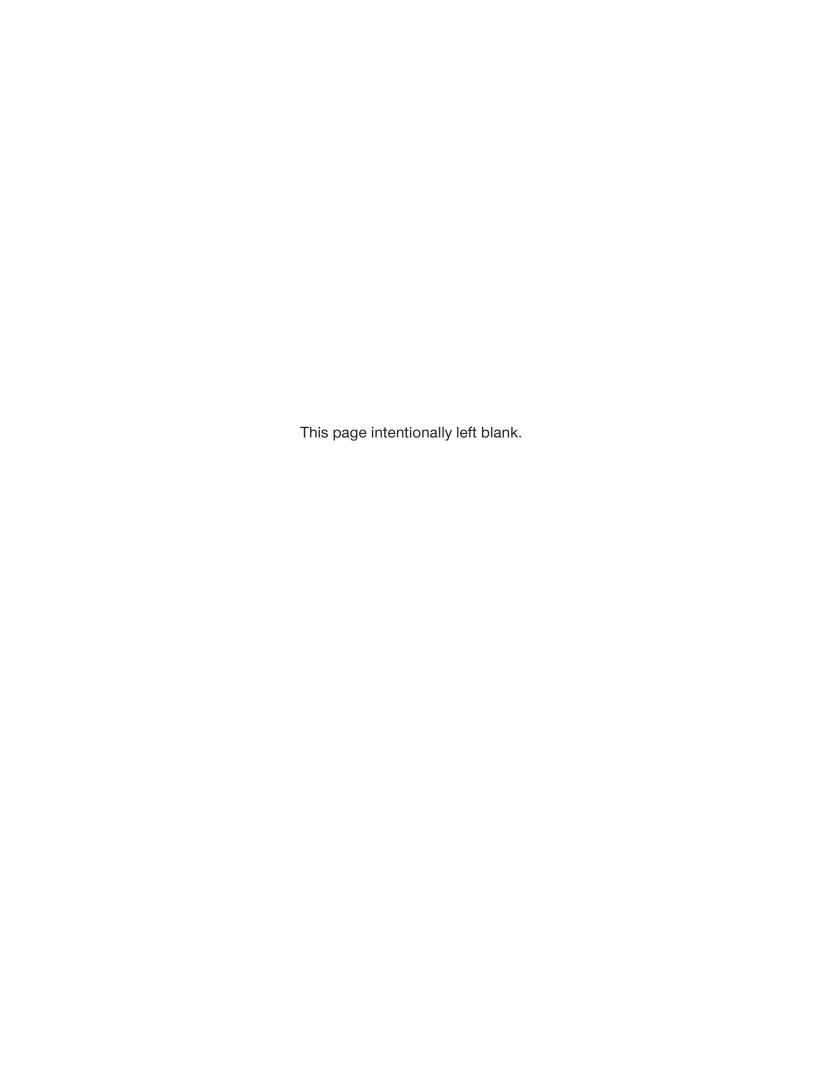




Please contact the plan if you nee (Braille).			in another la	inguage or an	acces	ssible format
☐ UnitedHealthcare MedicareCo	mplete Plar	1 (HI	МО) Н0755 -	030 - UH1		
This is a Health Maintenance Organospitals and other providers you	-	MO) pl	an. It has a r	network of doc	ctors,	specialists,
Information about you. (Ple	ase type or	print ir	n black or bl	ue ink)		
☐ Mr. Last Name ☐ Mrs. ☐ Ms.		First	First Name			Middle Initial
Birth Date MM-DD-YYYY			Sex □ Ma	ale 🗆 Female		
Daytime Phone Number () -		Mobile Pho	one Number () -
Permanent Residence Street Ad	dress (P.O. I	Box is	not allowed	i)		
City	County			State	ZIP Code	
Mailing Address (Only if it's diffe	erent from a	above.	You can giv	∪ ve a P.O. Box.)	
City	County			State	ZIP	Code
Email Address	I				1	
Enrollee Name						
Agent Name / ID No Y0066_180613_072818 Approved	t			UHC	CT19F	



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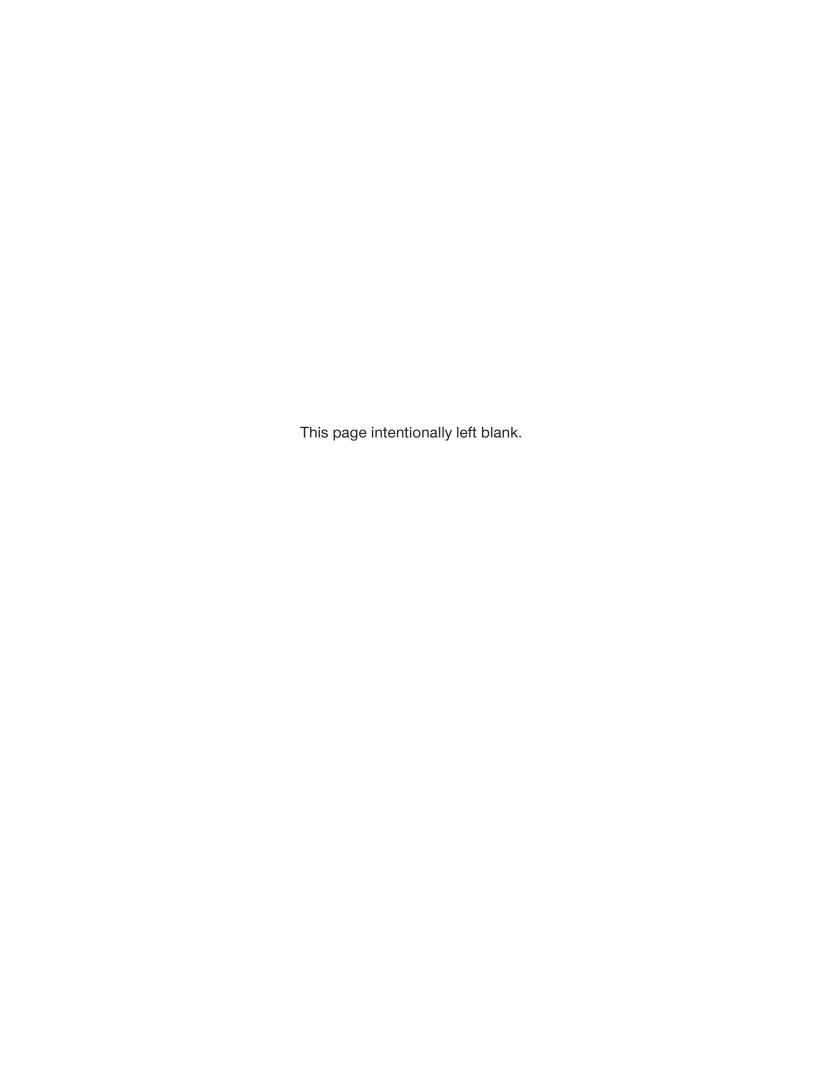
To select paperless delivery complete and sign the application and provide your email address.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (Explanation of Benefits, Annual Notice of Changes, and other wellness information) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

device such as a computer, tablet, or mobile phone.					
Check here to opt out of paperless delivery.					
☐ 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. We will only use your email address if you change delivery preference or if we have other information to share with you.					
Information about your Medicare.					
Please take out your red, white and blue Me	edicare card to complete this s	ection.			
 Fill out this information as it appears on your Medicare card. OR- 	icare card.				
☐ Attach a copy of your Medicare card or	Medicare Number:				
your letter from Social Security or the Railroad Retirement Board.	Sex:				
	Is Entitled to	Effective Date			
	Hospital (Part A)	MM-DD-YYYY			
	Medical (Part B)	_MM-DD-YYYY			
	You must have Medicare Part A and Part B to join a Medicare Advantage plan.				
How do you want to pay?					
If you have a monthly plan premium (including any late enrollment penalty you may owe), you can choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. You can also pay from your bank account through Electronic Funds Transfer (EFT), online or by mail.					
This plan has a premium (monthly payment). Please choose how you want to pay it. Note: If you have a late enrollment penalty (LEP), we'll add it to your premium.					
If you don't choose an option, we'll send a bill each month to your mailing address.					
☐ I want to pay from my Social Security or Railroad Retirement Board (RRB) check.					
I get monthly benefits from: ☐ Social Se					

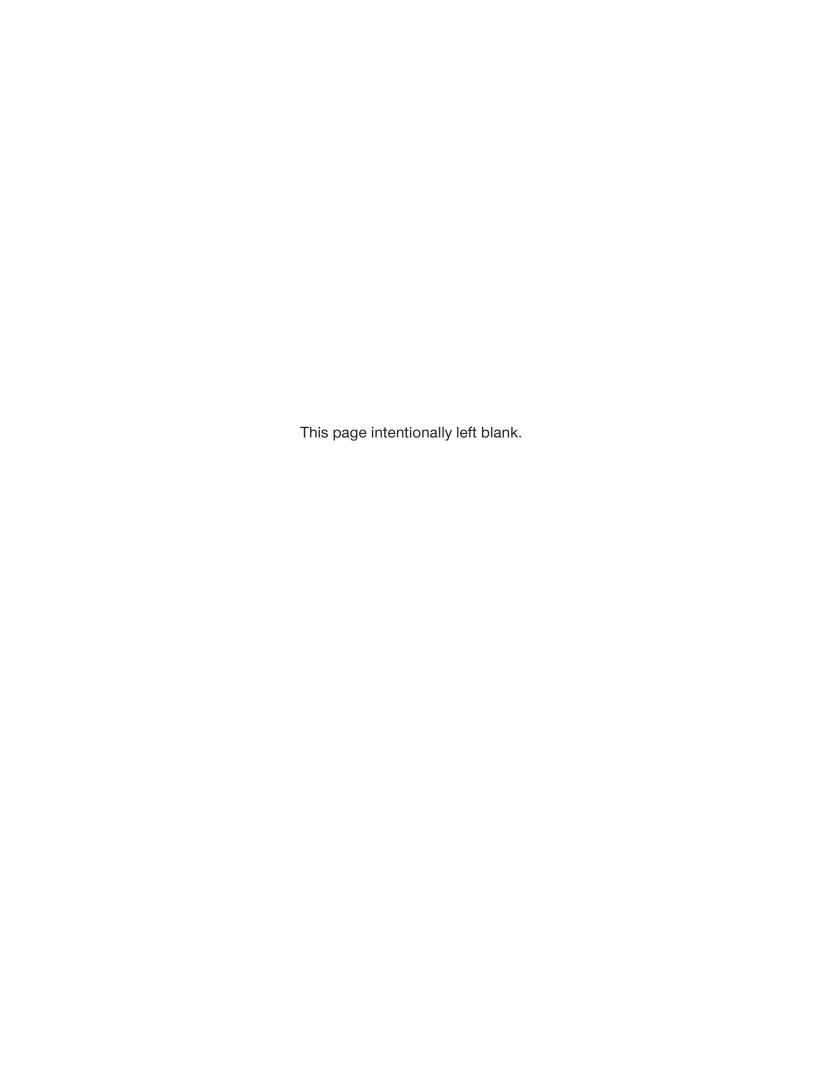
Enrollee Name _____

Y0066_180613_072818 Approved



include more than one premium. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction or there is a delay in setup, we will send you a paper bill for your monthly premiums. ☐ I want to pay directly from a bank account. □ Please attach a blank check from the account you'd like to use. Write "VOID" across the front. Please DO NOT send a deposit slip or money order. □ Please read the statement below. My bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). My bank will pay the funds from my checking or savings account on or about the fifth of each month. The charges may include up to \$200 of current retroactive charges plus the monthly premium amount. If I choose to stop paying directly from my account, I will tell both UHIC and my bank. I will give them a reasonable amount of time to change my method of payment. Account Type □ Checking □ Savings Account Holder Name: Bank Routing Number Bank Account Number Signature Date MM-DD-YYYY \square I want to pay online. Visit www.UHCMedicareSolutions.com to make a payment directly from a bank account. \square I want to pay by mail. We'll send a bill to your mailing address each month or you will receive an email notification if you signed up for e-delivery. If you want to pay by credit card. After you become a member, you can call us to have your monthly payment charged to your Visa or Mastercard. Until then, we'll send you a bill each month.

We'll set it up. It may take a few months before payment starts, so the first payment may

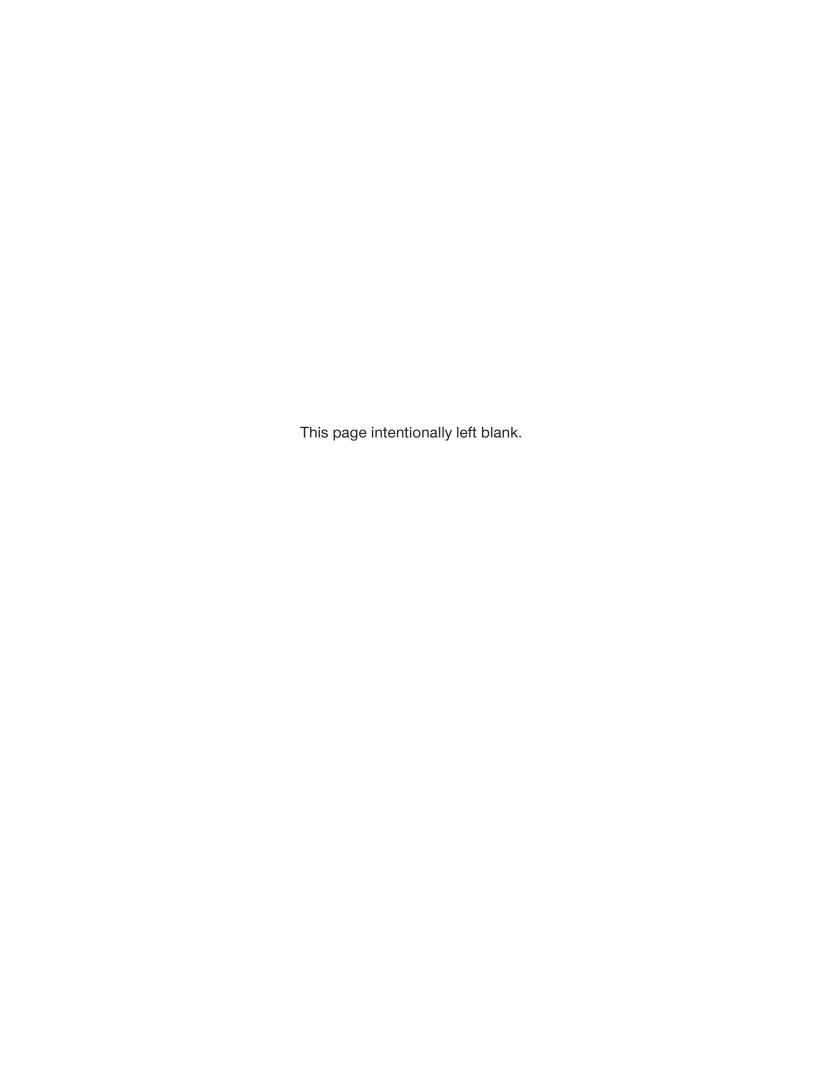


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A few notes about your costs.

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If you must pay a Part D-Income Related Monthly Adjustment Amount (Part Social Security (SS) will send you a letter and ask you how you want to pay it:	t D-IRMAA)		
 ☐ You can pay it from your SS check ☐ Medicare can bill you 			
☐ The Railroad Retirement Board (RRB) can bill you			
Please DO NOT pay the plan the Part D-IRMAA at this time.			
Need help with your prescription drug costs? If you have a limited income, you may be able to get Extra Help with your prescription drug qualify, Medicare could pay for 75% or more of your costs, including more drug premiums, annual deductibles, and coinsurance. Additionally, you won't legap or late enrollment penalty. Many people are eligible for these savings and If you qualify for Extra Help with your Medicare prescription drug coverage cost pay all or part of your plan premium. If Medicare pays only part of your premium for the amount that Medicare doesn't cover.	nthly prescription have a coverage don't even know it. sts, Medicare will		
For more information about this Extra Help, contact your local Social Security of Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can als Help online at www.socialsecurity.gov/prescriptionhelp.			
A few questions to help us manage your plan.			
1. Would you prefer plan information in another language or an accessible for	ormat?□ Yes □ No		
Please check what you'd like: Spanish Other			
If you don't see the language or format you want, please call us toll-free at 1-8 711 during 8 a.m 8 p.m. local time, 7 days a week. Or visit www.UHCMedica for online help.			
2. Do you have end stage renal disease?	☐ Yes ☐ No		
If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis; otherwise, we may need to contact you to obtain additional information.			
If "yes," are you currently a member of a health care company?	☐ Yes ☐ No		
Name of Company Member Number			
3. Are you enrolled in your State Medicaid program?	☐ Yes ☐ No		
If yes, please give us your Medicaid number:			
Enrollee Name			



Page 5 of 9 4. Do you live in a nursing home or a long-term care facility? ☐ Yes ☐ No If yes, please give us information on the long-term care facility: Name Address City **ZIP Code** State Phone Number () **MM-DD-YYYY** Date You Moved There 5. Do you have health insurance with an employer or union right now? ☐ Yes ☐ No If yes, you could lose that plan if you join this plan. Please talk to your employer or union. Ask how joining this plan could affect your current plan. You may also want to check your employer or union's website, or read any information sent to you. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help. ☐ Yes ☐ No 6. Do you or your spouse work? Do you or your spouse have other health insurance that will cover medical services? (Examples: Other employer group coverage, LTD coverage, Workman's Compensation, Auto Liability, or Veterans benefits) ☐ Yes ☐ No If yes, please complete the following: Name of Health Insurance Company Subscriber Name **Group Number** Member Number Effective Dates (if applicable) MM-DD-YYYY - MM-DD-YYYY 7. Do you have other insurance that will cover your prescription drugs? ☐ Yes ☐ No (Examples: Other private insurance, TRICARE, Federal employee coverage, VA benefits, or state programs.) If yes, what is it?

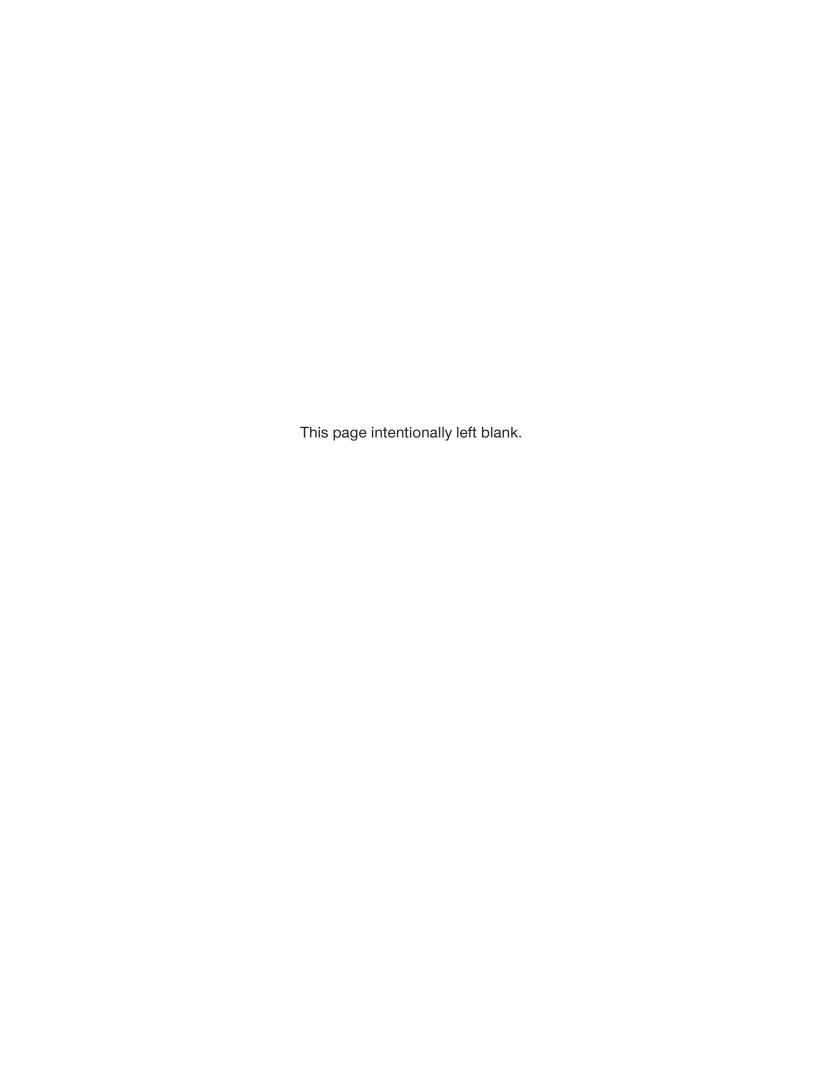
Group Number

Name of Other Insurance

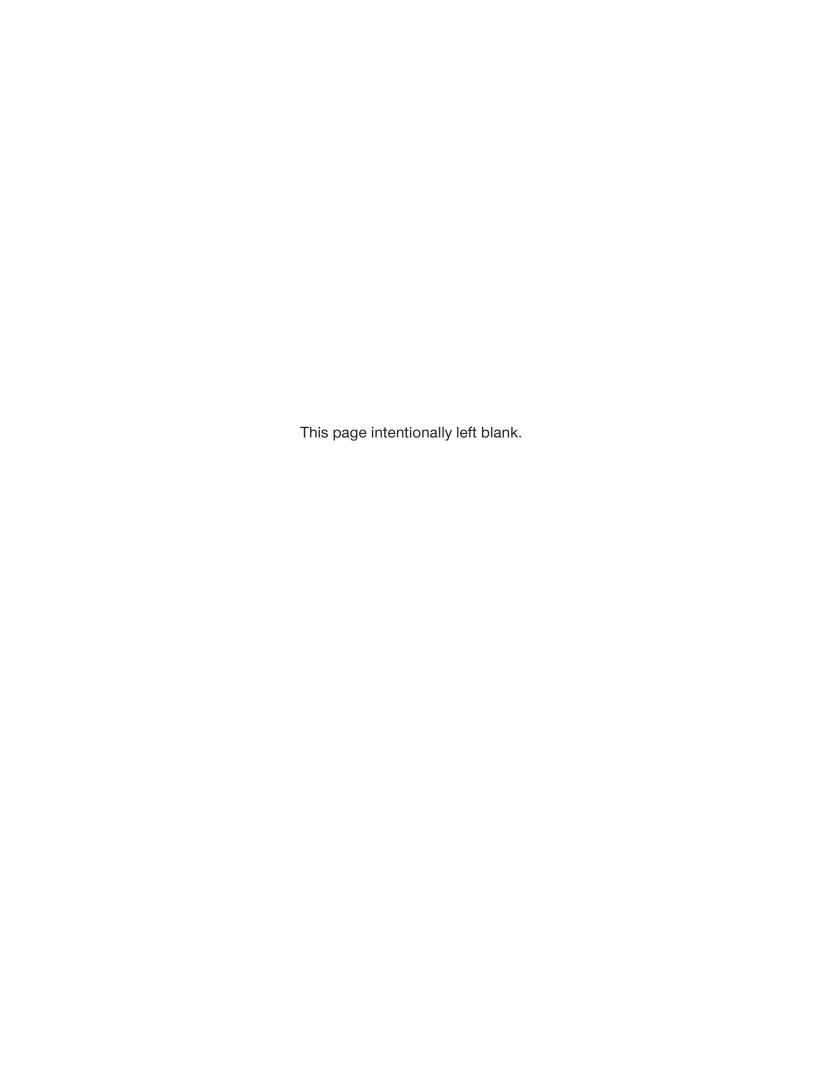
Member Number

Date Plan Started

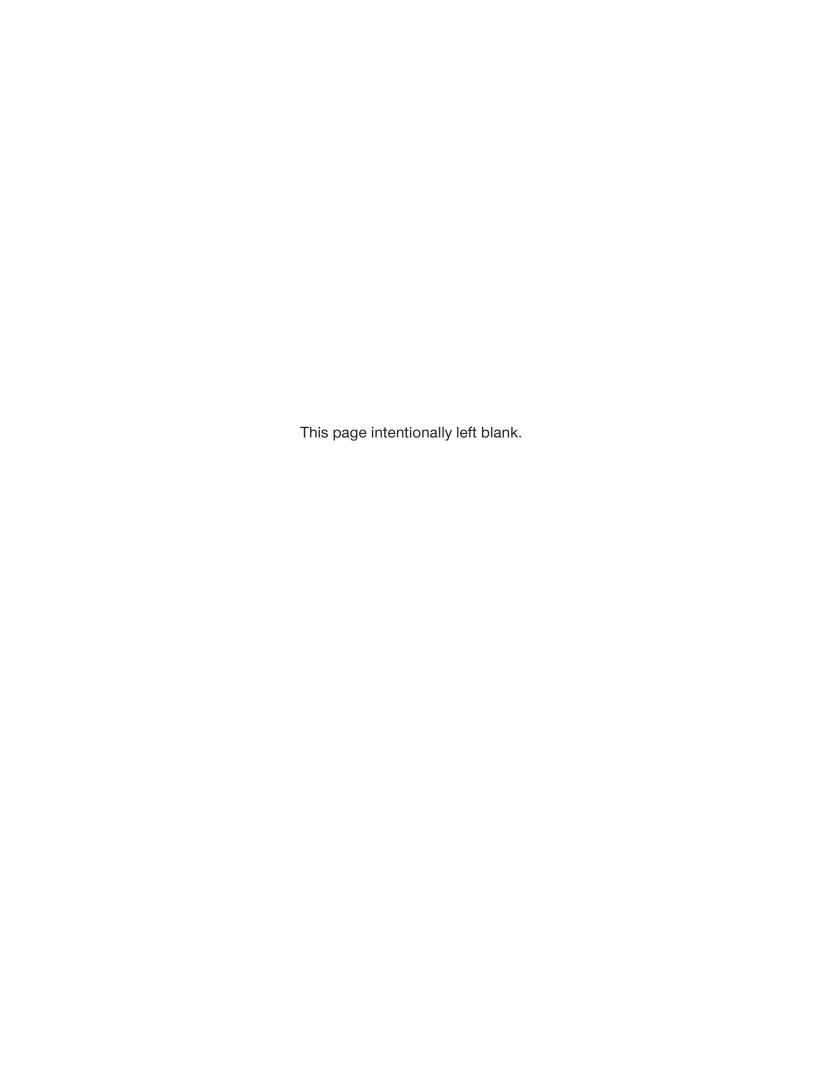
MM-DD-YYYY



8.	Please give us the name of your primary care	ase give us the name of your primary care 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	Phone Number ()	-			
	Provider/PCP Number:	(Please enter the number ex on the website or in the Pro- be 10 to 12 digits. Don't incl	vider Directory. It will			
	Are you now seeing or have you recently seen	this doctor?	☐ Yes ☐ No			
	Diagona wood and alam					
	Please read and sign.					
В	y completing this form, I agree to the followin	g:				
	☐ This is a Medicare Advantage plan. It has a confidence Supplement plan.	ontract with the federal gover	nment. This is not a			
	☐ I need to keep my Medicare Parts A and B. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.					
 I can only be in one Medicare health plan or Prescription Drug plan at a time. If I'm a member of another Medicare health plan or Prescription Drug plan and I join this plan, I will lose the other plan. If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan. 						
						☐ I may have to pay a late enrollment penalty (L and keep creditable prescription drug covera "Creditable" means the coverage is as good pay a LEP, the plan will tell me.
	□ I understand that I am joining the plan for the need to do so during the Open Enrollment Perprescription drug coverage between October situations that would allow me to leave the plan	eriod for Medicare Advantage r 15 and December 7. There r	AND Medicare			
	☐ This plan covers a specific area. If I plan to ma plan in the new area. Medicare may not coverage some limited coverage near the U.S. bo	ver me when I'm out of the co	• •			
	I will receive information on how to get an Evimember contract or subscriber agreement.) as the plan's terms and conditions. The plan listed in the EOC. If a service isn't listed in the plan won't pay for it. If I disagree with how the appeal.	idence of Coverage. (The EOG The EOC will list services the will cover services it approved EEOC or approved by the pla	plan covers, as well s, as well as services n, Medicare and the			
	☐ I understand that I must get my health care coplan's network. I can go to any doctor or hos		•			
Eı	nrollee Name					



services or out-of-area dialysis services. If I happen to pay full price for any network services, this plan provides refunds for all medically necessary covered benefits.					
☐ If I currently have Medicare Supplement Insurance (Medigap), I will cancel it in writing. I, not my agent, must cancel. I will cancel after my new plan tells me I've been accepted into the					
 plan. My plan will give my information to Medicare and other plans when needed for treatment, payment and health care operations. This may include my prescription drug information. Medicare uses the information to understand how my care was handled or billed. Other plans may need my information when they help pay for my care. Medicare may also give my information for research and other purposes. All federal laws and rules protecting my privacy will be followed. If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help. The information on this form is correct, to the best of my knowledge. I understand that if I put information on this form that I know is not true, I will lose 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 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 you have received your UnitedHealthcare member ID card, please call Customer Service at the number on the back of your UnitedHealthcare member ID card to update your authorization information on file. Signature of Applicant/Member/Authorized Representative Today's Date MM-DD-YYYY					
If you are the authorized representative, please sign above and complete the information below.					
Last Name	*NOT A SALES AGENT Last Name First Name				
Address					
City	State	ZIP Code			
Phone Number () – Relationship to Applicant					
Enrollee Name		OT4011114000040			
Y0066_180613_072818 Approved	UH	CT19HM4306813_001			

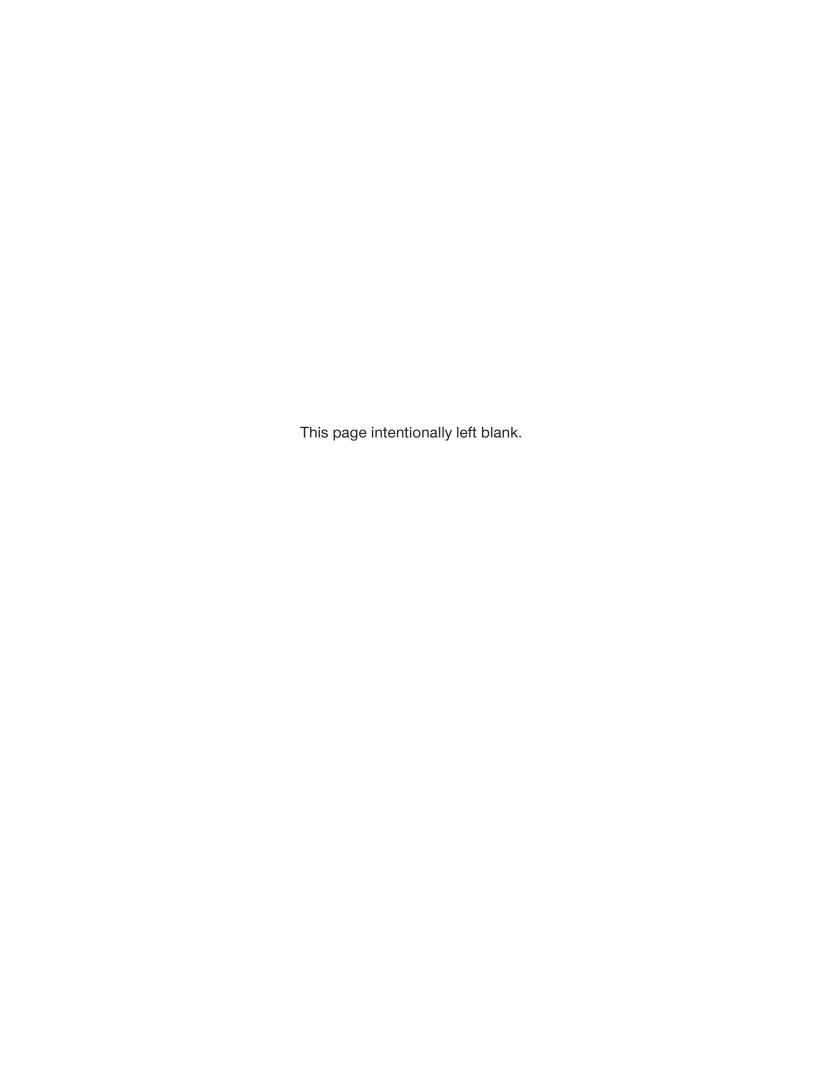


For licensed sales representative/agency use only.						
□ New Member□ Plan Change	Employer Group	Name				
Employer Group ID				Branch ID		
Licensed Sales Representative/Writing ID				Initial Receipt Date		
Licensed Sales Representative/Agent Name				Proposed Effective Date		
Licensed Sales Re	Licensed Sales Representative Phone Number () –					
Where did this application originate? □ National Retail/Mall Program □ Community Meeting □ Appointment □ Other □ Member Meeting □ Local Event Outreach □ Walmart Program How was this application submitted? □ Mail □ Fax □ Online				□ Other		
Agent must comp	olete					
□ AEP □ SEP (Chronic) □ OEPI □ IEP (MA-PD enrollees) □ ICEP (MA enrollees) □ SEP (Full Dual Eligible) □ OEP (Jan1 – Mar 31) □ OEPNEW □ SEP (SEP Reason)				□ IEP (MA-PD enrollees eligible for 2nd IEP)□ SEP (Partial Dual Eligible)□ SEP (Dual Eligible)		
□ SEP Eligibility Date Licensed Sales Representative Signature (required)						
Licensed Sales F	representative s	signature (requ	iired	i) MW-D	D-Y Y Y Y	

Please mail or fax this completed form to:

UnitedHealthcare 3315 Central AVE Hot Springs, AR 71913

Fax: 1-501-262-7070



Plans are insured through UnitedHealthcare® Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan's contract renewal with Medicare.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711). 注意:如果您說中文,您可以免費獲得語言援助服務。請致電 1-855-814-6894 (聽力語言殘障服務專線 TTY: 711).

