

2025 Enrollment Request Form

☐ UHC MedicareMax Dual Complete FL-V3 (HMO D-SNP) H5420-015-000

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	number	() –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			ohone nui	mber(s) I have provided	
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		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 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	pecause 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 eac Electronic Funds Transfer (EFT	c deduction from your Social S ch month. You can also pay fro	Security or Railroa	nd 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-Income Related Monthly Adjustment Amount (Part D-IRMAA),			
Social Security (SS) will send y	ou a letter and ask you how yo	ou 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 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	ıs manage your plan		
1. Would you prefer plan info	• • •	or an accessible	format?
	rmation in another language of Braille Large print Aud		•
Enrollee name			
Agent name/ID number Y0066_ERFMA_2025_C			 L25HM0220574_000

If you don't see the language or format you want, please call us toll-free at **1-866-367-7525**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **PCNhealth.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 I choose not to answer	anish origin r 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-binary6. Which of the following best representsLesbian or gayStraight, that is, not gay or lesbianBisexual	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		
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auto liability, or Veterans benefits) If yes, please complete the following: 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 Provider Directory. Provider or PCP full name Provider/PCP number (Please enter the number exactly as it appears of the plan website or in the		you or your spouse have other health insuranc amples: Other employer group coverage, LTD			
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 Provider Directory. Provider or PCP full name Provider/PCP number		If yes, please complete the following:			
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Provider/PCP number	Υοι	can find a list on the plan website or in the Pro	ovider Directory.		
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plan. Enrollee name		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 UnitedHealthcare will pay for benefits or so I understand that I can be enrolled in only one that enrollment in this plan will automatically eapply 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.	ess Medicaid or someone else pays for it. 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 dHealthcare "Evidence of Coverage" document liber agreement) will be covered. Neither Medicare services that are not covered. e 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 y Federal law that authorize the collection of this y). my protected health information with organizations applicable law as required to administer my health		

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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	rm I will be disenrolled	from the plan.
When I sign below, it means that I have rea	ad and ι	understand the inform	ation on this form
If I sign as an authorized representative, it meshow written proof (power of attorney, guard understand that I will need to submit written behalf of the member beyond this application received my UnitedHealthcare UCard®, I can UnitedHealthcare UCard to update my authorized.	lianship, proof of n. After n call Cu	etc.) of this right if Me this right, to the plan, this application has be stomer Service at the r	dicare asks for it. I if I wish to take action on en approved and I have
Signature of applicant/member/authorized	d repres	sentative Today	y's date
If you are the authorized representation information below (*Not a Sales Ager	_	ease sign above aı	nd complete the
Last name		irst name	
Address			
			,
City	S	State	Zip code
Phone number () —	F	Relationship to applicar	nt
		lating this favor on	h.,
For individuals helping enrollee with Complete this section if you're an individual	_	_	
members, or other third parties) helping an e			nooro, rarriny
Name		nship to enrollee	
Signature Natio		onal Producer Number (Agents/Brokers only)	
For Licensed Sales Representative/a	agency	use only	
Licensed Sales representative/Writing ID		Initial receipt date	
Licensed Sales representative/agent name		Proposed effective date	
Enrollee name		1	
Agent name/ID number			
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				Page 6 01 0
Employer group name				
Employer group ID			Branch ID	
Agent must complete				
☐ IEP (MA-PD	☐ ICEP (MA enrollees)		IEP (MA-PD	□ OEP (Jan 1 –
enrollees)	,		rollees eligible for	Mar 31)
,			d IEP)	,
☐ OEP (Newly	☐ SEP (Dual LIS		SEP (Change in	☐ SEP (Loss of
eligible)	change of status)		sidence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS		AEP (October 15-	• ,
_ 021 (011101110)	maintaining)		cember 7)	_ 01
□ SEP (SEP reason)			,	
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	

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 Dual Complete FL-V3 (HMO 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 Network 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.

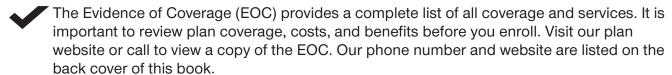
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

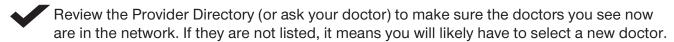
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

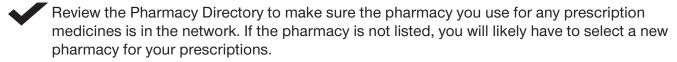
Enrollment checklist

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

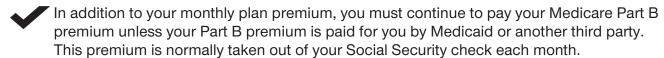








Understanding important rules



- Benefits may change on January 1 of each year.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- 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.