

2025 Enrollment Request Form

☐ UHC Dual Complete WA-S4 (HMO-POS D-SNP) H5008-020-000

| Information about you (Please | type or pri | nt in black or k | olue ink | | | |
|---|---|------------------|----------|---------------------|--|--|
| Last name | First name | | | Middle initial | | |
| Birth date | | Sex □ Male [| □ Femal | е | | |
| Home phone number () | _ | Mobile phone r | number | () — | | |
| \Box 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 | (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 | | | | | | |
| Y0066_ERFMA_2025_C | | | Į | JHWA25HP0220728_000 | | |

| Do you have other insurance (Examples: Other private insurprograms.) If yes, what is it? | | _ | ☐ Yes ☐ No A 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 | 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 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 Retiremer | nt Board (RRB) can bill you | | | | |
| ☐ I want to pay from my Socia | Security check | | | | |
| ☐ I want to pay from my Railro | ☐ 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 face and the last of | | | | | |
| A few questions to help u 1. Would you prefer plan info | • • • | or an accessible | format? | | |
| | rmation in another language o | | | | |
| | Braille □ Large print □ Aud | | • | | |
| Enrollee name | | | | | |
| Agent name/ID number Y0066_ERFMA_2025_C | | | /A25HP0220728_000 | | |

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 So | □ 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 Spanic 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 | | |
| Y0066 ERFMA 2025 C | | |

| 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 can find a list on the plan website or in the Pr | ovider Directory. | | | |
| Provider or PCP full name | | | | |
| 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 (For example) | • | | | |
| 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 followin | g: | | | |
| 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 | | | | |
| Enrollee name | | | | |
| Agent name/ID numberY0066_ERFMA_2025_C | UHWA25HP0220728_000 | | | |

| If y inf Lass Add | itedHealthcare UCard to update my augnature of applicant/member/author you are the authorized represer formation below (*Not a Sales A st name dress | ntative, please sign above and complete the agent) State State Zip code Relationship to applicant | - | | | | |
|-------------------|---|---|----------|--|--|--|--|
| If y inf Las | gnature of applicant/member/author you are the authorized represer formation below (* Not a Sales A st name dress | uthorization information on file. rized representative Today's date ntative, please sign above and complete the agent) First name State Zip code | | | | | |
| If y inf | itedHealthcare UCard to update my augnature of applicant/member/author you are the authorized represer formation below (*Not a Sales A st name dress | uthorization information on file. rized representative Today's date ntative, please sign above and complete the agent) First name | ; | | | | |
| If y inf | itedHealthcare UCard to update my augnature of applicant/member/author you are the authorized represent formation below (*Not a Sales A st name | uthorization information on file. rized representative Today's date ntative, please sign above and complete the agent) | • | | | | |
| Sig If y | itedHealthcare UCard to update my augnature of applicant/member/author you are the authorized representation below (*Not a Sales A | uthorization information on file. rized representative Today's date ntative, please sign above and complete the agent) | . | | | | |
| Sig | itedHealthcare UCard to update my augnature of applicant/member/author | uthorization information on file. rized representative Today's date ntative, please sign above and complete the | , | | | | |
| Sig | itedHealthcare UCard to update my augnature of applicant/member/author | uthorization information on file. rized representative Today's date | | | | | |
| | itedHealthcare UCard to update my au | uthorization information on file. | | | | | |
| Uni | | • | | | | | |
| beł | half of the member beyond this applic | ation. After this application has been approved and I can call Customer Service at the number on my | | | | | |
| sho | ow written proof (power of attorney, gu | it means I have the legal right under state law to sign. uardianship, etc.) of this right if Medicare asks for it. I ten proof of this right, to the plan, if I wish to take acti | | | | | |
| | | e read and understand the information on this form | | | | | |
| | My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. | | | | | | |
| | 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. | | | | | | |
| | or person(s) for permissible purposes under applicable law as required to administer my health plan. | | | | | | |
| | 9 · · · · · · · · · · · · · · · · · · · | | | | | | |
| | 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 | | | | | | |
| | Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan | | | | | | |
| | • | :his Medicare Advantage Plan. I acknowledge that the | | | | | |
| | apply for MA Private Fee-for-Service plans). | matically end my enrollment in another MA plan (exce (PFFS), MA Medicare Medical Savings Account (MSA) this Medicare Advantage Plan. I acknowledge that the | • | | | | |

(also known as a member contract or subscriber agreement) will be covered. Neither Medicare

| | lping enrollee with | | - | | - |
|---|---|--|-------------------------------------|--|--|
| • | if you're an individual | , | _ | | ounselors, family |
| members, or other third parties) helping an e | | | | | |
| name | | Relationship to enrollee | | | |
| Signature | | National Producer Number (Agents/Brokers only) | | | |
| For Licensed Sale | s Representative/ | agen | ICV II | ise only | |
| For Licensed Sales Representative/a Licensed Sales representative/Writing ID | | | | Initial receipt dat | e |
| Licensed Sales representative/agent name | | | | Proposed effecti | ve date |
| Employer group name | 9 | | | | |
| Employer group ID | | | В | Branch ID | |
| Agent must complete ☐ IEP (MA-PD enrollees) ☐ OEP (Newly eligible) ☐ SEP (Chronic) ☐ SEP (SEP reason) | □ ICEP (MA enrolle □ SEP (Dual LIS change of status) □ SEP (Dual LIS maintaining) | | enrol 2nd I SE resid AE | P (MA-PD llees eligible for IEP) EP (Change in lence) EP (October 15- ember 7) | ☐ OEP (Jan 1 – Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI |
| Enrollee name Agent name/ID numbe Y0066_ERFMA_2025_C | | | | | UHWA25HP0220728_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-S4 (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.

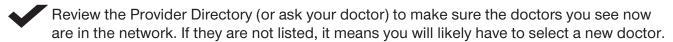
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

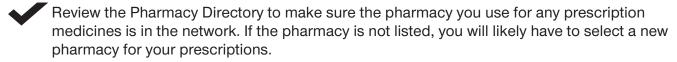
Enrollment checklist

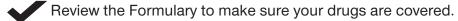
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

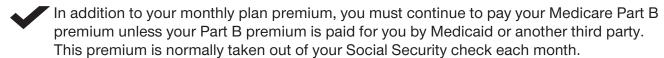








Understanding important rules



- Benefits may change on January 1 of each year.
- Our plan allows you to see providers outside of our network (non-contracted providers). Check the EOC to see which out-of-network services are covered on this plan. 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 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.