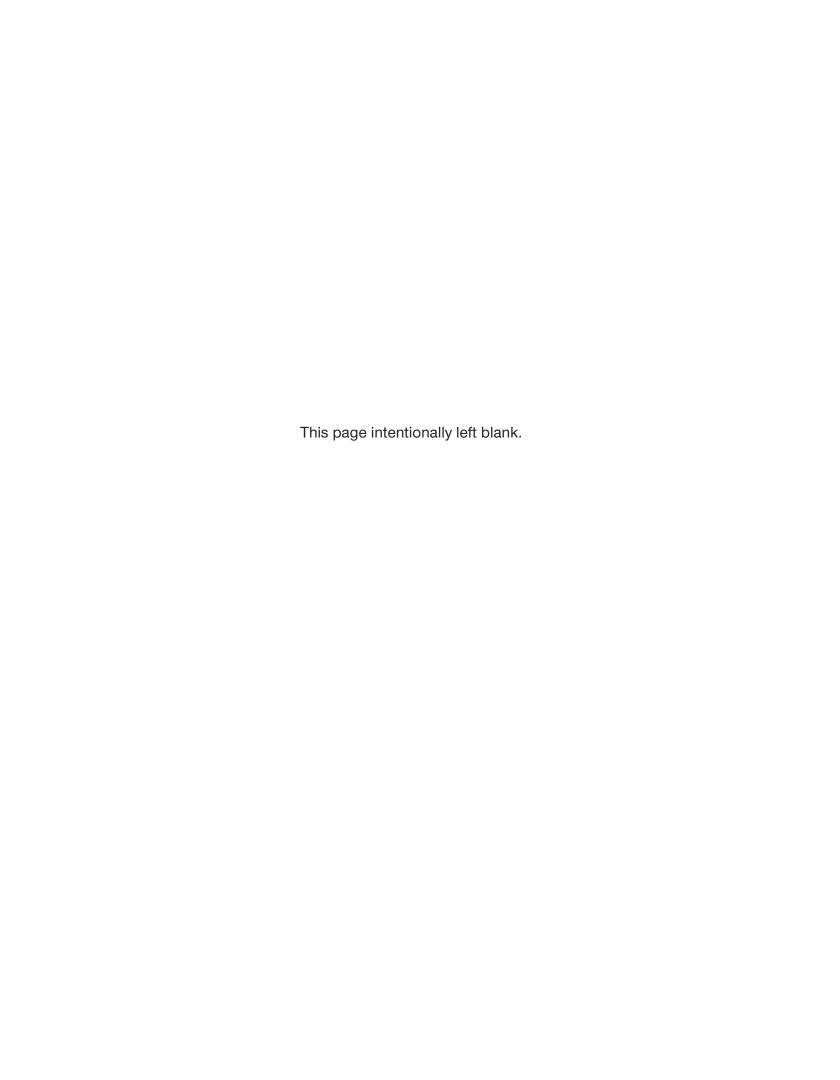




2023 Enrollment Request Form

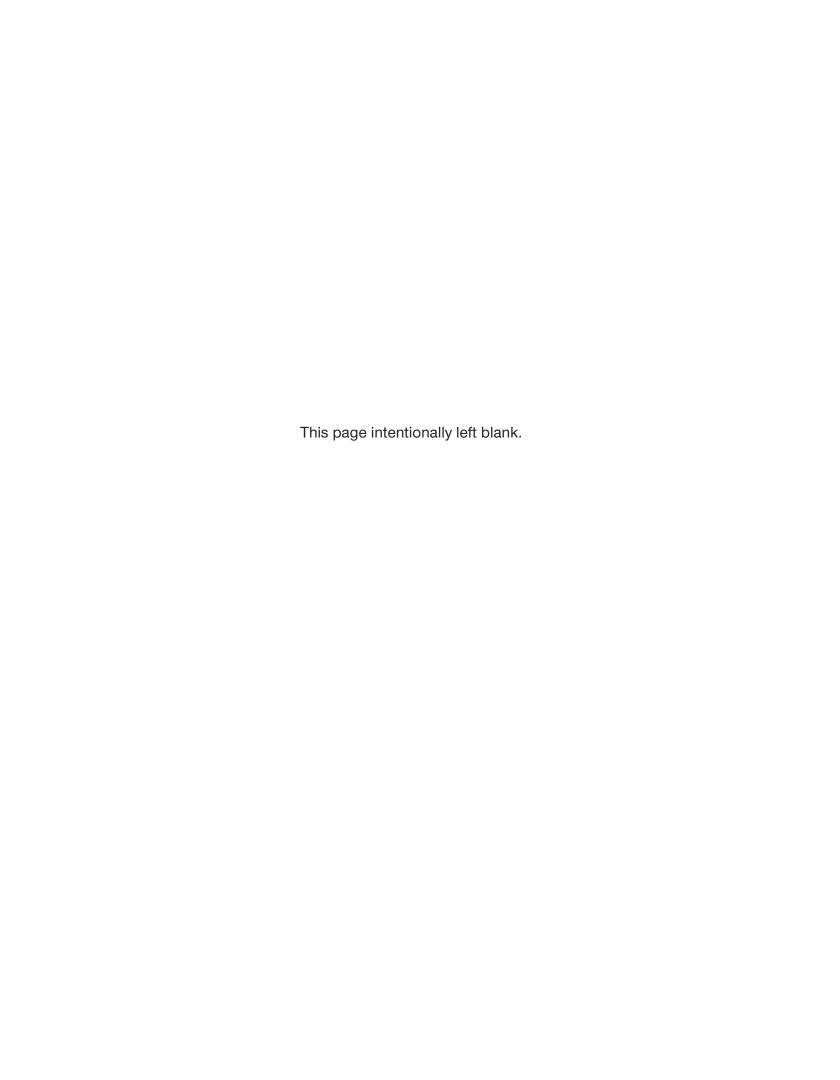
☐ Preferred Special Care Miami-Dade (HMO C-SNP) H1045-018-000 - PS1

Information about yo	u (Please	e type or print in	black or blue	e ink)		
Last Name		First Name			Middle Initial	
Birth Date			Sex ☐ Male ☐ Female			
Home Phone Number () -			Mobile Phone Number () -			
Medicare Number						
Permanent Residence Str	eet Addre	ess (P.O. Box is	not allowed)		
City				State	ZIP Code	
Mailing Address (Only if it	t's differ	ent from above.	You can giv	e a P.O. I	Box.)	
City				State	ZIP Code	
Email Address (Optional)						
Do you have other insurar	nce that v	will cover your p	orescription	drugs?	□ Yes □ No	
(Examples: Other private in programs.) If yes, what is it?	surance,	TRICARE, feder	ral employee	coverage	e, VA benefits, or state	
Name of Other Insurance						
Member Number	Gr	oup Number	R	xBin	RxPCN (Optional)	
Answering these questions them out.	is your o	choice. You can't	t be denied c	overage b	pecause you don't fill	
How do you want to p	pay?					
Enralla a Nama						
Enrollee Name Agent Name / ID No						
Y0066_ERFMA1_2023_C					PCFL23HM0049522_00	

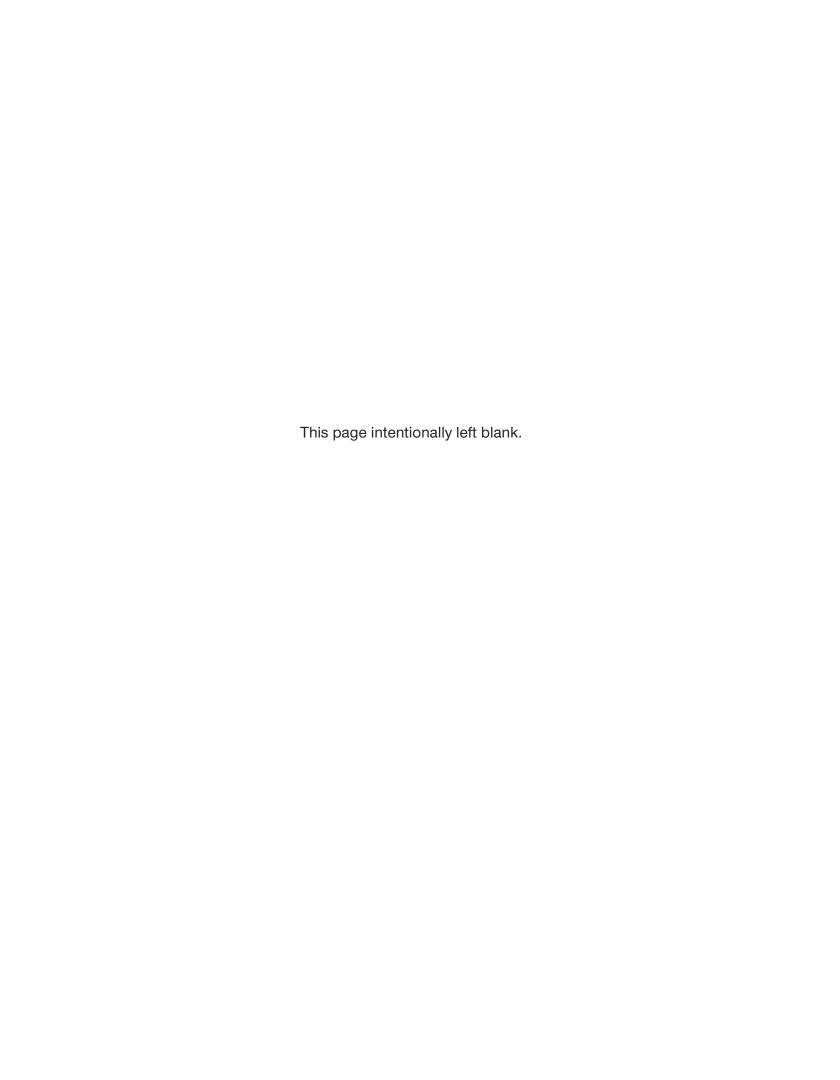


If you have a monthly plan premium (including any late enrollment penalty you may owe) you can pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT).

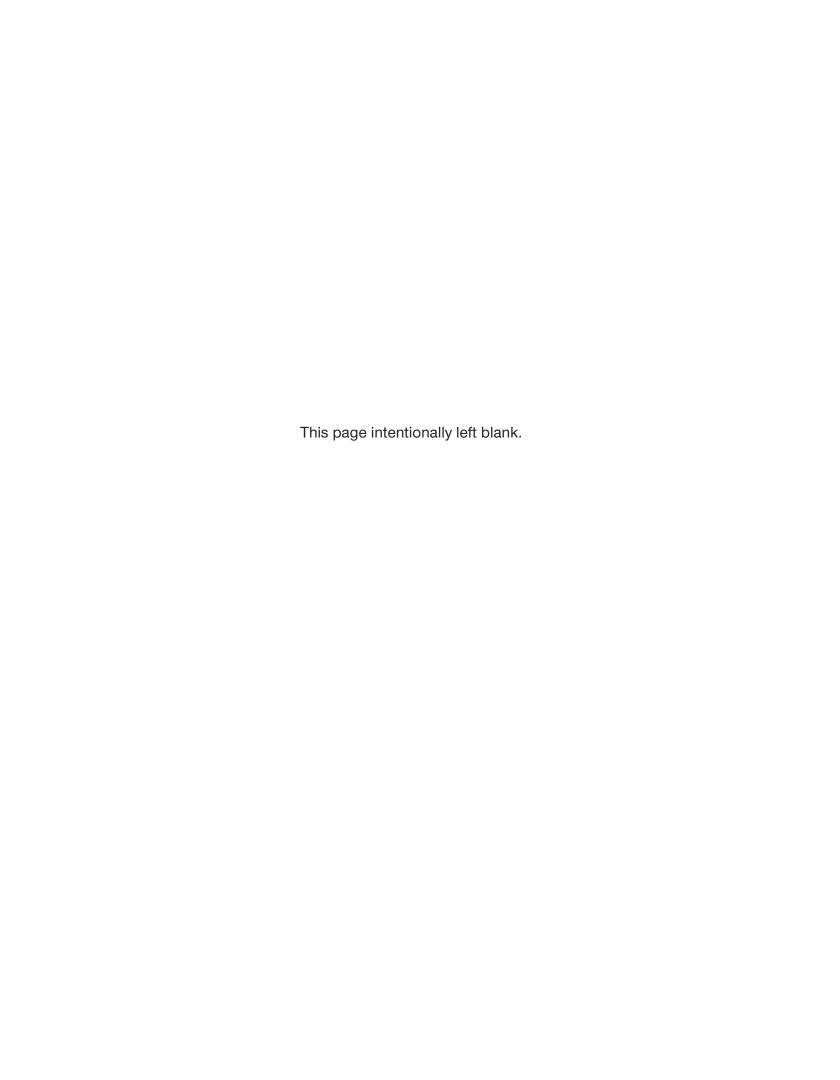
(RRB) benefit check each month. You can also pay from a bank account through Electronic Funds If you don't choose an option below, we'll send a bill each month to your mailing address. If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) Social Security (SS) will send you 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 ☐ 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: \square Spanish \square Braille \square 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, Chicano/a ____ Yes, Puerto Rican Yes, Cuban Yes, another Hispanic, Latino, or Spanish origin I choose not to answer.



3. What's your race? Select all that	apply.				
White Black or African American					
American Indian or Alaska N	lative				
Asian Indian	Chinese	Filipino			
Japanese	Korean	Vietnamese			
Other Asian	Native Hawaiian	Samoan			
Guamanian or Chamorro _	Other Pacific Islander				
I choose not to answer.					
4. Do you or your spouse work?		☐ Yes ☐ No			
Do you or your spouse have other h	ealth insurance that will cov	er medical services?			
(Examples: Other employer group of	overage, LTD coverage, Wo	rkers' Compensation,			
auto liability, or Veterans benefits)		☐ Yes ☐ No			
If yes, please complete the following	g:				
Name of Health Insurance Compar	าy				
Member Number					
5. Please give us the name of your p	 primary care provider (PCP), clinic or health center.			
You can find a list on the plan web					
Provider or PCP Full Name					
Provider/PCP Number:	(Please enter the	he number exactly as it appears			
	on the website	or in the Provider Directory. It will			
		jits. Don't include dashes.)			
Are you now seeing or have you rec	ently seen this provider?	☐ Yes ☐ No			
Please read and sign					
By completing this form, I agree to t	the following:				
☐ I must keep both Part A and Part	B to stay in UnitedHealthcar	re. I must keep paying my Part B			
premium if I have one, unless Me	-				
□ I understand that people with Me	dicare are generally not cov	ered under Medicare while out of			
the country, except for limited co	verage near the U.S. border	. This plan covers emergency and			
urgent care outside of the U.S. So	ee the Summary of Benefits	for more information.			
☐ I understand that when my United	dHealthcare coverage begin	s, I must get all of my medical and			
prescription drug benefits from l	JnitedHealthcare. Benefits a	and services authorized by			
UnitedHealthcare and contained	in my UnitedHealthcare "Evi	idence 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.			
Enrollee Name					



 □ Release of Information: By joining this Medical Drug Plan, I acknowledge that the plan will release is necessary for treatment, payment, and he UnitedHealthcare will release my information, in Medicare, who may release it for research and authorize the collection of this information (see □ I give UnitedHealthcare permission to share my organizations or person(s) for permissible purp administer my health plan. □ I give consent for all entities under UnitedHealth UnitedHealthcare to call the phone number(s) I □ The information on this form is correct to the beintentionally provide false information on this form Is woluntary. However plan. 	ase my information to Me alth care operations. I also neluding my prescription of other purposes applicable. Privacy Act Statement be protected health informations under applicable law heare and any outside ver have provided. The provided of the provided	dicare and other plans acknowledge that drug event data, to e to federal law that low). tion with as required to andor used by derstand that if I om the plan.	
When I sign below, it means that I have read and	understand the informat	ion on this form	
If I sign as an authorized representative, it means I is show written proof (Power of attorney, guardianship understand that I will need to submit written proof of behalf of the member beyond this application. After received my UCard, I can call Customer Service at the authorization information on file. Signature of Applicant/Member/Authorized Representative, it means I is show written proof of the submit and the submit a	o, etc.) of this right if Medic of this right, to the plan, if I this application has been the number on my UCard	care asks for it. I wish to take action on approved and I have to update my	
If you are the authorized representative, information below	please sign above an	d complete the	
*NOT A SALES AGENT			
Last Name	First Name		
Address			
City	State	ZIP Code	
Phone Number () –	Relationship to Applicant		
Enrollee Name		PCFL23HM0049522_001	

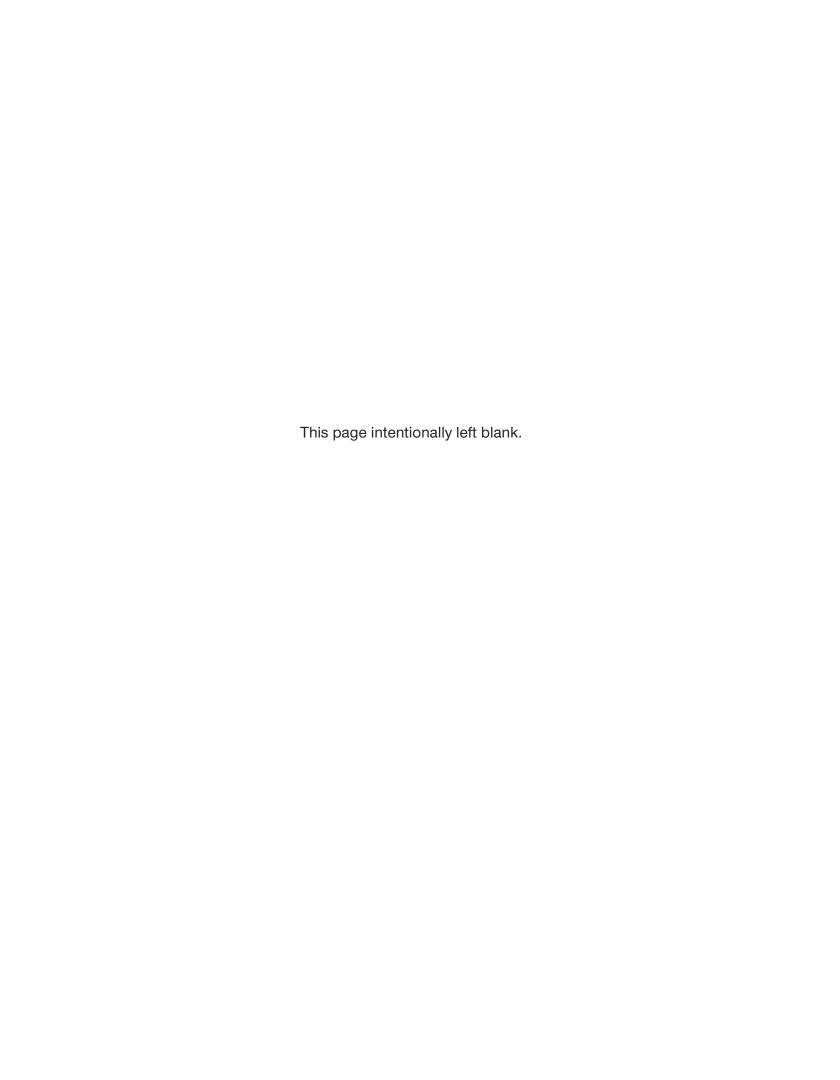


For licensed sales representative/agency use only						
Employer Group Name						
Employer Group ID		Branch ID				
Licensed Sales Representative/Writing ID				Initial Receipt Date		
Licensed Sales Representative/Agent Name				Proposed Effective Date		
Agent must complete						
☐ IEP (MA-PD enrollees)	☐ 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 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



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.

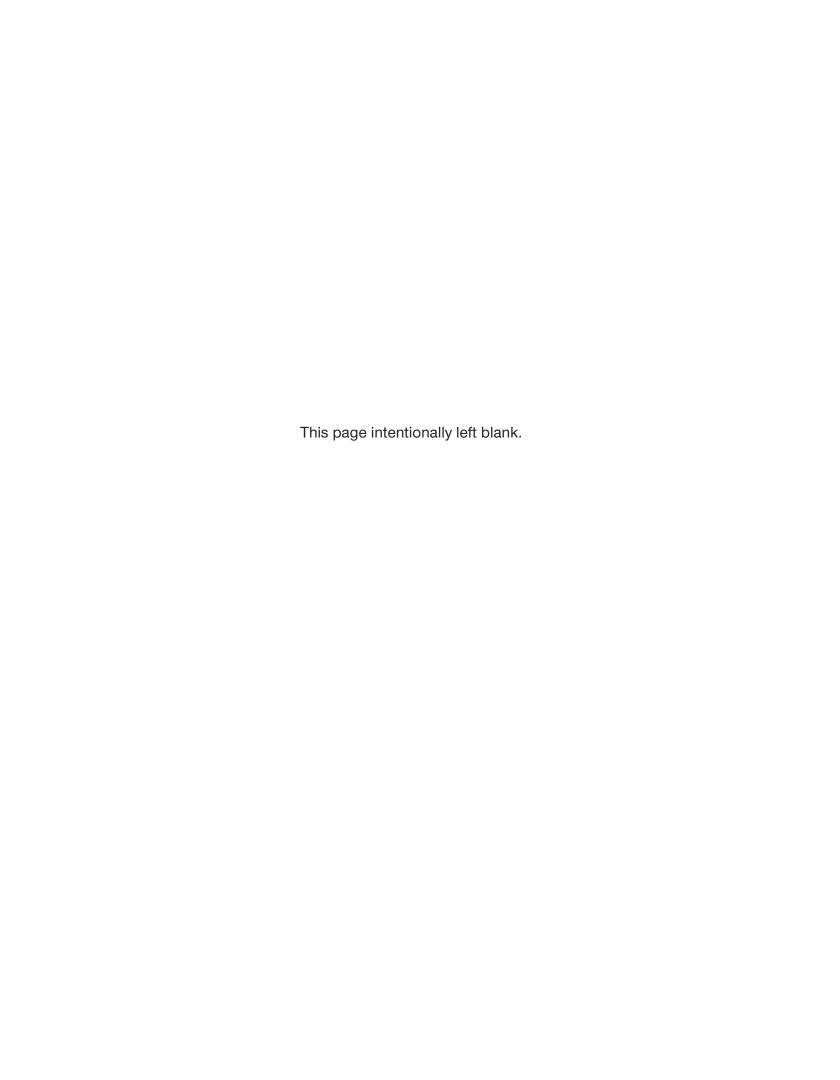
Preferred Care Partners is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare. This plan is available to anyone having a qualifying 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: 7/31/2023

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



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).



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.