

2024 Enrollment Request Form

☐ UHC Preferred Dual Complete FL-D01P (HMO D-SNP) H1045-038-000 - B6N

Information about y	ou (Please	e type or print in	black or blu	e ink)	
Last name		First name			Middle initial
Birth date			Sex □ Ma	ıle □ Fer	nale
Home phone number (ome phone number () -		Mobile phone number () -		
Social Security number (Required for people wh	o are enro	lling in D-SNP pl	ans):	-	-
Medicare number					
Permanent residence str	reet addres	ss (P.O. box is n	ot allowed)		
City	Co	ounty		State	ZIP code
Mailing address (Only if	it's differe	ent from above.	You can giv	e a P.O. b	oox.)
City				State	ZIP code
Email address (optional)					
Do you have other insura	ance that	will cover your p	prescription	drugs?	□ Yes □ No
(Examples: Other private programs.) If yes, what is it?	insurance,	TRICARE, fede	ral employee	coverage	e, VA benefits or state
Name of other insurance)				
Member number	Gr	oup number	R	xBin	RxPCN (optional)
Answering these questior them out.	ns is your o	choice. You can't	t be denied o	coverage b	pecause you don't fill
Enrollee name					
Agent name/ID number _ Y0066 ERFMA 2024 C					PCFL24HM0133860 0

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 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 us manage your plan	
Would you prefer plan information in another language or an acce	ssible format?∟ Yes ∟ No
Please check what you'd like: ☐ Spanish ☐ Braille ☐ Other	
If you don't see the language or format you want, please call us toll-fro 711 , 8 a.m8 p.m. local time, 7 days a week. Or visit myPreferredCa	
2.Are you enrolled in your state Medicaid program?	☐ Yes ☐ No
If yes, please give us your Medicaid number:	- —
Enrollee name	
Agent name/ID number	
Y0066_ERFMA_2024_C	PCFL24HM0133860_000

. Are you Hispanic, Latino/a, or S	•	pply.		
No, not of Hispanic, Latino				
Yes, Mexican, Mexican An	nerican, or Chicano/a			
Yes, Puerto Rican				
Yes, Cuban				
Yes, another Hispanic, Lat	ino, or Spanish origin			
I choose not to answer				
· What's your race? Select all that	t apply.			
White	Black or African American			
American Indian or Alaska	Native			
Asian Indian	Chinese	Filipino		
Japanese	Korean	Vietnamese		
Other Asian	Native Hawaiian	Samoan		
Guamanian or Chamorro	Other Pacific Islander			
I choose not to answer				
Member/Citizen of a feder	ral or state recognized Tribe (nar	ne of Tribe)		
. Do you or your spouse work?		□ Yes □ No		
Daylar anylarin anarraa hayla athan	boolth incurrence that will cover	madical continue?		
	health insurance that will cover			
(Examples: Other employer group	coverage, LTD coverage, Worke	ers' Compensation,		
(Examples: Other employer group auto liability, or Veterans benefits)	coverage, LTD coverage, Worke			
(Examples: Other employer group	coverage, LTD coverage, Worke	ers' Compensation,		
(Examples: Other employer group auto liability, or Veterans benefits)	coverage, LTD coverage, Workeng:	ers' Compensation,		
(Examples: Other employer group auto liability, or Veterans benefits) If yes, please complete the following	coverage, LTD coverage, Workeng:	ers' Compensation,		
(Examples: Other employer group auto liability, or Veterans benefits) If yes, please complete the following Name of health insurance compagnets Member number	coverage, LTD coverage, Workenge:	ers' Compensation, ☐ Yes ☐ No		
(Examples: Other employer group auto liability, or Veterans benefits) If yes, please complete the following the Name of health insurance compagnets the following the Name of health insurance compagnets the	coverage, LTD coverage, Workeng: Iny Primary care provider (PCP), o	ers' Compensation, ☐ Yes ☐ No Clinic or health center.		
(Examples: Other employer group auto liability, or Veterans benefits) If yes, please complete the following Name of health insurance company Member number Please give us the name of your	coverage, LTD coverage, Workeng: Iny Primary care provider (PCP), o	ers' Compensation, ☐ Yes ☐ No Clinic or health center.		
(Examples: Other employer group auto liability, or Veterans benefits) If yes, please complete the following Name of health insurance comparts. Member number Please give us the name of your You can find a list on the plan wellow.	ng: r primary care provider (PCP), or bsite or in the Provider Directory (Please enter the	ers' Compensation, Yes No Clinic or health center.		
(Examples: Other employer group auto liability, or Veterans benefits) If yes, please complete the following Name of health insurance compass. Member number Please give us the name of your You can find a list on the plan well Provider or PCP full name	r primary care provider (PCP), or bsite or in the Provider Directory (Please enter the on the website or	clinic or health center. number exactly as it appears in the Provider Directory. It will		
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(Examples: Other employer group auto liability, or Veterans benefits) If yes, please complete the following Name of health insurance compass. Member number Please give us the name of your You can find a list on the plan well Provider or PCP full name	r primary care provider (PCP), or bsite or in the Provider Directory (Please enter the on the website or be 10 to 12 digits	ers' Compensation, Yes No Clinic or health center. Inumber exactly as it appears in the Provider Directory. It will. Don't include dashes.)		
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Please read and sign

By completing this form, I agree to the following:

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 □ I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it. □ I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information. □ I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered. □ I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private-Fee-For-Service (PFFS), MA Medicare Medical Savings Account (MSA) plans). □ Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make
payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
☐ I give UnitedHealthcare permission to share my protected health information with
organizations or person(s) for permissible purposes under applicable law as required to administer my health plan.
☐ I give consent for all entities under UnitedHealthcare and its affiliates and any outside vendor used by UnitedHealthcare to call the phone number(s) I have provided using an autodialer and/or prerecorded voice.
 The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan. My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
/hen I sign below, it means that I have read and understand the information on this form
I sign as an authorized representative, it means I have the legal right under state law to sign. I can

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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.

Enrollee name	
Agent name/ID number	
	DOT! 0 !! !! 10 ! 00000 000

Signature of applicant/member/authorized representative Today's date

If you are the authorized represent information below	tative, please sign ab	ove and complete the
*Not a Sales Agent		
Last name	First name	
Address		
City	State	ZIP code
Phone number () –	Relationship to a	pplicant
Enrollee name		

For Licensed Sales	Representative/age	ncy use onl	y		
Licensed Sales Representative/writing ID			Initial rec	Initial receipt date	
Licensed Sales Representative/agent name			Proposed	Proposed effective date	
Employer group name					
Employer group ID		Branch I	D		
Agent must complete					
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PI enrollees elig 2nd IEP)		☐ OEP (Jan 1 - Mar 31)	
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	☐ SEP (Charresidence) ☐ AEP (Octo		☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ 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

Enroll	ee nam	e	
Aaent	name/	ID nu	mber_
_	ERFMA		

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-D01P (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 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.

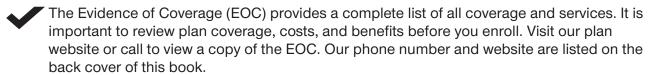
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

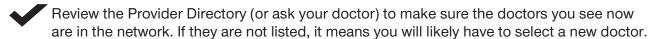
OMB No. 0938-1378 Expires: 7/31/2024 Y0066 ERFMA 2024 C

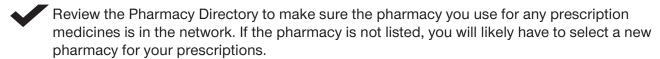
Enrollment checklist

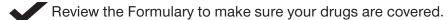
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits









Understanding important rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medicaid or another third party. This premium is normally taken out of your Social Security check each month.
- 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 healthcare 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.