

2025 Enrollment Request Form

☐ UHC Dual Complete WA-Q1 (PPO D-SNP) H2001-079-000

Information about you (Please type or print in black or blue ink)					
Last name	First name			Middle initial	
Birth date		Sex □ Male □ Female			
Home phone number ()	_	Mobile phone	() –		
☐ 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.					
Social Security number (Required for people who are enrolling in D-SNP plans):					
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		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 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	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 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 Railro	ad Retirement Board (RRB) ch	neck		
\square I want to pay directly from a	☐ 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	• • •			
1. Would you prefer plan info	rmation in another language	or an accessible	format?	
	rmation in another language of Braille □ Large print □ Aud		•	
Enrollee name				
Agent name/ID number				
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If you don't see the language or format you want, please call us toll-free at **1-844-560-4944**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **UHC.com/CommunityPlan** for online help.

2. Are you enrolled in Washington Apple I If yes, please give us your ProviderOne S	⊔ Yes ⊔ No	
3. Are you Hispanic, Latino/a, or Spanish No, not of Hispanic, Latino/a, or Spanish Yes, Mexican, Mexican American, o 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 Non-binary	I use a different term: I choose not to answer	
6. Which of the following best represents Lesbian or gay Straight, that is, not gay or lesbian Bisexual	I use a different term:	
7. Do you or your spouse work?		☐ Yes ☐ No
Enrollee name		
Agent name/ID number		

Do you or your spouse have other health insurance	
(Examples: Other employer group coverage, LTD	·
auto liability, or Veterans benefits)	☐ Yes ☐ No
If yes, please complete the following:	
Name of health insurance company	
Member number	
8. Please give us the name of your primary care	e provider (PCP), clinic or health center.
You aren't limited to this list. You may go to any do	octor who accepts Medicare and the plan's
payment terms.	
You can find a list on the plan website or in the Pr	ovider Directory.
Provider or PCP full name	T
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 this	s provider?
your plan communications. You will get many of your required plan communications.	-
an email when new communications (For example Changes) are available online. You can access the computer, tablet or mobile phone.	e: Explanation of Benefits or the Annual Notice of ese communications through any device such as a
If you would rather have hard copies of require	d materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you have some communications are very large and may preference for delivery at any time.	nard copies of required materials. Please note that not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the following	g:
paying my Part B premium if I have one, unle I understand that people with Medicare are g	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and
 I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealth 	coverage begins, I must get all of my medical and care. Benefits and services authorized by
Enrollee name	
Agent name/ID number	
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(also known as a member contract or subs	,					
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	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.						
☐ The information on this form is correct to t	•	S				
intentionally provide false information on t		•				
 My response to this form is voluntary. How 	ever, failure to respo	nd may affect enrollment in the				
plan.						
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 mea						
show written proof (power of attorney, guardian		· ·				
understand that I will need to submit written pr	. , ,					
behalf of the member beyond this application.		•				
received my UnitedHealthcare UCard®, I can c	all Customer Service	at the number on my				
UnitedHealthcare UCard to update my authorize	zation information on	file.				
Signature of applicant/member/authorized i	representative	Today's date				
If you are the authorized representative		ove and complete the				
information below (*Not a Sales Agent)						
Last name	First name					
Address						
City	State	Zip code				
Phone number () —	Relationship to a	pplicant				
Enrollee name						
Agent name/ID number						

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UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document

Fautadividuals bal	For individuals helping enrollee with completing this form only				
Complete this section			-	_	-
members, or other thir	•		•		ouriseiors, rairilly
Name				hip to enrollee	
					<u></u>
Signature		Natio	nal F	Producer Number	(Agents/Brokers only)
For Licensed Sales	s Representative/	agend	cy u	se only	
Licensed Sales repres	entative/Writing ID			Initial receipt date	е
Licensed Sales repres	entative/agent name			Proposed effective	ve date
Employer group name					
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD	; □ ICEP (MA enrolle	es) [] IEF	P (MA-PD	☐ OEP (Jan 1 -
enrollees)	(,	enrollees eligible for Mar 31)		,
_	_		2nd I	•	_
☐ OEP (Newly	•	•		EP (Change in	☐ SEP (Loss of
eligible) □ SEP (Chronic)	☐ SEP (Dual LIS	change of status) resid		EP (October 15-	EGHP coverage) □ OEPI
_ = (=,	maintaining)			mber 7)	
☐ SEP (SEP reason) _					
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C					UHWA25LP0221059_000

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 Dual Complete WA-Q1 (PPO 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.

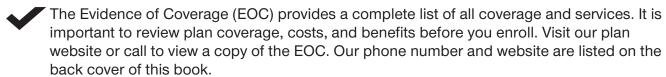
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

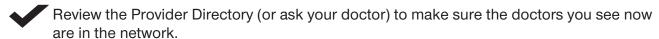
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

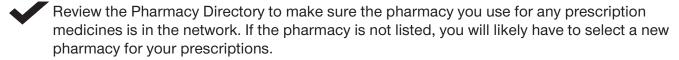
Enrollment checklist

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

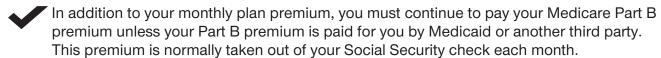


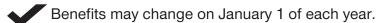


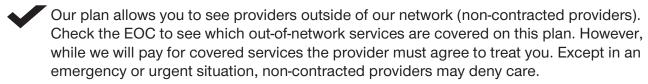




Understanding important rules







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.

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.