

2024 Enrollment Request Form

☐ UHC Preferred Medicare Advantage FL-002P (HMO) H1045-037-000 - B6C

Information about y	ou (Please	e type or print in	black or blu	ue ink)			
		First name			Mid	Middle initial	
Birth date			Sex □ Male □ Female				
Home phone number () -			Mobile phone number () -				
Medicare number							
Permanent residence str	eet addres	ss (P.O. box is n	ot allowed)				
City	Co	ounty		State		ZIP code	
Mailing address (Only if	it's differe	ent from above.	You can giv	ve a P.O. k	oox.)		
City				State		ZIP code	
Email address (optional)							
Do you have other insura	ance that v	will cover your _l	orescription	drugs?		☐ Yes ☐ No	
(Examples: Other private i programs.)	nsurance,	TRICARE, fede	ral employee	e coverage	e, VA	benefits or state	
If yes, what is it? Name of other insurance							
Member number	Gr	oup number		DyRin		DyDCN (antional)	
Wellibei Hullibei		oup number	RxBin			RxPCN (optional)	
Answering these question them out.	s is your c	hoice. You can'	t be denied	coverage I	oecai	use you don't fill	
How do you want to	pay?						
Enrollee name							
Agent name/ID number _							
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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 1-844-723-6470, 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	apply.	
White	Black or African America	an
American Indian or Alaska I	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 federa	al or state recognized Tribe (n	name of Tribe)
4. Do you or your spouse work?		☐ Yes ☐ No
Do you or your spouse have other	health insurance that will cove	er medical services?
(Examples: Other employer group	coverage, LTD coverage, Wo	rkers' Compensation,
auto liability, or Veterans benefits)		☐ Yes ☐ No
If yes, please complete the following	ng:	
Name of health insurance compar	ny	
Member number		
5. Please give us the name of your	primary care provider (PCP)	, clinic or health center.
You can find a list on the plan web	osite or in the Provider Directo	ory.
Provider or PCP full name		_
Provider/PCP number:	(Please enter th	ne number exactly as it appears
	•	or in the Provider Directory. It will
		its. Don't include dashes.)
Are you now seeing or have you re		☐ Yes ☐ No
Please read and sign		
By completing this form, I agree to	the following:	
☐ I must keep both Hospital (Part A	A) and Medical (Part B) to stay	y in UnitedHealthcare. I must
keep paying my Part B premium	•	
☐ I understand that people with Me		• •
	•	This plan covers emergency and
	svorago moar ano oto: boraon	
	See the Summary of Renefite t	
•	See the Summary of Benefits f	
☐ I understand that when my Unite	edHealthcare coverage begins	s, I must get all of my medical and
☐ I understand that when my Unite prescription drug benefits from U	edHealthcare coverage begins UnitedHealthcare. Benefits an	s, I must get all of my medical and and services authorized by
☐ I understand that when my Unite prescription drug benefits from UnitedHealthcare and contained	edHealthcare coverage begins UnitedHealthcare. Benefits an I in my UnitedHealthcare "Evid	s, I must get all of my medical and and services authorized by
☐ I understand that when my Unite prescription drug benefits from U	edHealthcare coverage begins UnitedHealthcare. Benefits an I in my UnitedHealthcare "Evid	s, I must get all of my medical and and services authorized by

 (also known as a member contract or subscriber agreement) will be covered. In 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 that enrollment in this plan will automatically end my enrollment in another MA (exceptions apply for MA Private-Fee-For-Service (PFFS), MA Medicare Medicare Account (MSA) plans). Release of information: By joining this Medicare Advantage Plan, I acknowle will share my information with Medicare, who may use it to track my enrollment payments, and for other purposes allowed by Federal law that authorize the confirmation (see Privacy Act Statement below). I give UnitedHealthcare permission to share my protected health information worganizations or person(s) for permissible purposes under applicable law as readminister my health plan. I give consent for all entities under UnitedHealthcare and its affiliates and any used by UnitedHealthcare to call the phone number(s) I have provided using a and/or prerecorded voice. The information on this form is correct to the best of my knowledge. I understatintentionally provide false information on this form I will be disenrolled from the My response to this form is voluntary. However, failure to respond may affect on plan. 	at a time - and A plan al Savings dge that the plan at, to make collection of this with equired to outside vendor an autodialer and that if I e plan.
When I sign below, it means that I have read and understand the information o	n this form
If I sign as an authorized representative, it means I have the legal right under state show written proof (power of attorney, guardianship, etc.) of this right if Medicare a understand that I will need to submit written proof of this right, to the plan, if I wish behalf of the member beyond this application. After this application has been appreceived my UnitedHealthcare UCard®, I can call Customer Service at the number UnitedHealthcare UCard to update my authorization information on file. Signature of applicant/member/authorized representative Today's date	law to sign. I can asks for it. I to take action on roved and I have
eignature of applicant, member, authorized representative reday e date	
Enrollee name	
Agent name/ID number	
•	FL24HM0133859_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/age	ncy use onl	y			
Licensed Sales Representative/writing ID				Initial receipt date		
Licensed Sales Representative/agent name				Proposed effective date		
Employer group name						
Employer group ID		Branch I	D			
Agent must complete						
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PI enrollees elig 2nd IEP)		☐ OEP (Jan 1 - Mar 31)		
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	☐ SEP (Charresidence) ☐ AEP (Octo		☐ SEP (Loss of EGHP coverage) ☐ OEPI		
☐ SEP (SEP reason)						
Licensed Sales Repres	sentative signature (opti	ional)	Da	ite		

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

Enrollee name
Agent name/ID number _
Agent name/ib number _
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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 Medicare Advantage FL-002P (HMO) 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 information is available for free in other languages. Please call our customer service number located on the back cover of this book.

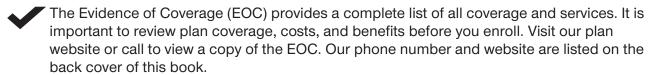
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

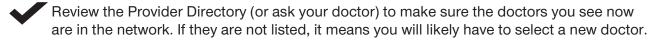
OMB No. 0938-1378 Expires: 7/31/2024 Y0066 ERFMA 2024 C

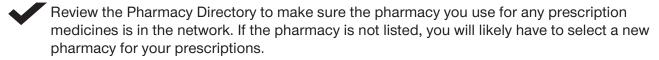
Enrollment checklist

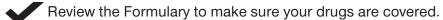
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

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.