

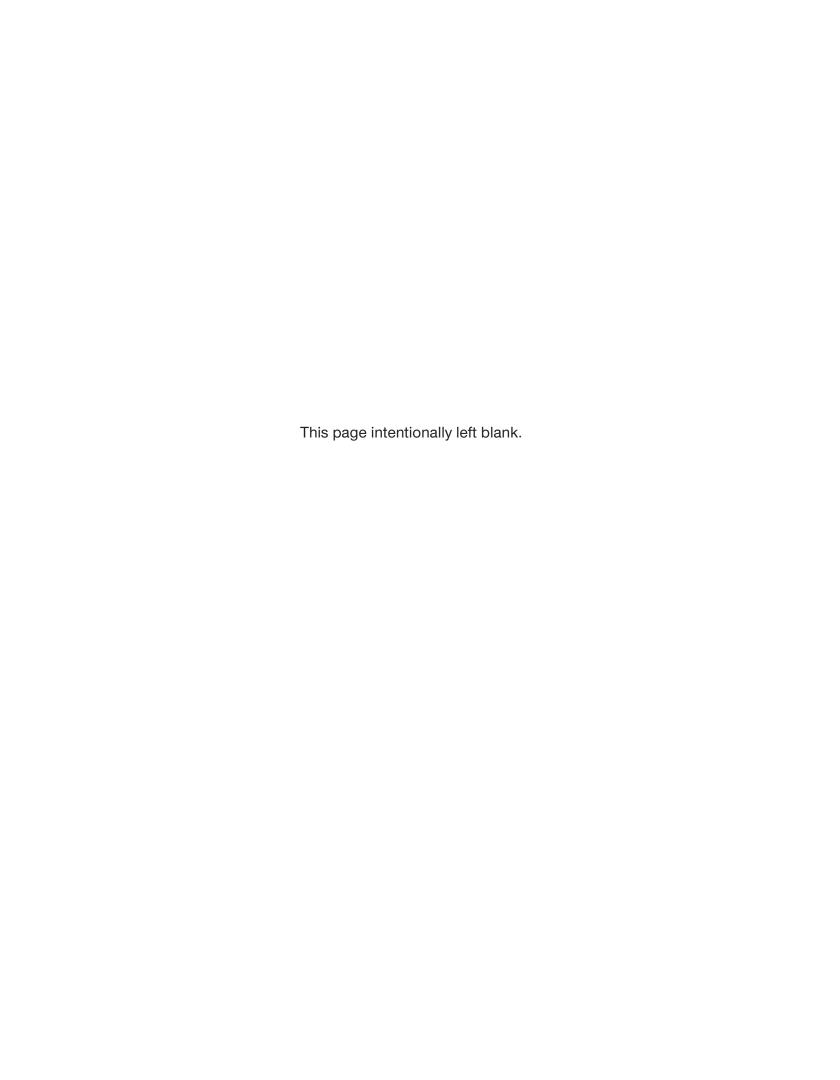




2022 Enrollment Request Form

☐ Erickson Advantage® Freedom (HMO-POS) H5652-006-000 - EF

| Information about you | . (Pleas | se type or print ir | n black or b | olue ink) | | | |
|-------------------------------------------------------------|----------|---------------------|---------------------------|---------------|----------|---------------------|--|
| Last Name | | First Name | Mid | | | fiddle Initial | |
| Birth Date | | | Sex □ Male □ Female | | | | |
| Home Phone Number () - | | | Mobile Phone Number () - | | | | |
| Medicare Number | | | | | | | |
| Permanent Residence Stree | et Addr | ess (P.O. Box is | not allowe | ed) | | | |
| City | | | State | | ZIP Code | | |
| Mailing Address (Only if it's | differ | ent from above. | You can g | jive a P.O. I | Box.) | | |
| City | | | | State | | ZIP Code | |
| Email Address (optional) | | | | | | | |
| Do you have other insurance | e that v | will cover your p | orescriptio | n drugs? | | ☐ Yes ☐ No | |
| (Examples: Other private insuprograms.) If yes, what is it? | urance, | TRICARE, Fede | ral employ | ee coverag | e, VA | benefits, or state | |
| Name of Other Insurance | | | | | | | |
| Member Number | Gr | Group Number | | RxBin | | RxPCN (optional) | |
| Answering these questions is them out. | s your c | choice. You can't | be denied | l coverage l | oecau | use you don't fill | |
| How do you want to pa | ay? | | | | | | |
| Enrollee Name | | | | | | | |
| Agent Name / ID No. | | | | | | EDEVO0DO 1000001 00 | |
| 70066 ERFMA 2022 C | | | | | | EREX22PO4988881 0 | |

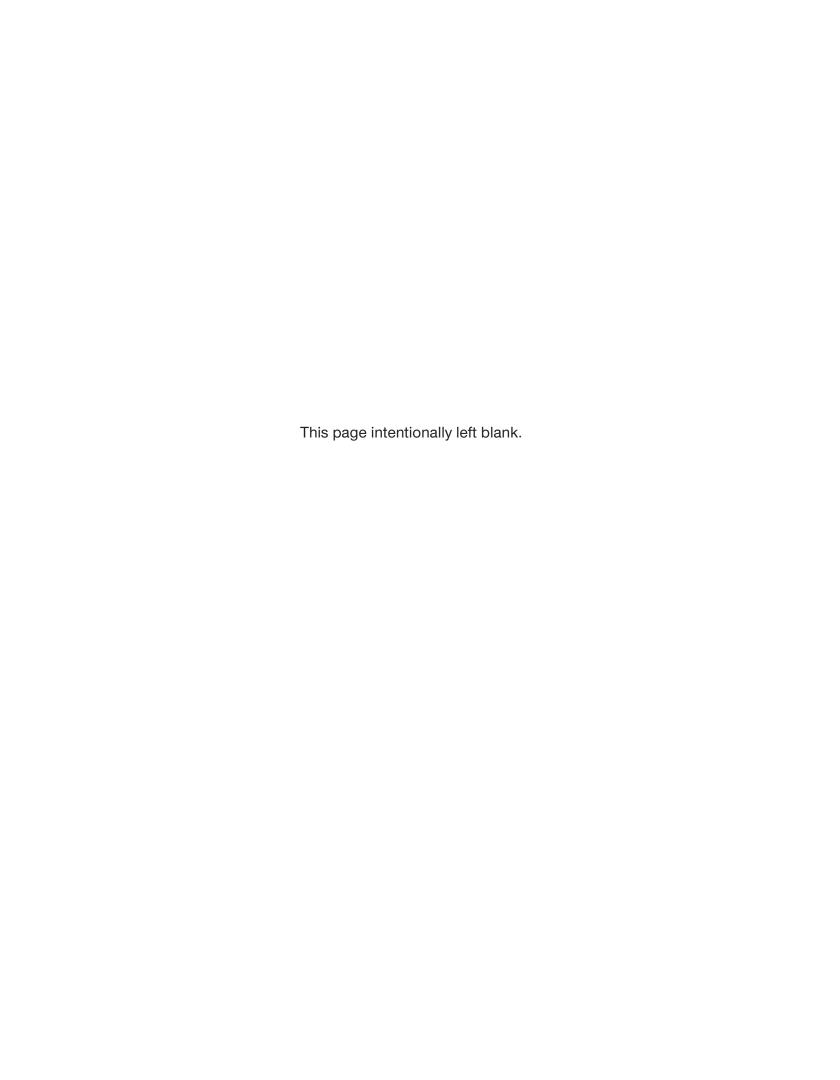


If you have a monthly plan premium (including any late enrollment penalty you may owe) you can pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT).

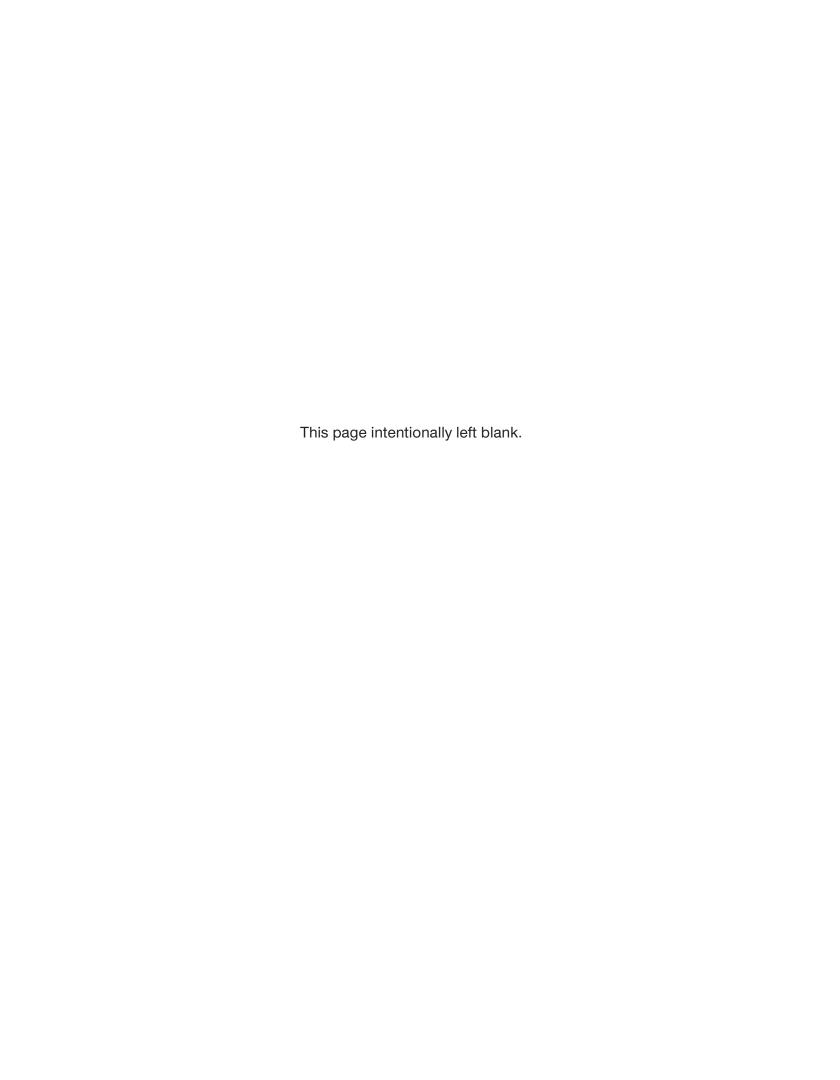
Transfer (EFT). If you don't choose an option below, we'll send a bill each month to your mailing address. If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) Social Security (SS) will send you a letter and ask you how you want to pay it: ☐ You can pay it from your SS check ☐ Medicare can bill you ☐ The Railroad Retirement Board (RRB) can bill you ☐ I want to pay from my Social Security ☐ 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 1-866-774-9671, TTY 711 during 8 a.m. - 8 p.m. local time, 7 days a week. Or visit www.EricksonAdvantage.com for online help. 2. Do you or your spouse work? ☐ Yes ☐ No 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 Member Number

Y0066_ERFMA_2022_C

Enrollee Name _



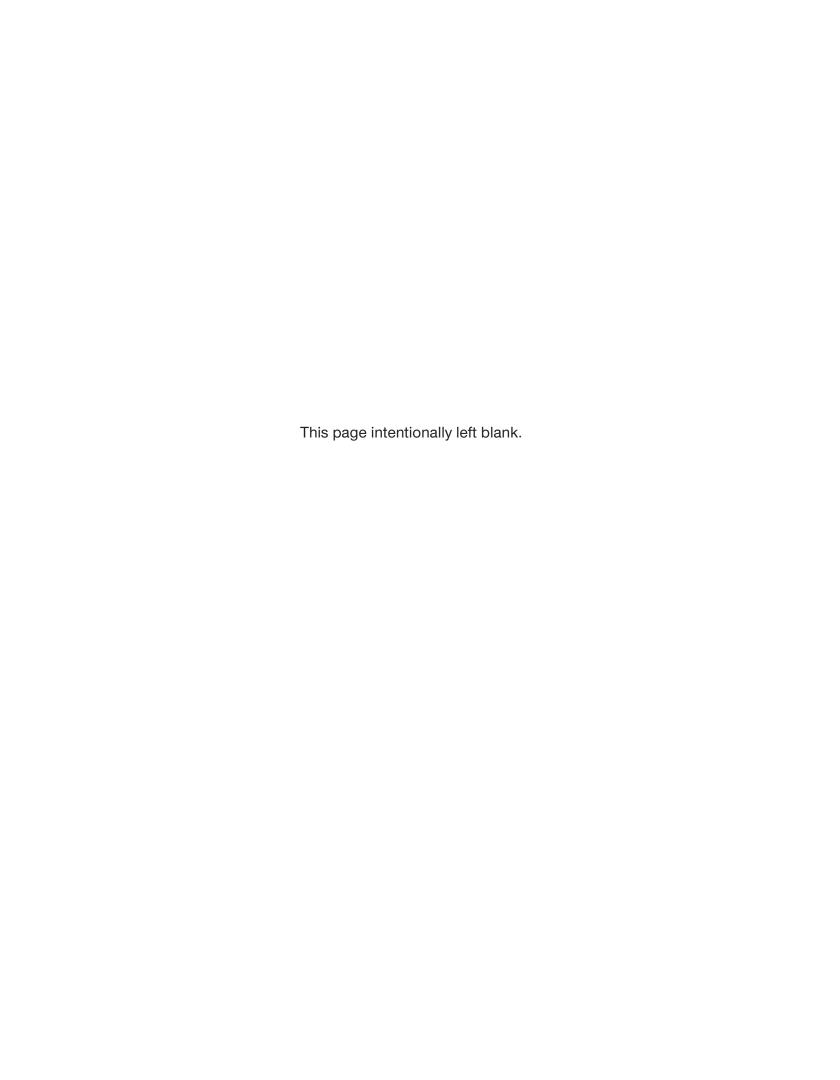
| 3. Please give us the name of your primary care You can find a list on the plan website or in the | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 be 10 to 12 digits. Don't include dashes.) |
| Please read and sign. | |
| By completing this form, I agree to the followin | g: |
| premium if I have one, unless Medicaid or so I understand that people with Medicare are go the country, except for limited coverage near urgent care outside of the U.S. See the Summare I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealth UnitedHealthcare and contained in my United (also known as a member contract or subscrauthorization, neither Medicare nor United If I currently have Medicare Supplement Insumy agent, must cancel. I will cancel after my plan. Release of Information: By joining this Medicare Drug Plan, I acknowledge that the plan will reas is necessary for treatment, payment, and I UnitedHealthcare will release my information Medicare, who may release it for research an authorize the collection of this information (so I give UnitedHealthcare permission to share rorganizations or person(s) for permissible puradminister my health plan. I give consent for all entities under UnitedHealthcare to call the phone number (so The information on this form is correct, to the intentionally provide false information on this | generally not covered under Medicare while out of the U.S. border. This plan covers emergency and mary of Benefits for more information. coverage begins, I must get all of my medical and mare. Benefits and services authorized by dHealthcare "Evidence of Coverage" document liber agreement) will be covered. Without Healthcare will pay for benefits or services. rance (Medigap), I will cancel it in writing. I, not new plan tells me I've been accepted into the licare Advantage Plan or Medicare Prescription elease my information to Medicare and other plans health care operations. I also acknowledge that a including my prescription drug event data, to ad other purposes applicable to Federal law that the Privacy Act Statement below). In protected health information with proses under applicable law as required to althcare and any outside vendor used by I have provided. The best of my knowledge. I understand that if I form I will be disenrolled from the plan. The form I will be disenrolled from the plan. The form I will be disenrolled from the plan. The form I will be disenrolled from the plan. The form I will be disenrolled from the plan. The form I will be disenrolled from the plan. |



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 member ID card, I can call Customer Service at the number on my member ID card 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 | | | | |

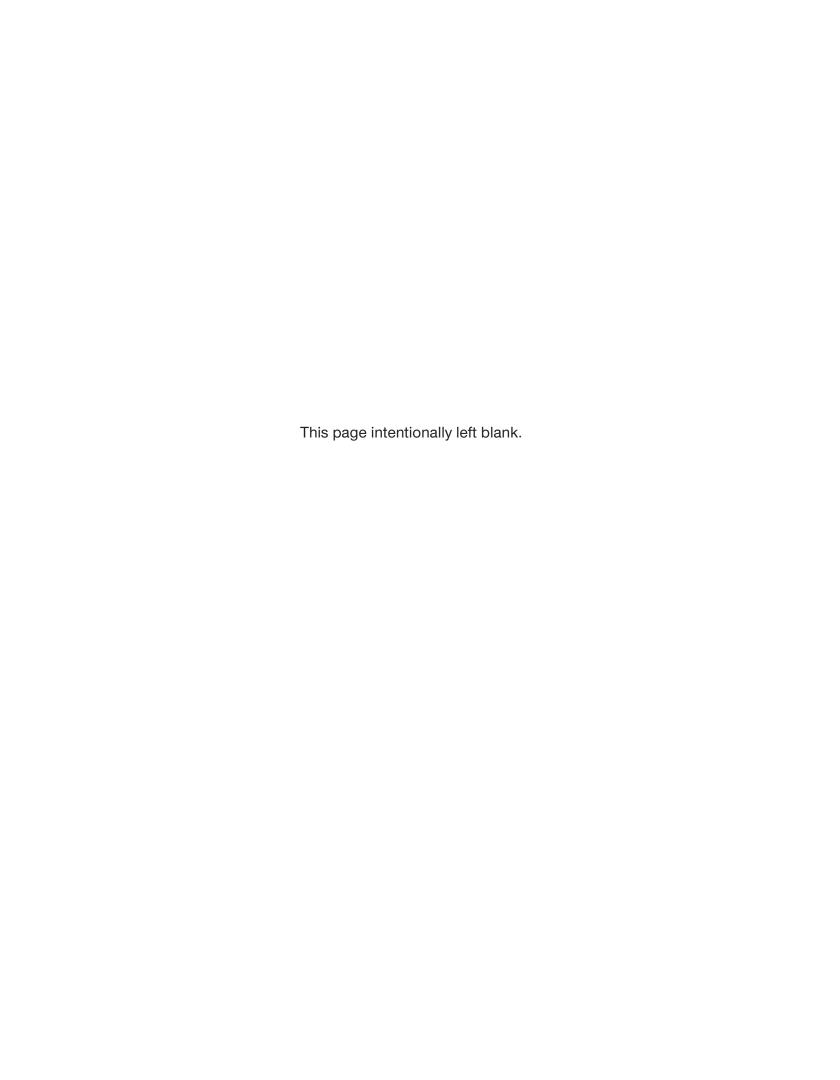


| For licensed sales representative/agency use only. | | | | | | |
|-----------------------------------------------------------|-----------------------------------|----------------------------------------------|-------------------------|----------------------|-------------------------------|--|
| Employer 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 (Jan1 - Mar 31) | |
| ☐ OEP (newly eligible) | ☐ SEP (Dual LIS change of status) | ☐ SEP (change in residence) | | | ☐ SEP (loss of EGHP coverage) | |
| ☐ SEP (Chronic) | ☐ SEP (Dual LIS maintaining) | ☐ AEP (October 15- December 7) | | | □ 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

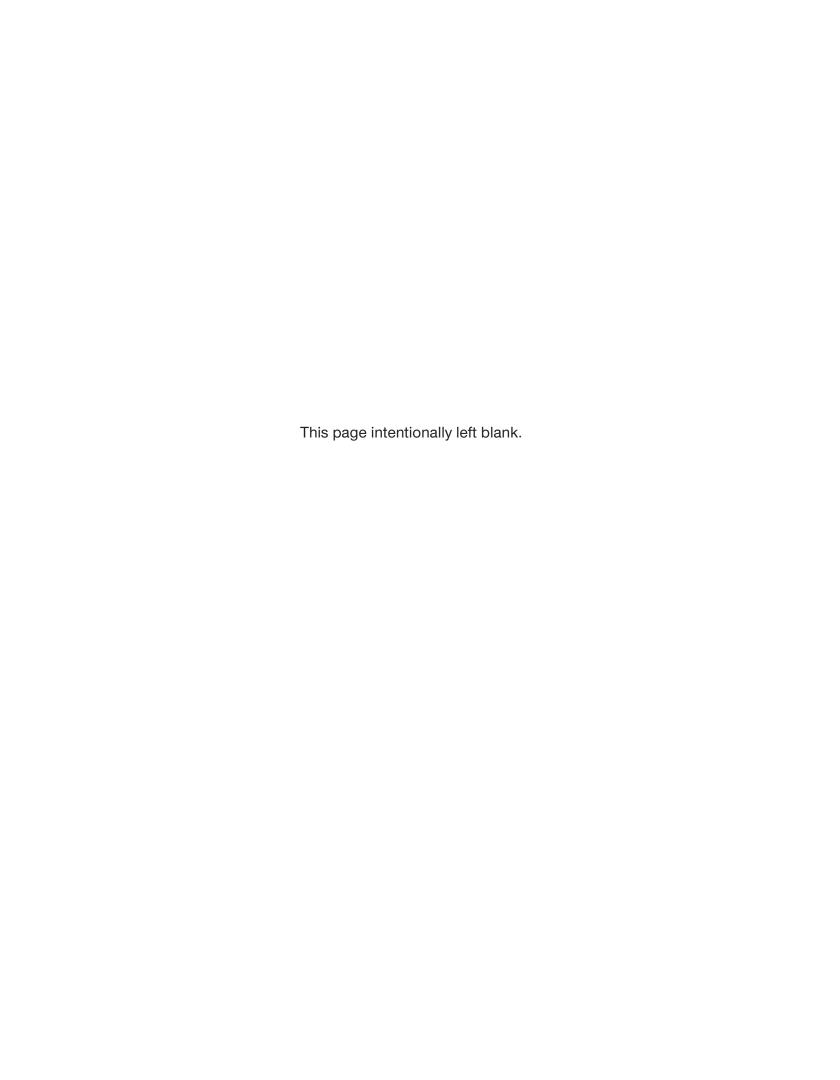


PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social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

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.

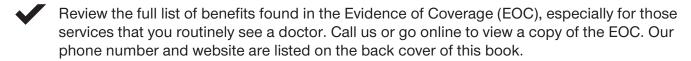
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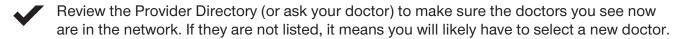


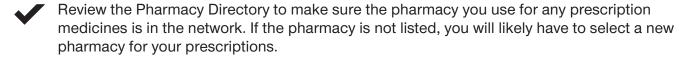
Enrollment checklist

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

