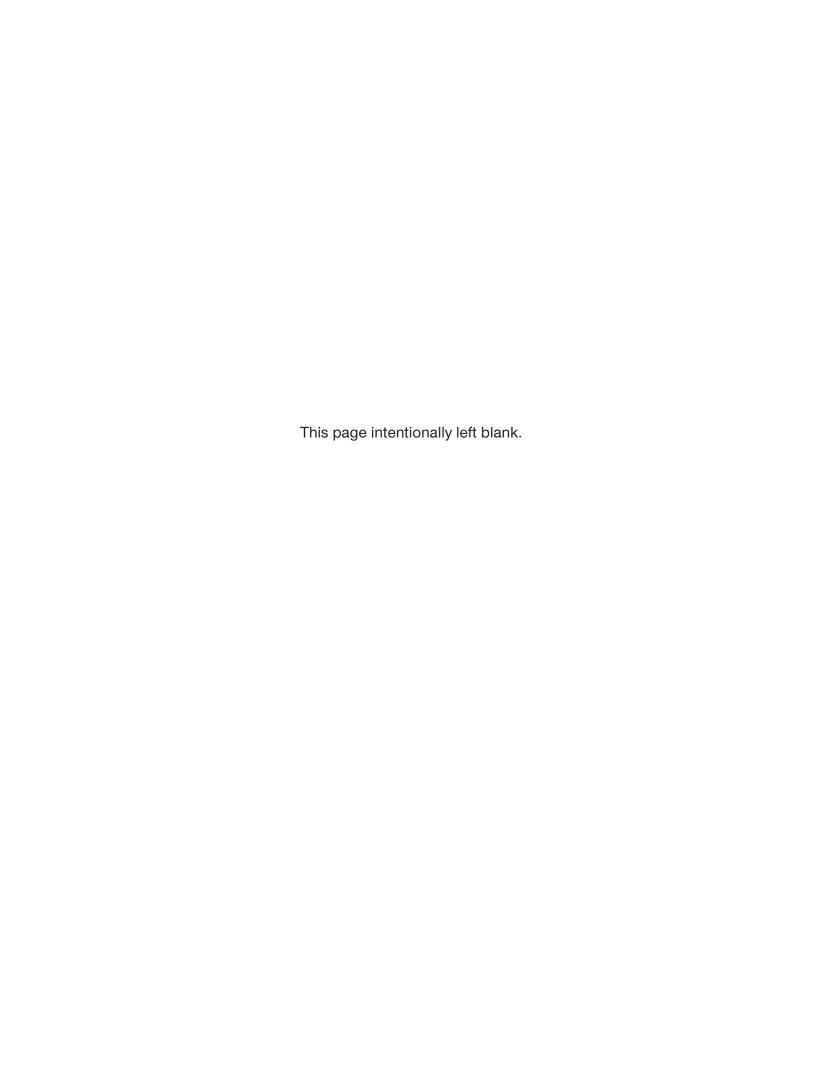




2023 Enrollment Request Form

☐ UnitedHealthcare Dual Complete® ONE (HMO D-SNP) H3113-005-000 - UD1

Information about y	ou (Please	e type or print in	black or blue	e ink)		
Last Name		First Name	Middle Initial			lle Initial
Birth Date			Sex □ Male □ Female			
Home Phone Number () -			Mobile Phone Number () -			
Social Security Number (Required for people who	are enrol	ling in D-SNP pla	ans):	-	_	
Medicare Number						
Permanent Residence St	reet Addre	ess (P.O. Box is	not allowed)		
City	Co	County				ZIP Code
Mailing Address (Only if	it's differe	ent from above.	You can giv	e a P.O. I	Box.)	
City				State		ZIP Code
Email Address (Optional))					
Do you have other insura	ınce that v	will cover your p	orescription	drugs?		☐ Yes ☐ No
(Examples: Other private i programs.) If yes, what is it?	nsurance,	TRICARE, feder	ral employee	coverage	e, VA b	penefits, or state
Name of Other Insurance)					
Member Number	Gr	oup Number	R	xBin	F	RxPCN (Optional)
Answering these question them out.	s is your c	hoice. You can't	be denied c	overage k	oecau	se you don't fill
Enrollee Name						
Agent Name / ID No Y0066_ERFMA1_2023_C					C	SNJ23HM0049769_00



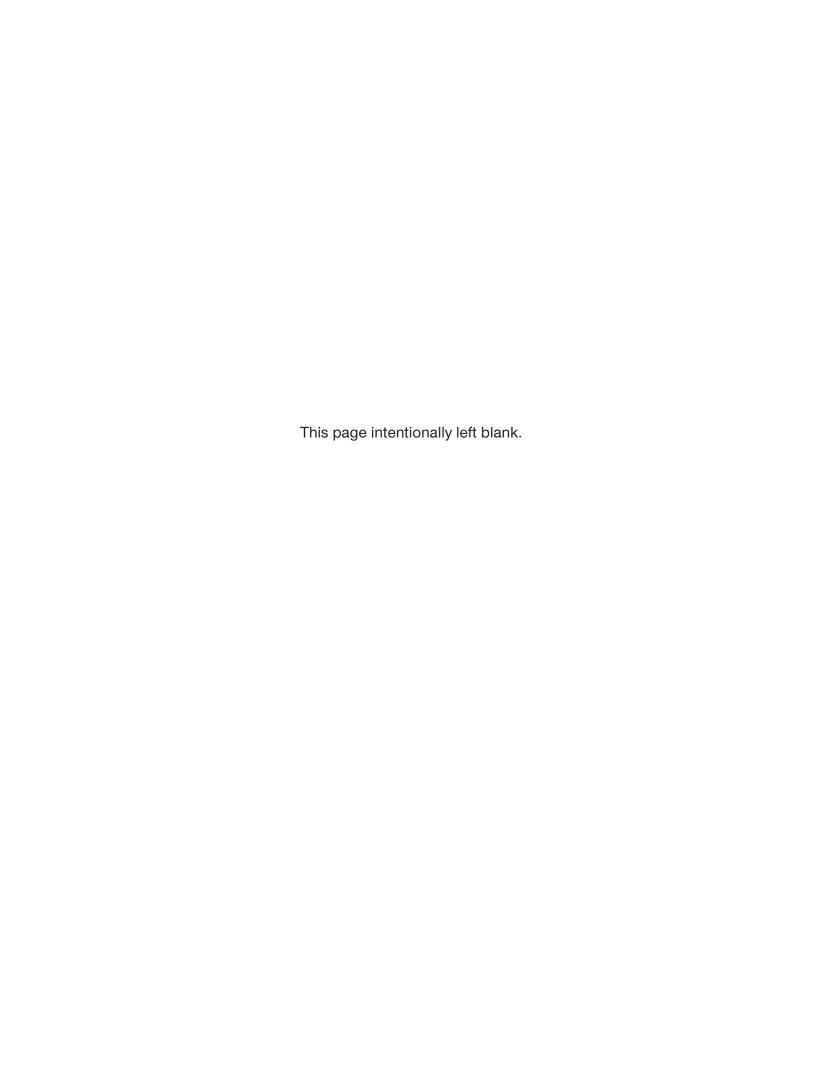
How do you want to pay?

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).

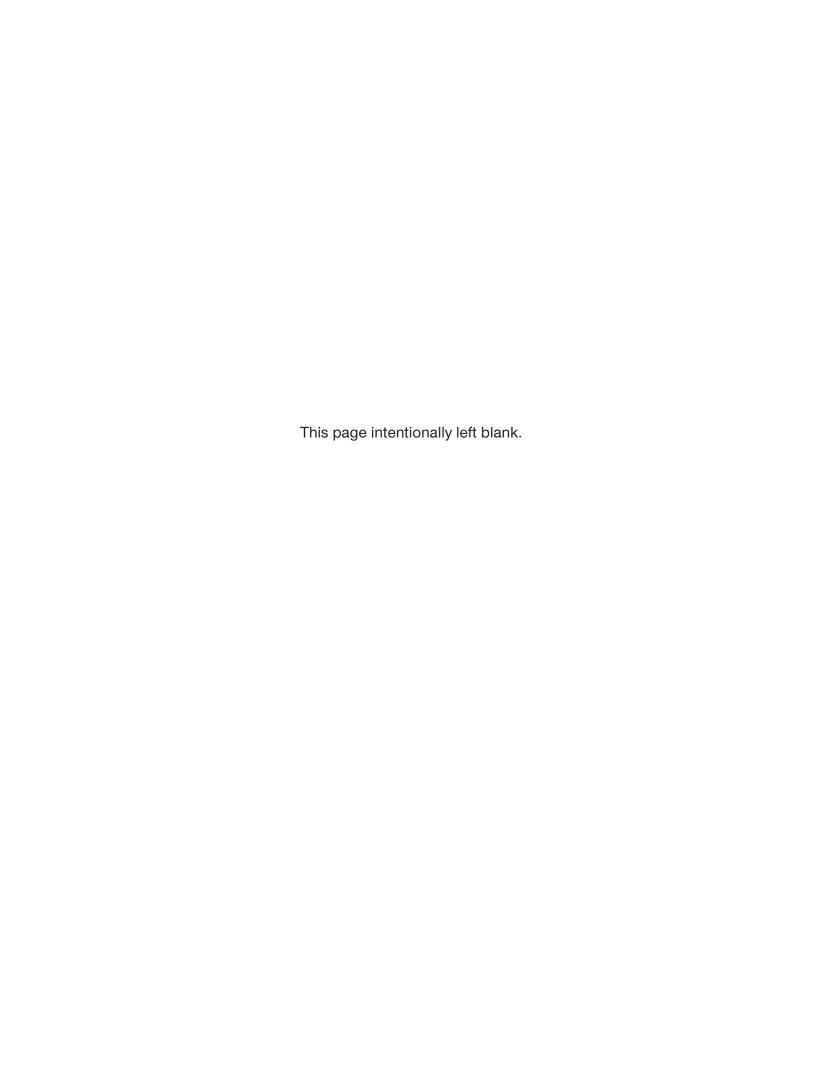
If you don't choose an option below, we'll send a bill each month to your mailing address.

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:

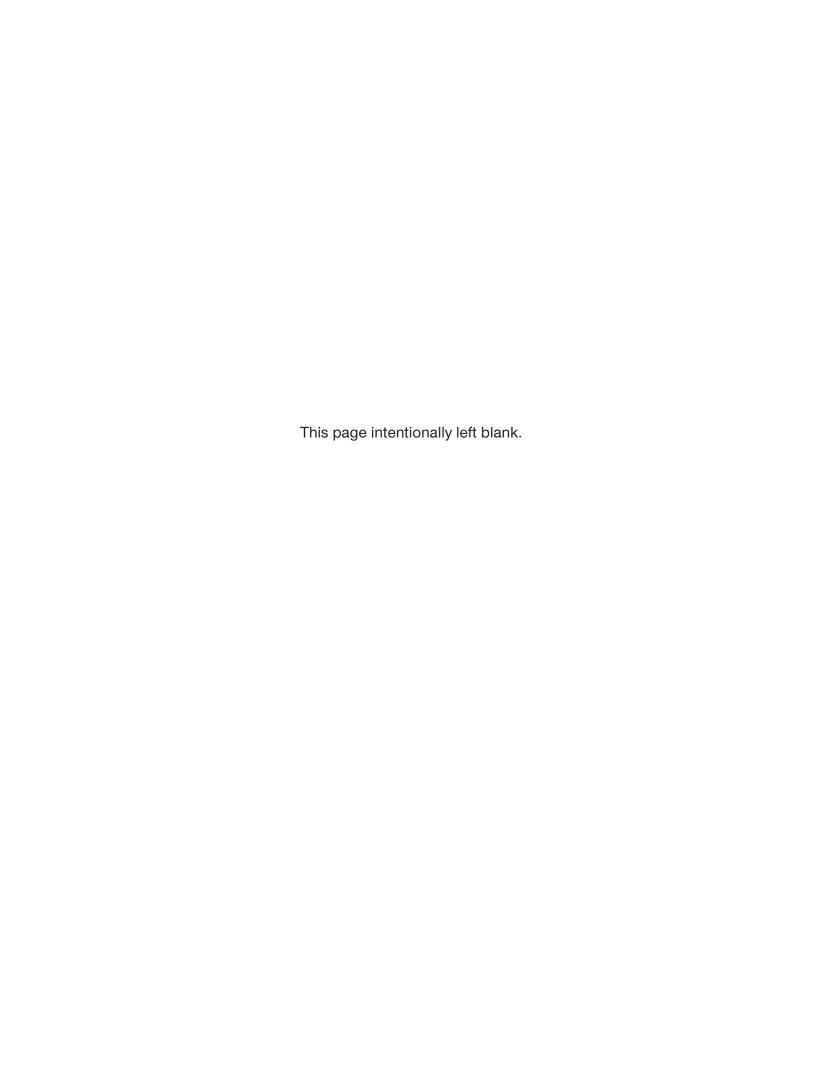
Security (SS) will send you a letter and ask you how you want to pay it:
☐ You can pay it from your SS check
☐ Medicare can bill you
☐ The Railroad Retirement Board (RRB) can bill you
☐ I want to pay from my Social Security
☐ I want to pay from my Railroad Retirement Board (RRB) check
☐ I want to pay 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 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 1-844-560-4944 , TTY 711 8 a.m8 p.m. local time, 7 days a week. Or visit UHCCommunityPlan.com for online help.
2.Are you enrolled in your state Medicaid program?
If yes, please give us your Medicaid number:



3. Are you Hispanic, Latino/a, or Spanish origin					
No, not of Hispanic, Latino/a, or Spanis					
Yes, Mexican, Mexican American, Chic	ano/a				
Yes, Puerto Rican Yes, Cuban Yes, Cuban					
I choose not to answer.					
4. What's your race? Select all that apply.					
	or African American				
American Indian or Alaska Native					
Asian Indian Chines					
Japanese Korean					
Other Asian Native					
Guamanian or Chamorro Other F	acific Islander				
I choose not to answer.					
5. Do you or your spouse work?	□ Yes □ No				
Do you or your spouse have other health insura	ance that will cover medical services?				
(Examples: Other employer group coverage, L					
auto liability, or Veterans benefits)	☐ Yes ☐ No				
If yes, please complete the following:	L 163 L 110				
——————————————————————————————————————					
Name of Health Insurance Company					
Member Number					
6. Please give us the name of your primary car	e 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				
	on the website or in the Provider Directory. It will				
Are you now seeing or have you recently seen	be 10 to 12 digits. Don't include dashes.) this provider? □ Yes □ No				
Providing your email address above automatic your plan communications.	ally enrolls you in paperless delivery for some of				
You will get many of your required plan commun	ications delivered electronically. We will send you an				
email when new communications (For example: I					
Enrollee Name Y0066_ERFMA1_2023_C	CSNJ23HM0049769_001				



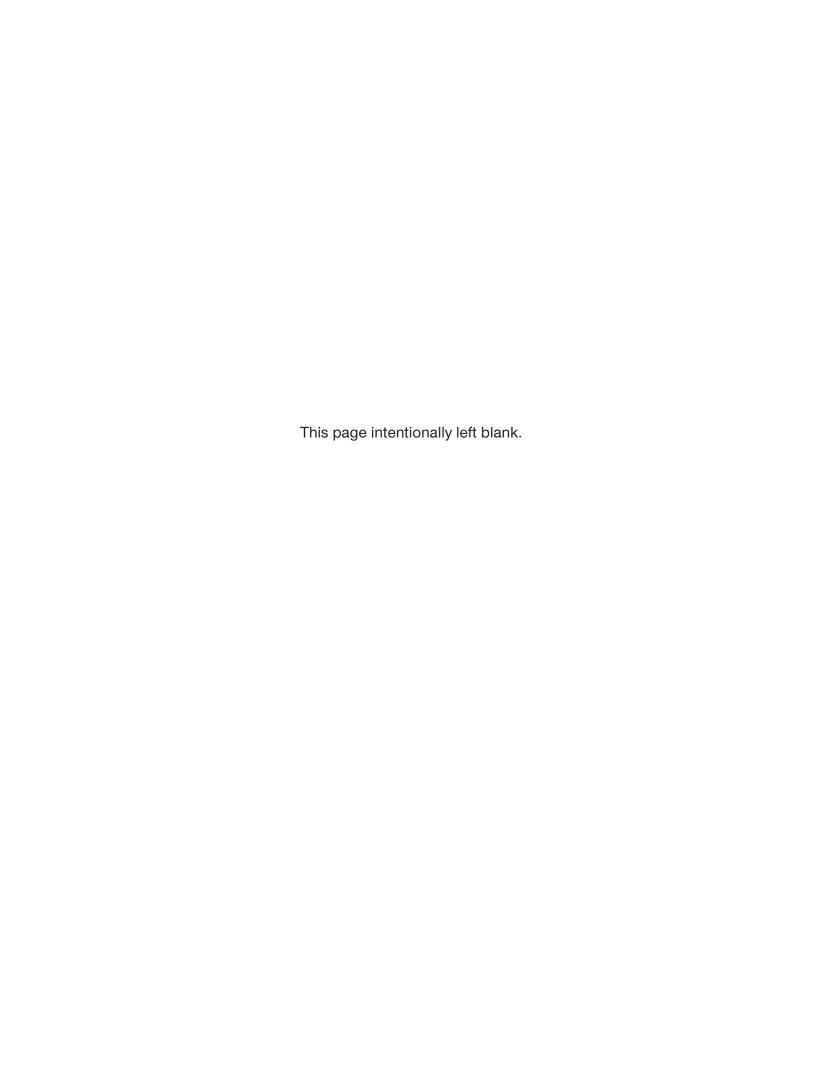
Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone. If you would rather have hard copies of required materials mailed to you, please check here: ☐ Instead of paperless delivery, we will mail you hard copies of required materials. 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 Part A and 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. Without authorization, neither Medicare nor UnitedHealthcare will pay for benefits or services. ☐ **Release of Information:** By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that UnitedHealthcare will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes applicable to 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 any outside vendor used by UnitedHealthcare to call the phone number(s) I have provided. ☐ 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. 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 representative, please sign above and complete the information below				
*NOT A SALES AGENT				
Last Name	First Name			
Address				
City	State	ZIP Code		
Phone Number () –	Relationship to Applicant			

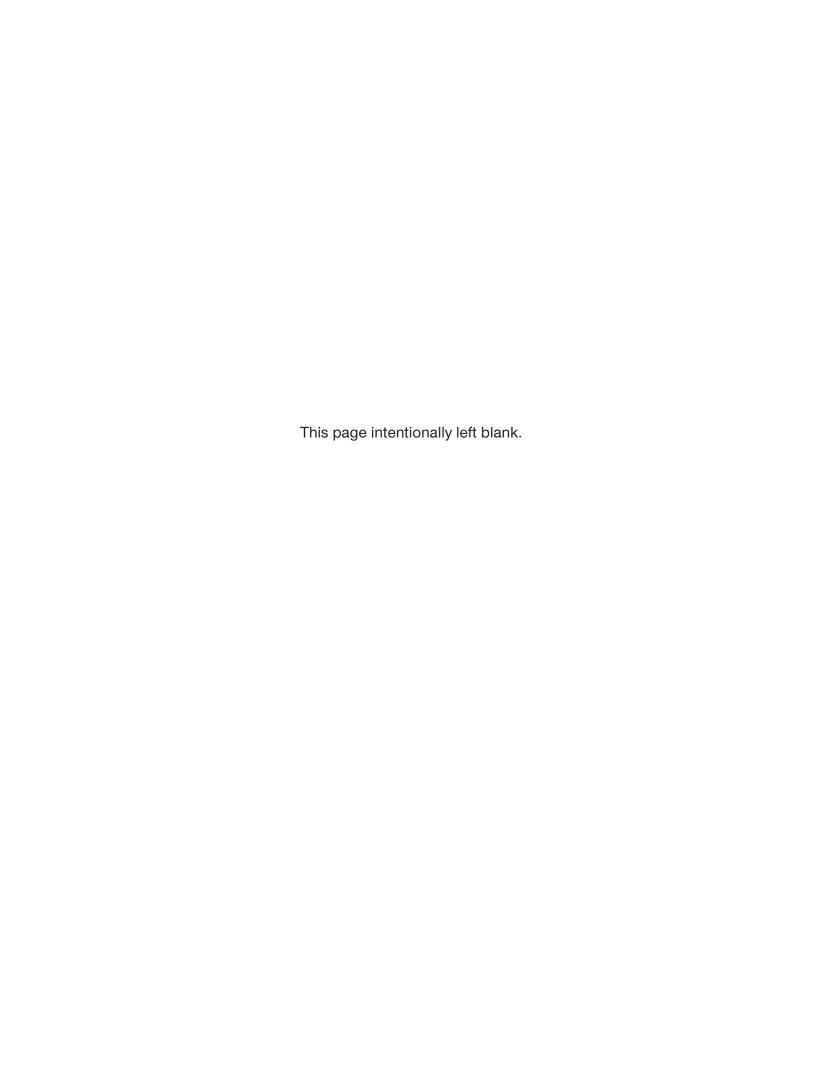


For licensed sales representative/agency use only						
Employer Group Name						
Employer Group ID			Branch ID			
Licensed Sales Representative/Writing ID				Initial Receipt Date		
Licensed Sales Representative/Agent Name				Proposed Effective Date		
Agent must complete						
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PD enrollees eligible for 2nd IEP)			☐ OEP (Jan 1 - Mar 31)	
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	☐ SEP (Change in residence) ☐ AEP (October 15-December 7)			☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ SEP (SEP Reason) _						
Licensed Sales Repre	esentative Signature (Op	tiona	1)		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



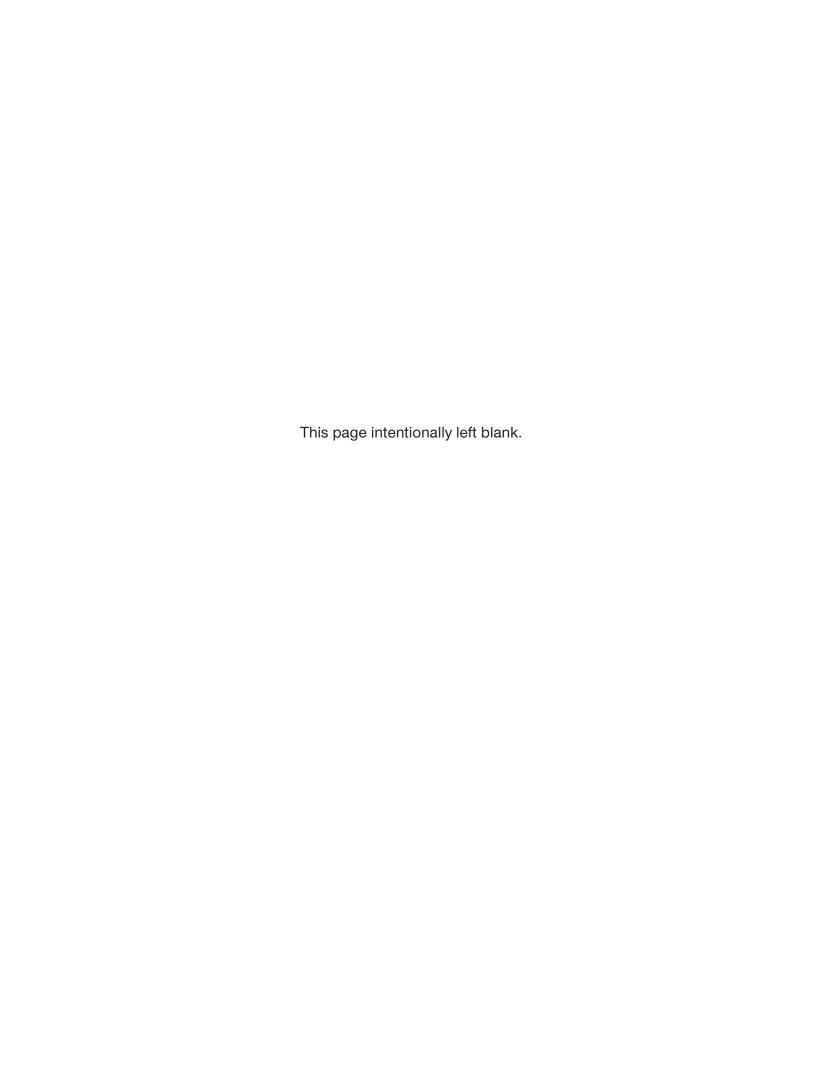
PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social 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.

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: 7/31/2023

Y0066 ERFMA1 2023 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



The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit our plan website or call to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.



Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.



Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.



Review the formulary to make sure your drugs are covered.

Understanding Important Rules



Benefits, premiums and/or copays/coinsurance 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).



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.