

2025 Enrollment Request Form

☐ UHC MedicareMax Medicare Advantage FL-0028 (HMO) H5420-001-000

Information about you (Dlassa	tuno or pri	nt in blook or b	المام نصاد		
	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 		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		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				PNFL25HM0220578_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		PNFI	L25HM0220578_000

If you don't see the language or format you want, please call us toll-free at **1-844-723-6471**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **PCNhealth.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	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, ETB coverage, Workers Compensation,	☐ Yes ☐ No	
If yes, please complete the following:		_ 100 _ 110	
Enrollee name			
Enrollee nameAgent name/ID number			
V0066 EREMA 2025 C	DNEL 25HM0	220578 000	

Name of health insurance company	
Member number	
7. Please give us the name of your primary ca	are 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	this provider?
Please read and sign	
By completing this form, I agree to the follow	ving:
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 Sulunderstand that when my UnitedHealthca prescription drug benefits from UnitedHealthcare unitedHealthcare and contained in my UnitedHealthcare and contract or substant unitedHealthcare will pay for benefits of I understand that I can be enrolled in only of that enrollment in this plan will automatical	are coverage begins, I must get all of my medical and lthcare. Benefits and services authorized by tedHealthcare "Evidence of Coverage" document scriber agreement) will be covered. Neither Medicare
will share my information with Medicare, w payments, and for other purposes allowed information (see Privacy Act Statement bel I give UnitedHealthcare permission to share	edicare Advantage Plan, I acknowledge that the plan tho may use it to track my enrollment, to make by Federal law that authorize the collection of this low). The my protected health information with organizations applicable law as required to administer my health
plan.	
intentionally provide false information on the	he best of my knowledge. I understand that if I nis 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	

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/authorized representative Today's date				
If you are the authorized representa information below (*Not a Sales Age	· •	se sign above an	d complete the	
Last name	·	t name		
Address				
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 an experience of the complete this section if you're an individual members, or other third parties in the complete this section if you're an individual members, or other third parties in the complete this section if you're an individual members, or other third parties in the complete this section if you're an individual members, or other third parties in the complete this section is section if you're an individual members, or other third parties in the complete third parties in the co			selors, family	
Name	Relationship to enrollee			
Signature	National I	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		
		I		
Enrollee name				
Agent name/ID number			NFL25HM0220578 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	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 MedicareMax Medicare Advantage FL-0028 (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 Network 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.

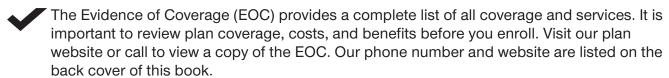
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

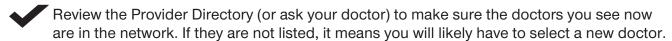
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

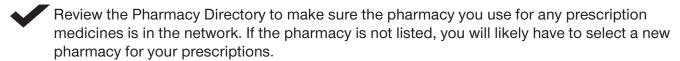
Enrollment checklist

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





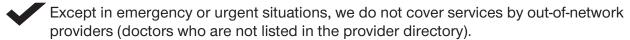




Understanding important rules







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.