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care.
- 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.