

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC AZ-0011 (PPO) H2406-078-000

Information about you (Discos		ما برم دام ماد میرا	المائية	
Information about you (Please		nt in black or t	piue ink	
Last name	First name			Middle initial
		T		
Birth date		Sex Male	☐ Femal	е
Home phone number ()	_	Mobile phone r	number (() –
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			hone nur	mber(s) I have provided
Medicare number				
Permanent residence street address	(Don't enter	a P.O. box. Not	e: For in	dividuals experiencing
homelessness, a PO Box may be co	-			
City	County		State	Zip code
Mailing address (Only if it's differen	t from above	e. You can give a	a P.O. bo	ox.)
City			State	Zip code
Email address (optional)		l		
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C				AAAZ25LP0220940_000

Do you have other insurance (Examples: Other private insura programs.) If yes, what is it?	• • •	•	☐ Yes ☐ No benefits or state
Name of other insurance			
Member number	Group number	RxBin	RxPCN (optional)
Answering these questions is your choice. You can't be denied coverage because you don't fill them out.			
How do you want to pay? If you have a monthly plan prer pay your premium by automatic Board (RRB) benefit check each	nium (including any late enroll c deduction from your Social S	Security or Railroa	d Retirement
Electronic Funds Transfer (EFT	•	anth to your mailir	ag addraga
If you don't choose an option b		-	
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 you	r SS check		
☐ Medicare can bill you			
☐ The Railroad Retiremen	t 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 u	s manage your plan		
1. Would you prefer plan info	• • •	or an accessible	format?
	rmation in another language or Braille		•
Enrollee name			
Agent name/ID number			
Y0066_ERFMA_2025_C		AAA	Z25LP0220940_000

If you don't see the language or format you want, please call UnitedHealthcare toll-free at **1-844-723-6473**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **AARPMedicarePlans.com** for online help.

2. Are you Hispanic, Latino/a, or Spanish		
No, not of Hispanic, Latino/a, or Spa	•	
Yes, Mexican, Mexican American, o	r Chicano/a	
Yes, Puerto Rican		
Yes, Cuban		
Yes, another Hispanic, Latino, or Sp	panish origin	
I choose not to answer		
3. What's your race? Select all that apply.	•	
American Indian or Alaska Native	Black or African American	
Asian:	Native Hawaiian or Pacific Islander:	
Asian Indian	Guamanian or Chamorro	
Chinese	Native Hawaiian	
Filipino	Samoan	
Japanese	Other Pacific Islander	
Korean		
Vietnamese	White	
Other Asian	I choose not to answer	
4. What is your gender? Select one Woman	recognized Tribe (name of Tribe)I use a different term:	
Man		
Non-binary	I choose not to answer	
5. Which of the following best represents	how you think of yourself? Select one.	
Lesbian or gay	I use a different term:	
Straight, that is, not gay or lesbian	I don't know	
Bisexual	I choose not to answer	
6. Do you or your spouse work?		☐ Yes ☐ No
	ourance that will cover medical conject?	
Do you or your spouse have other health ins (Examples: Other employer group coverage		
auto liability, or Veterans benefits)	e, LID coverage, workers Compensation,	☐ Yes ☐ No
auto hability, or veteralis benefits)		П 169 П IVO
Enrollee name		
Agent name/ID number		
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If yes, please complete the following:		
Name of health insurance company		
Member number		
7. Please give us the name of your primary ca	are provider (PCP), clinic or health center.	
You aren't limited to this list. You may go to any payment terms. You can find a list on the plan website or in the		
Provider or PCP full name	Trovidor Biroctory.	
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.)	
Are you now seeing or have you recently seen	this provider? ☐ Yes ☐ No	
an email when new communications (For exame Changes) are available online. You can access computer, tablet or mobile phone.	unications delivered electronically. We will send you aple: Explanation of Benefits or the Annual Notice of these communications through any device such as a ired materials mailed to you, please check here:	
• •	u hard copies of required materials. Please note that ay not fit in all mailboxes. You can change your	
Please read and sign		
By completing this form, I agree to the follow	ving:	
paying my Part B premium if I have one, up I understand that people with Medicare are the country, except for limited coverage ne urgent care outside of the U.S. See the Su I understand that when my UnitedHealthca prescription drug benefits from UnitedHealthcare and contained in my UnitedHealthcare.	are coverage begins, I must get all of my medical and althcare. Benefits and services authorized by tedHealthcare "Evidence of Coverage" document scriber agreement) will be covered. Neither Medicare	
Enrollee name		
Agent name/ID number Y0066_ERFMA_2025_C		

I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA)					
plans). Release of information: By joining this Medwill share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below).	o may use it to track my en by Federal law that authoriz w).	rollment, to make e the collection of this			
☐ I give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health					
 plan. The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan. My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. 					
When I sign below, it means that I have read a	nd understand the inform	ation on this form			
show written proof (power of attorney, guardians understand that I will need to submit written proof behalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorization. Signature of applicant/member/authorized re	of of this right, to the plan, ifter this application has be I Customer Service at the rition information on file. presentative Today	if I wish to take action on en approved and I have number on my y's date			
If you are the authorized representative information below (*Not a Sales Agent)	, piease sign above ar	nd complete the			
Last name	First name				
Address					
City	State	Zip code			
Phone number () —	Relationship to applicar	nt			
Enrollee name					
Agent name/ID numberY0066_ERFMA_2025_C		 AAAZ25LP0220940_000			

			_		
For individuals hel	ping enrollee with	cor	nple	eting this form o	nly
Complete this section	if you're an individual	(i.e. a	agent	ts, brokers, SHIP co	ounselors, family
members, or other thir	•	•	_		•
Name	<u>- - - - - - - - - - </u>			ship to enrollee	
Name		1 1010	ation	orilp to critolice	
0:		NI - 4	• 1	Dua dua an Manada an	/A t /D t t)
Signature		Nat	ionai	Producer Number	(Agents/Brokers only)
For Licensed Sale	s Representative/	agei	ncy	use only	
Licensed Sales repres	entative/Writing ID			Initial receipt dat	e
	3				
Licensed Sales repres	entative/agent name			Proposed effective	ve date
Employer are a second					
Employer group name					
Employer group ID				Branch ID	
Agent must complete	<u> </u>				
☐ IEP (MA-PD	☐ ICEP (MA enrollee	es)		EP (MA-PD	□ OEP (Jan 1 -
enrollees)	•	•		ollees eligible for	Mar 31)
,				IEP)	,
☐ OEP (Newly	☐ SEP (Dual LIS			EP (Change in	☐ SEP (Loss of
,				,	•
eligible)	change of status)			dence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS			EP (October 15-	☐ OEPI
	maintaining)		Dec	ember 7)	
Enrollee name					
Agent name/ID number	f				
Y0066_ERFMA_2025_C					AAAZ25LP0220940_000

☐ SEP (SEP reason)	
Licensed Sales representative signature (optional)	Date
Please mail or fax this completed for	rm 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	ge

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.

AARP Medicare Advantage from UHC AZ-0011 (PPO) 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.

UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers. You do not need to be an AARP member to enroll. AARP encourages you to consider your needs when selecting products and does not make specific product recommendations for individuals.

This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

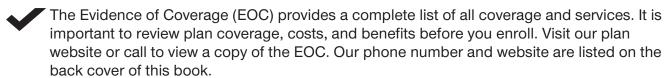
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

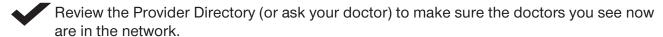
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

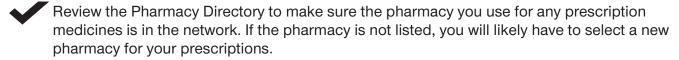
Enrollment checklist

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



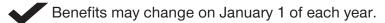


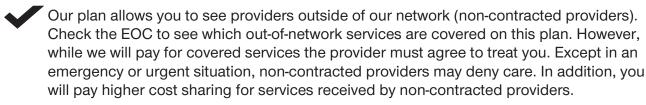


Review the Formulary to make sure your drugs are covered.

Understanding important rules







Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care 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.