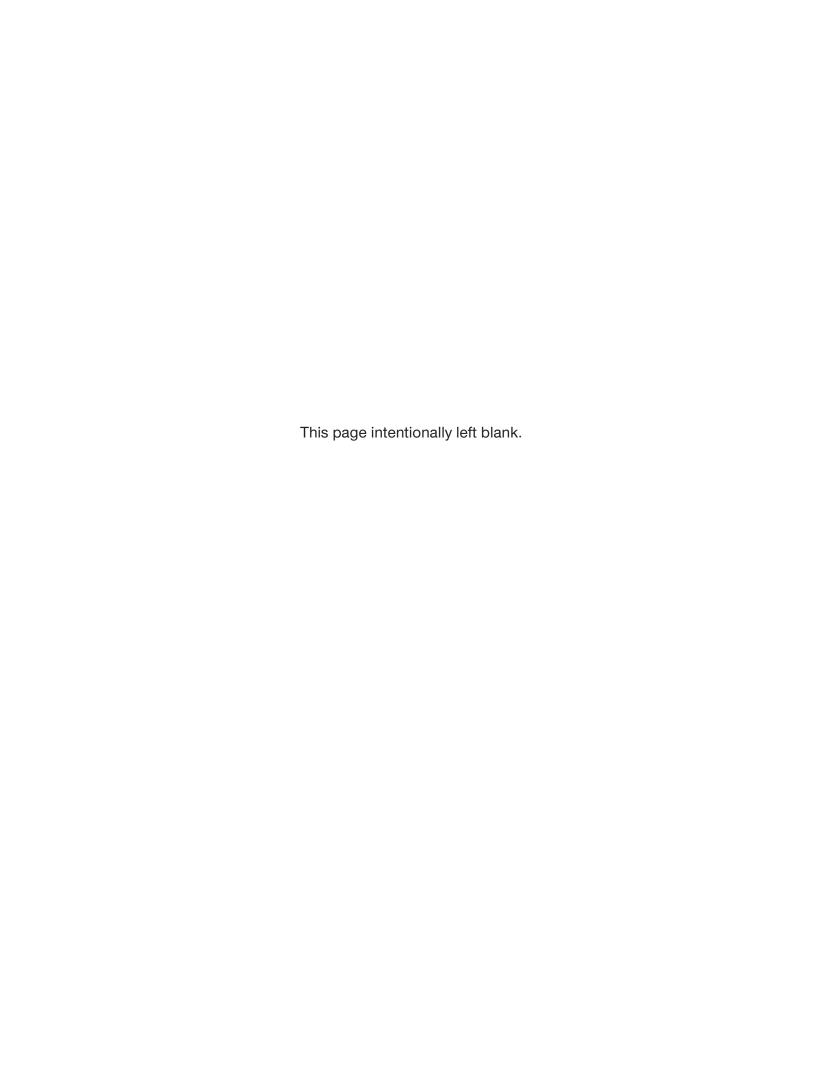


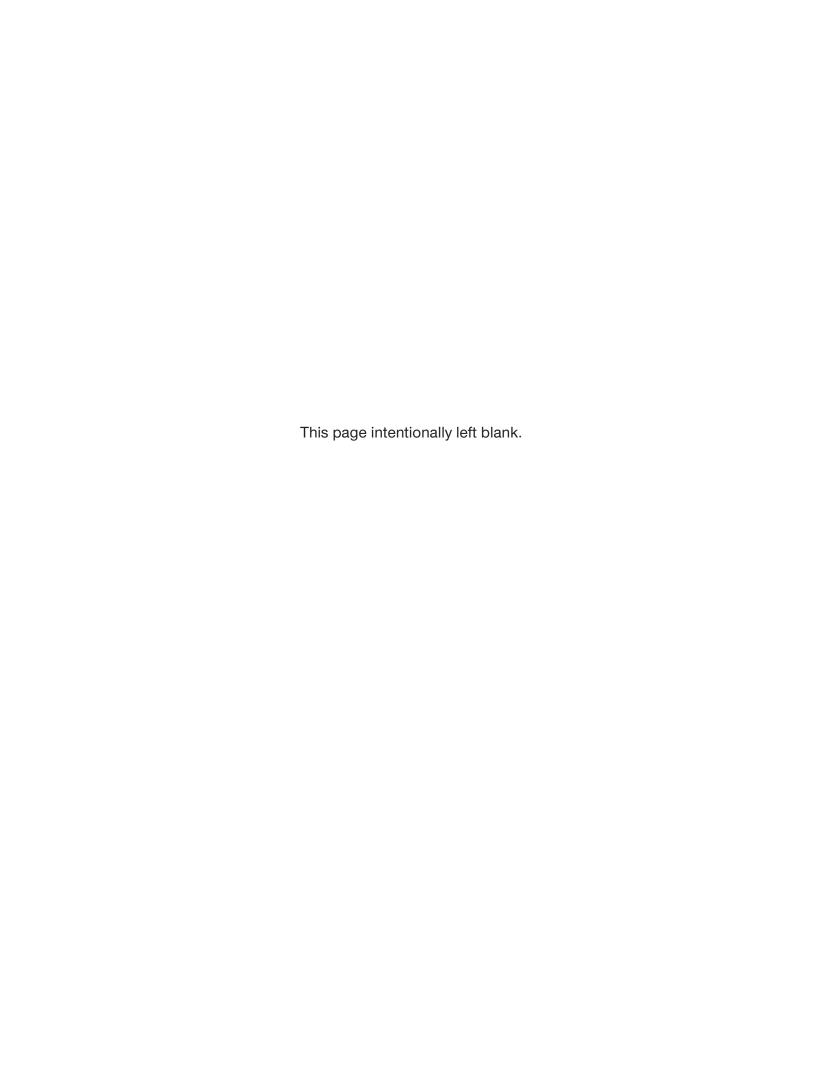




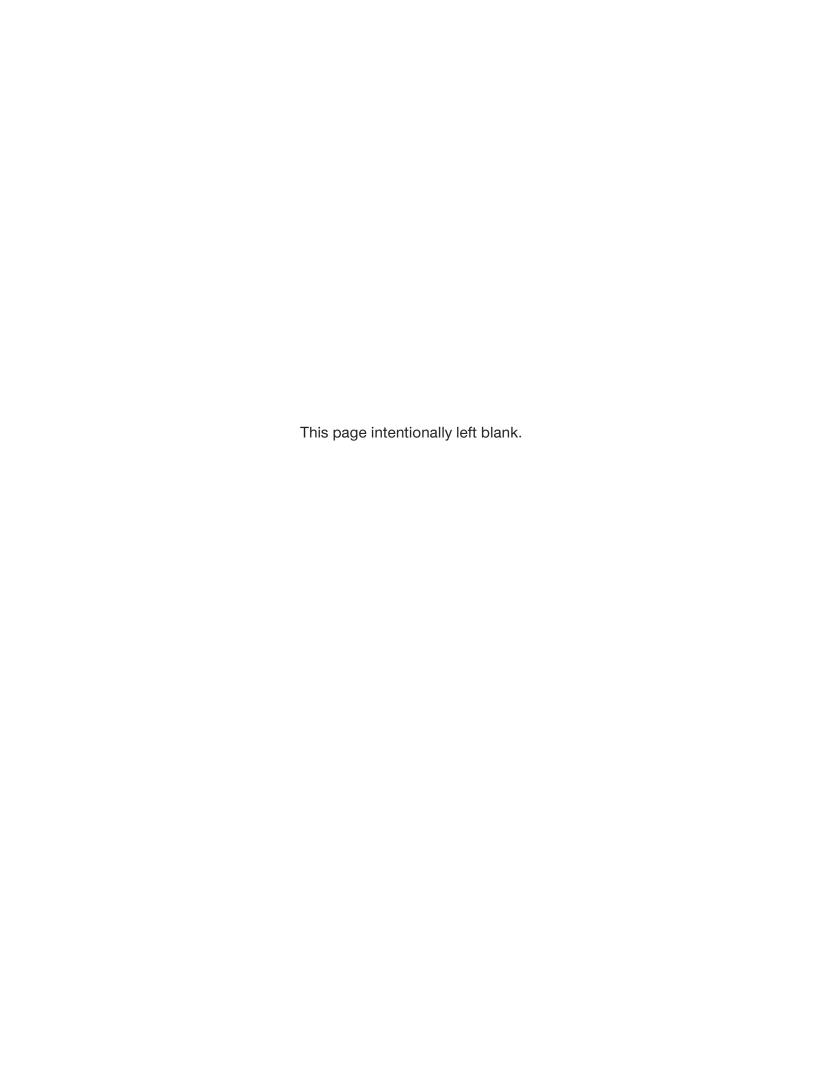
☐ Erickson Advantage® Liberty w	•		008-000) - EL	.1	
Select optional supplement	tal benefits in	addition to	what is	incl	uded with your	
You can add the following benefit you are enrolling, or within 3 mon more information, including costs Platinum Dental Rider	ths after your effe					
Information about you. (Plea	ase type or print ir	n black or blue	ink)			
Last Name	First Name	First Name		Middle Initial		
Birth Date		Sex □ Male □ Female				
Home Phone Number ()	- Mobile Phon		e Numb	Number () -		
Medicare Number						
Permanent Residence Street Add	ress (P.O. Box is	not allowed)				
City	ounty	unty			ZIP Code	
Mailing Address (Only if it's diffe	rent from above.	You can give	a P.O. I	Box.)		
City			State		ZIP Code	
Email Address (optional)						
Enrollee NameAgent Name / ID No						
Y0066_ERFMA_2022_C					EREX22PO4988882_000	



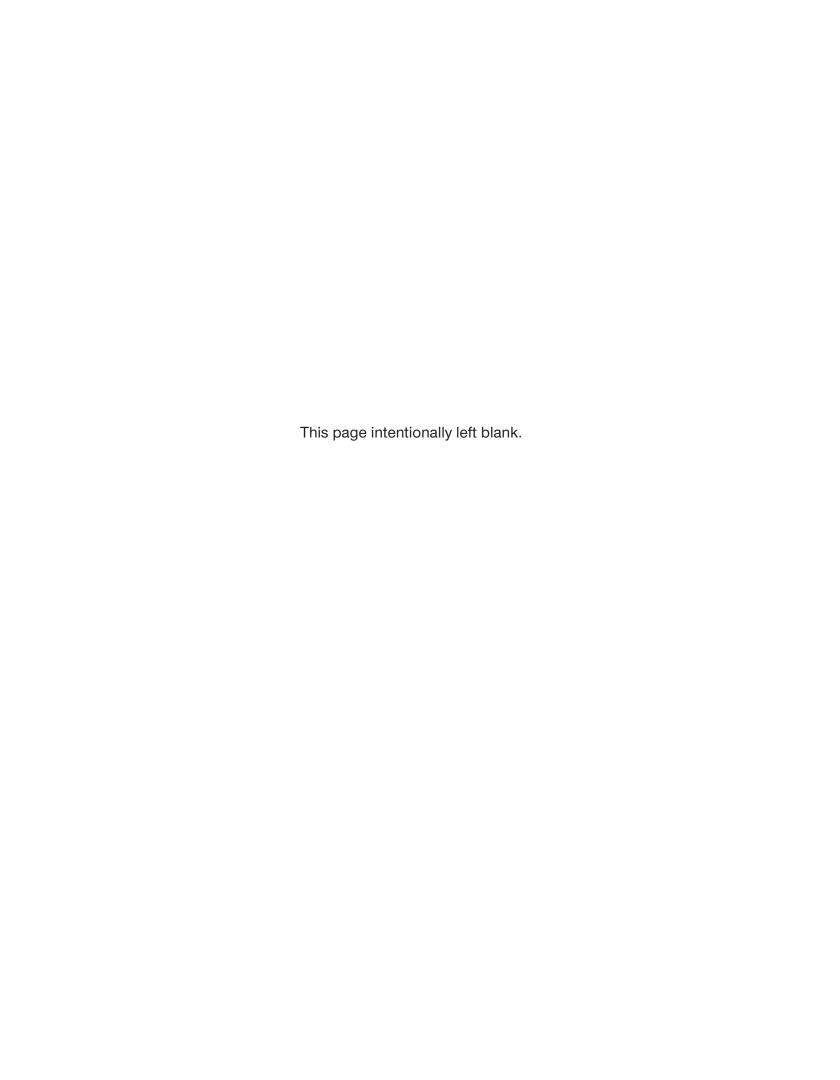
(Examples: Other private in programs.) If yes, what is it?	surance, TRICARE, Federal e	employee coverage	e, VA benefits, or state	
Name of Other Insurance				
Member Number	Group Number	RxBin	RxPCN (optional)	
Answering these questions them out.	is your choice. You can't be	denied coverage b	ecause you don't fill	
How do you want to	pay?			
pay your premium by auto	premium (including any late omatic deduction from your S k each month. You can also (EFT).	ocial Security or R	ailroad Retirement	
If you don't choose an op	tion below, we'll send a bill e	ach month to your	mailing address.	
	ncome Related Monthly Adjust a letter and ask you how yo	•	art D-IRMAA) Social	
☐ You can pay it from	n your SS check			
☐ Medicare can bill y	ou			
☐ The Railroad Retirement Board (RRB) can bill you				
☐ I want to pay from my S	Social Security			
☐ I want to pay from my F	Railroad Retirement Board (R	RB) check		
☐ I want to pay directly from	om a bank account			
Account Type □ Chec Account Holder Name	king □ Savings :			
	r_/_/_/_/_/_/_/_/ r_/_/_/_/_/_/_/_/_/_/_			



A few questions to help us manage you	ır plan.
1. Would you prefer plan information in anothe Please check what you'd like: Spanish Spanish Spanish Spanish Spanish S	r language or an accessible format?□ Yes □ No □ Braille □ Other
, , , , , , , , , , , , , , , , , , , ,	nt, please call us toll-free at 1-866-774-9671, TTY week. Or visit www.EricksonAdvantage.com for
2. Do you or your spouse work?	☐ Yes ☐ No
Do you or your spouse have other health insura (Examples: Other employer group coverage, LT Auto Liability, or Veterans benefits) If yes, please complete the following:	
Name of Health Insurance Company	
Member Number	
You can find a list on the plan website or in the Provider or PCP Full Name Provider/PCP Number:	Provider Directory. (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 I must keep both Part A and Part B to stay in	



If I currently have Medicare Supplement Insural my agent, must cancel. I will cancel after my ne plan.			
 □ 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 bintentionally provide false information on this form plan. □ My response to this form is voluntary. However plan. 	ase my information to Meralth 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 in the provided of the provided	dicare and other plans acknowledge that drug event data, to to Federal law that low). tion with as required to addruged 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 he 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 member ID card, I can call Customer Supdate my authorization information on file.	o, etc.) of this right if Medio of this right, to the plan, if I this application has been	care asks for it. I wish to take action on approved and I have	
Signature of Applicant/Member/Authorized Repr	resentative Today's Dat	e	
If you are the authorized representative, information below. *NOT A SALES AGENT	please sign above an	d complete the	
Last Name	First Name		
Address			
City	State	ZIP Code	
Phone Number () -	Relationship to Applicant		

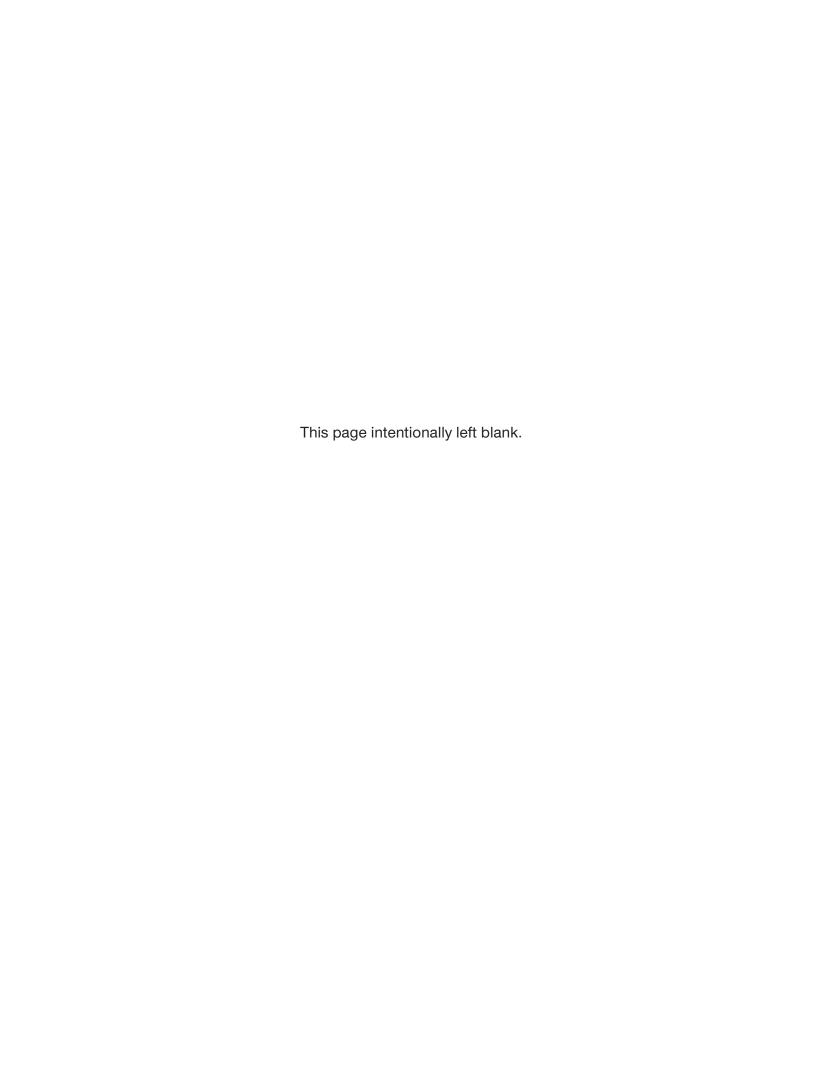


For licensed sales representative/agency use only.					
Employer Group Name					
Employer Group ID			Branch I		
Licensed Sales Representative/Writing ID			Initial Receipt Date		
Licensed Sales Representative/Agent Name			Proposed Effective Date		
Agent must complete					
☐ IEP (MA-PD enrollees)	☐ ICEP (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)		er 15-	□ 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

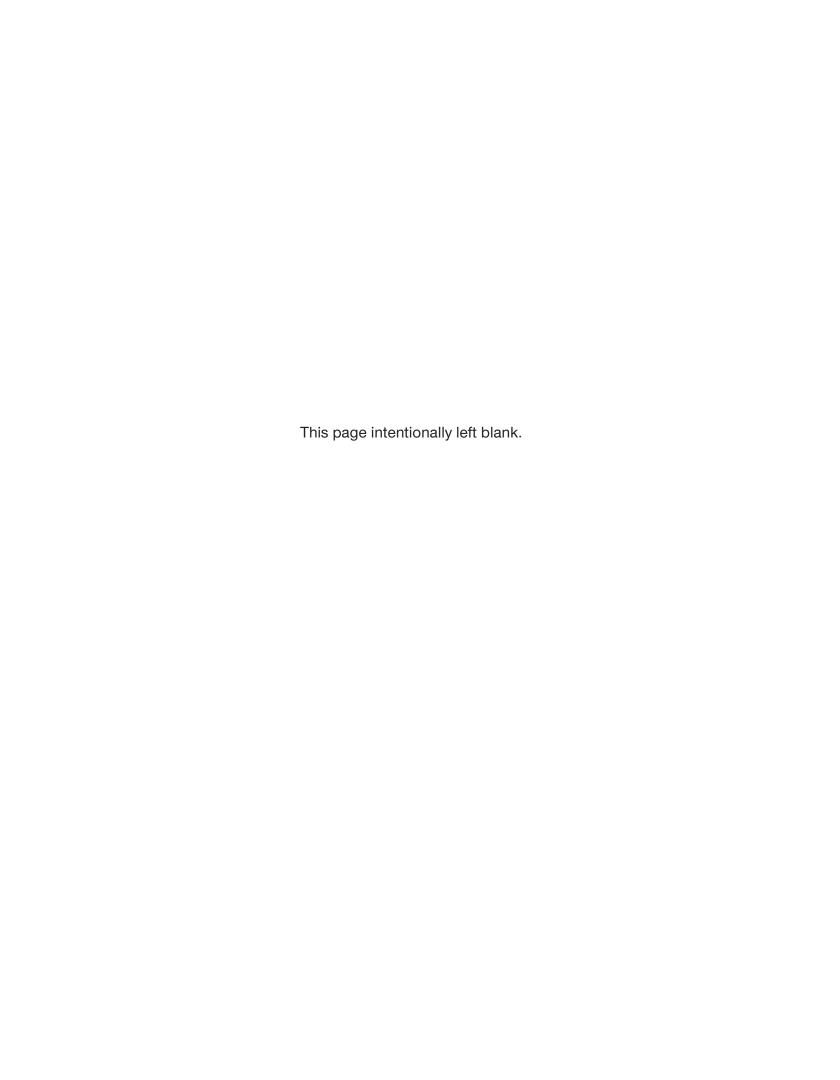


PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social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

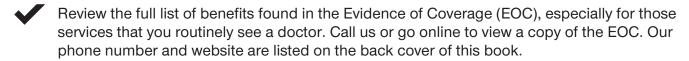
OMB No. 0938-1378 Expires: 7/31/2023 Y0066 ERFMA 2022 C

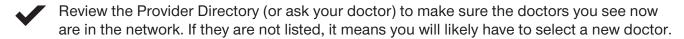


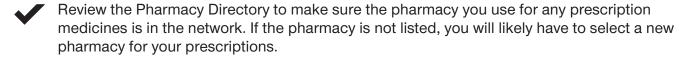
Enrollment checklist

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

