

# **2024 Enrollment Request Form**

☐ UHC Dual Complete TX-V005 (HMO-POS D-SNP) H5322-026-000 - BKR

Information about you	(Please	e type or print in	black or blu	ue ink)		
Last name		First name			Middle initi	al
Birth date			Sex □ M	ale 🗆 Fer	male	
Home phone number ( ) -			Mobile phone number ( ) -			
Social Security number (Required for people who ar	e enrol	ling in D-SNP pla	ans):	-	-	
Medicare number						
Permanent residence street	addres	ss (P.O. box is n	ot allowed)	)		
City	County		State	ZIP c	ode	
Mailing address (Only if it's	differe	ent from above.	You can gi	ve a P.O. l	oox.)	
City				State	ZIP c	ode
Email address (optional)						
Do you have other insurance	e that v	will cover your p	orescription	n drugs?	□Y€	es 🗆 No
(Examples: Other private insuprograms.) If yes, what is it?	ırance,	TRICARE, feder	al employe	e coverage	e, VA benefit	s or state
Name of other insurance						
lember number Group number		1	RxBin	RxPCN	l (optional)	
Answering these questions is them out.	your c	hoice. You can't	be denied	coverage I	because you	ı don't fill
Enrollee name						
Agent name/ID number Y0066 ERFMA 2024 C						HP0134327 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	
1. Would you prefer plan information in another language or an accessible	e 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-free at <b>711,</b> 8 a.m8 p.m. local time, 7 days a week. Or visit <b>UHCCommunityPlan</b>	•
2.Are you enrolled in your state Medicaid program?	☐ Yes ☐ No
If yes, please give us your Medicaid number:	
Enrollee nameAgent name/ID number	

3. Are you Hispanic, Latino/a, or Sp			
No, not of Hispanic, Latino/a, or Spanish origin Yes, Mexican, Mexican American, or Chicano/a			
	ericari, or Grilleario, a		
	Yes, Puerto Rican		
Yes, Cuban Yes, another Hispanic, Latino, or Spanish origin I choose not to answer			
			T choose not to answer
4. What's your race? Select all that			
White	Black or African American		
American Indian or Alaska I			
Asian Indian	Chinese Filipino		
Japanese	Korean Vietnamese		
	Native Hawaiian Samoan		
Guamanian or Chamorro	Other Pacific Islander		
I choose not to answer	al avadata vasa vaisa d Tviba (vasas of Tviba)		
Member/Citizen of a federa	al or state recognized Tribe (name of Tribe)		
5. Do you or your spouse work?	□Yes	П №	
	health insurance that will cover medical services?		
	coverage, LTD coverage, Workers' Compensation,	□ N-	
auto liability, or Veterans benefits)	□Yes	⊔ NO	
If yes, please complete the following	g.		
Name of health insurance compar	ıy		
Member number			
6. Please give us the name of your	primary care provider (PCP), clinic or health center.		
You can find a list on the plan web			
Provider or PCP full name			
Provider/PCP number:	(Please enter the number exactly as it appe		
	on the website or in the Provider Directory.	I+ will	
		. IL WIII	
	be 10 to 12 digits. Don't include dashes.)	. IL WIII	
Are you now seeing or have you re	be 10 to 12 digits. Don't include dashes.) cently seen this provider?	. IL WIII	
	,		
Providing your email address above your plan communications.	cently seen this provider?		
Providing your email address above	cently seen this provider?		

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

you would rather have hard copies of required materials mailed to you, please check here:
Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.
Please read and sign
By completing this form, I agree to the following:
□ 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 in
nrollee name
gent name/ID number
0066_ERFMA_2024_C CSTX24HP0134327_000

#### 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 represinformation below	sentative, 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	applicant
Inrollee name		
Agent name/ID number		
70066_ERFMA_2024_C		CSTX24HP013432

For Licensed Sales	Representative/age	ncy use only	7			
Licensed Sales Representative/writing ID				Initial receipt date		
Licensed Sales Representative/agent name Proposed effective date				d effective date		
Employer group name						
Employer group ID		Branch II				
Agent must complete						
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PD enrollees eligi 2nd IEP)		☐ OEP (Jan 1 – Mar 31)		
☐ OEP (Newly eligible)	☐ SEP (Dual LIS change of status)	☐ SEP (Chang		☐ SEP (Loss of EGHP coverage)		
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)	☐ AEP (Octob December 7)	er 15-	□ OEPI		
☐ SEP (SEP reason)						
Licensed Sales Repre	sentative signature (opt	ional)	Da	te		

## 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	
VODES EDEMA 2024 C	

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 Dual Complete TX-V005 (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.

This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

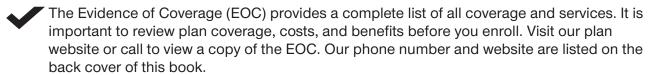
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

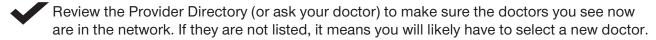
OMB No. 0938-1378 Expires: 7/31/2024 Y0066 ERFMA 2024 C

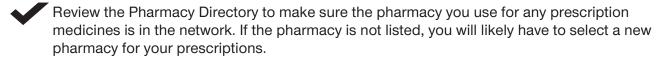
# **Enrollment checklist**

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**







Review the Formulary to make sure your drugs are covered.

#### **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.
- Our plan allows you to see providers outside of our network (non-contracted providers). 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 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.