

2025 Enrollment Request Form

☐ UHC MedicareMax Complete Care FL-30 (HMO C-SNP) H5420-014-000

Information about you (Dlagge	+	atia black ar bl	المنامان		
Information about you (Please	T	nt in black or bi	iue ink)	·	
Last name	First name			Middle initial	
Birth date		Sex □ Male □ Female			
Home phone number ()	 Mobile phone number 		umber () —	
☐ 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 (Don't enter a P.O. box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address)					
City	County	5	State	Zip code	
Mailing address (Only if it's differen	t from above	e. You can give a	P.O. bo	x.)	
City		5	State	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C				 PNFL25HM0220575_000	
TUUUU_ENFIVIA_ZUZU_U			1	FINFL23FINU22U3/3_UUU	

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 premium (including any late enrollment penalty you may owe), you can pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT).					
If you don't choose an option b	pelow, 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	ou want to pay it:			
☐ You can pay it from you	r SS check				
☐ Medicare can bill you					
The Railroad Retirement	t Board (RRB) can bill you				
\square 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 information in another language or an accessible format?					
If you would prefer plan information in another language or accessible format, please check what you'd like: ☐ Spanish ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD					
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C		PNFI	L25HM0220575_000		

If you don't see the language or format you want, please call us toll-free at **1-855-656-9531**, 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	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:		0010			
Enrollee name					
Enrollee nameAgent name/ID number					
V0066 EREMA 2025 C	DNEL 25HM0	220575 000			

Name of health insurance company				
Member number				
7. Please give us the name of your primary ca	re provider (PCP), clinic or health center.			
You can find a list on the plan website or in the F	Provider 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 th				
Please read and sign	no providor.			
By completing this form, I agree to the followi	ng:			
paying my Part B premium if I have one, und I understand that people with Medicare are the country, except for limited coverage nea urgent care outside of the U.S. See the Sum I understand that when my UnitedHealthcar prescription drug benefits from UnitedHealt UnitedHealthcare and contained in my Unite (also known as a member contract or subsc nor UnitedHealthcare will pay for benefits of I understand that I can be enrolled in only of that enrollment in this plan will automatically	generally not covered under Medicare while out of ar the U.S. border. This plan covers emergency and nmary of Benefits for more information. e coverage begins, I must get all of my medical and hcare. Benefits and services authorized by edHealthcare "Evidence of Coverage" document criber agreement) will be covered. Neither Medicare			
 Release of information: By joining this Med will share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement belowed I give UnitedHealthcare permission to share 	dicare Advantage Plan, I acknowledge that the plan to may use it to track my enrollment, to make by Federal law that authorize the collection of this bw). The my protected health information with organizations or applicable law as required to administer my health			
plan.The information on this form is correct to the intentionally provide false information on this	e best of my knowledge. I understand that if I			
Enrollog namo				
Enrollee name Agent name/ID number				
Y0066_ERFMA_2025_C	PNFL25HM0220575_000			

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.

information below (*Not a Sales A	,		
Last name	First name)	
Address			
City	State		Zip code
Phone number () —	Relationsl	Relationship to applicant	
For individuals helping enrollee vector of the complete this section if you're an individual members, or other third parties) helping	dual (i.e. agents, brok	ers, SHIP cou	-
	dual (i.e. agents, brok	ers, SHIP cou s form.	-
Complete this section if you're an individual members, or other third parties) helping	dual (i.e. agents, brok an enrollee fill out th Relationship to	ers, SHIP coul s form. enrollee	-
Complete this section if you're an individual members, or other third parties) helping Name	dual (i.e. agents, brok an enrollee fill out th Relationship to National Produc	ers, SHIP coul s form. enrollee cer Number (A	nselors, family
Complete this section if you're an individual members, or other third parties) helping Name Signature	dual (i.e. agents, brok an enrollee fill out th Relationship to National Productive/agency use or	ers, SHIP coul s form. enrollee cer Number (A	nselors, family

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)		
\square SEP (SEP reason) $_$					
Licensed Sales representative signature (optional) Date					
Diago mail or fay this completed form to:					
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 Complete Care FL-30 (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 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 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.

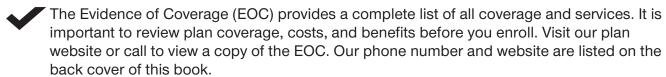
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

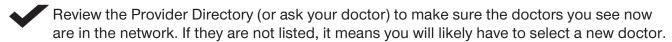
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

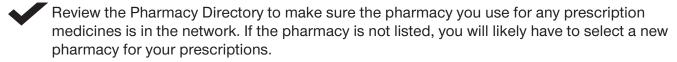
Enrollment checklist

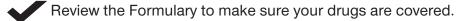
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





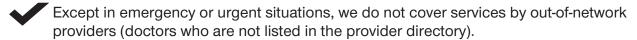


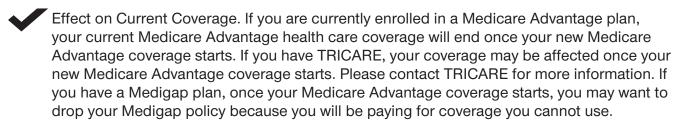


Understanding important rules









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.