

## 2024 Enrollment Request Form

☐ UHC Preferred Complete Care FL-0003 (HMO C-SNP) H1045-018-000 - B5L

Information about ye	<b>ou</b> (Please type or pr	rint in blac	k or blue ink)		
Last name	First nam	е	Middle i		I
Birth date		Sex	Sex □ Male □ Female		
Home phone number ( ) -		Мо	Mobile phone number ( ) -		
Medicare number					
Permanent residence stre	eet address (P.O. bo	x is not al	lowed)		
City	County	County		ZIP co	de
Mailing address (Only if	it's different from ab	oove. You	can give a P.O.	box.)	
City			State	ZIP co	de
Email address (optional)					
Do you have other insura	ınce that will cover y	our pres	cription drugs?	☐ Yes	s □ No
(Examples: Other private i programs.)	nsurance, TRICARE,	federal e	mployee coverag	e, VA benefits	or state
If yes, what is it?  Name of other insurance					
Member number	Group number	Group number		RxPCN	(optional)
Answering these question them out.	s is your choice. You	can't be	denied coverage	because you	don't fill
How do you want to	pay?				
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2024_C				PCFL24H	M0133850_0

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).

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 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 1-855-548-1564, TTY 711, 8 a.m.-8 p.m. local time, 7 days a week. Or visit myPreferredCare.com for online help. 2. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply. \_\_\_\_ No, not of Hispanic, Latino/a, or Spanish origin Yes, Mexican, Mexican American, or Chicano/a \_\_\_\_ Yes, Puerto Rican Yes, Cuban Yes, another Hispanic, Latino, or Spanish origin I choose not to answer Enrollee name \_\_\_\_\_

3. What's your race? Select all that	at apply.	
White	Black or African America	n
American Indian or Alaska	a 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 fede	eral or state recognized Tribe (na	ame of Tribe)
4. Do you or your spouse work?		☐ Yes ☐ No
Do you or your spouse have othe	r health insurance that will cove	r medical services?
(Examples: Other employer group	o coverage, LTD coverage, Worl	kers' Compensation,
auto liability, or Veterans benefits	)	☐ Yes ☐ No
If yes, please complete the follow	ing:	
Name of health insurance comp	any	
·	•	
Member number		
5. Please give us the name of you	r primary care provider (PCP).	clinic or health center.
You can find a list on the plan we		
<u>·</u>	sparce of in the Provider Director	y.
Provider or PCP full name		
Provider/PCP number:	•	e number exactly as it appears
		or in the Provider Directory. It will
Are you new seeing or hove your		s. Don't include dashes.)
Are you now seeing or have you	ecently seen this provider?	☐ Yes ☐ No
Please read and sign		
By completing this form, I agree t	o the following:	
	_	to I halfe all to the const
☐ I must keep both Hospital (Part		
	m if I have one, unless Medicaid	• •
$\square$ I understand that people with N	• •	
the country, except for limited	coverage near the U.S. border. <sup>-</sup>	This plan covers emergency and
•	See the Summary of Benefits for	
$\square$ I understand that when my Uni	tedHealthcare coverage begins,	, I must get all of my medical and
prescription drug benefits from	n UnitedHealthcare. Benefits and	d services authorized by
UnitedHealthcare and contained	ed in my UnitedHealthcare "Evid	ence of Coverage" document
Enrollee name		
Agent name/ID number		
Y0066_ERFMA_2024_C		PCFL24HM0133850_000

<ul> <li>(also known as a member contract or subscriber agreement) will be covered. Neither M nor UnitedHealthcare will pay for benefits or services that are not covered.</li> <li>I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time 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).</li> <li>Release of information: By joining this Medicare Advantage Plan, I acknowledge that twill 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 information (see Privacy Act Statement below).</li> <li>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.</li> <li>I give consent for all entities under UnitedHealthcare and its affiliates and any outside we used by UnitedHealthcare to call the phone number(s) I have provided using an autodical and/or prerecorded voice.</li> <li>The information on this form is correct to the best of my knowledge. I understand that if intentionally provide false information on this form I will be disenrolled from the plan.</li> <li>My response to this form is voluntary. However, failure to respond may affect enrollment plan.</li> </ul>	- and he plan e of this endor aler
When I sign below, it means that I have read and understand the information on this for	m
If I sign as an authorized representative, it means I have the legal right under state law to sign show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it understand that I will need to submit written proof of this right, to the plan, if I wish to take as behalf of the member beyond this application. After this application has been approved and received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file.	I ction on
Signature of applicant/member/authorized representative Today's date	
Enrollee name	
Enrollee nameAgent name/ID number	
Y0066_ERFMA_2024_C PCFL24HM013	3850_000

# 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 ( ) -

Enrollee name \_\_\_\_\_\_Agent name/ID number \_\_\_\_\_

For Licensed Sales Representative/agency use only					
Licensed Sales Representative/writing ID				Initial receipt date	
Licensed Sales Representative/agent name			Proposed effective date		
Employer group name					
Employer group ID		Branch II	)		
Agent must complete					
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PE enrollees eligi 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 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

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 Complete Care FL-0003 (HMO C-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. 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. Enrollment in the plan depends on the plan's contract renewal with Medicare. This plan is available to anyone having a qualifying chronic care condition.

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

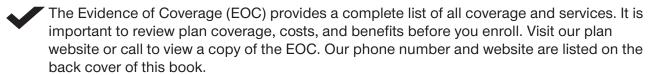
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

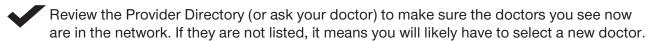
OMB No. 0938-1378 Expires: 7/31/2024 Y0066 ERFMA 2024 C

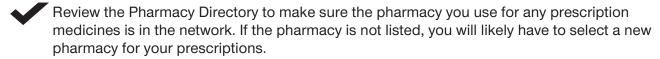
### **Enrollment checklist**

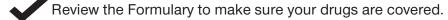
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

### **Understanding the benefits**









### **Understanding important rules**

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. 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 Chronic Condition Special Needs Plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.