

# **2025** Enrollment Request Form

☐ AARP® Medicare Advantage from UHC CA-023P (HMO-POS) H0543-222-000

# Select optional supplemental benefits in addition to what is included with your plan

You can add the following benefit rider for an extra cost. You can purchase the rider now while you are enrolling, or within 3 months after your effective date. See the Summary of Benefits for more information, including costs.

| ☐ Platinum Dental Rider   |             |                        |      |                      |  |
|---|-------------|------------------------|------|----------------------|--|
| Information about you (Please   | type or pri | nt in black or blue ir | k)   |                      |  |
| Last name   | First name  |                        | Mi   | Middle initial       |  |
| Birth date  |             | Sex □ Male □ Female    |      |                      |  |
| Home phone number ( )   | _           | Mobile phone numbe     | r (  | ) –                  |  |
| ☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord    |             | •                      | umbe | er(s) I have provide |  |
| Medicare number   |             |                        |      |                      |  |
| Permanent residence street address homelessness, a PO Box may be co           | -           |                        |      | -                    |  |
| City  | County      | State                  |      | Zip code             |  |
| Mailing address (Only if it's different from above. You can give a P.O. box.) |             |                        |      |                      |  |
| City  |             | State                  |      | Zip code             |  |
| Email address (optional)  |             |                        |      |                      |  |
|   |             |                        |      |                      |  |
| Enrollee name   |             |                        |      |                      |  |
| Agent name/ID number  |             |                        |      |                      |  |
| Y0066_ERFMA_2025_C  |             |                        | AAC  | A25HP0221327_000     |  |

| Do you have other insurance (Examples: Other private insura programs.) If yes, what is it?  |   | •                   | ☐ Yes ☐ No<br>benefits or state |
|---|---|---------------------|---------------------------------|
| Name of other insurance   |   |                     |                                 |
| Member number   | Group number  | RxBin               | RxPCN (optional)                |
| Answering these questions is fill them out.   | your choice. You can't be de  | enied coverage b    | ecause you don't                |
| How do you want to pay?  If you have a monthly plan prer pay your premium by automatic Board (RRB) benefit check each Electronic Funds Transfer (EFT) | nium (including any late enroll<br>c deduction from your Social S<br>ch month. You can also pay fro | Security or Railroa | d Retirement                    |
| If you don't choose an option b   | elow, we'll send a bill each mo   | onth to your mailir | ng address.                     |
| If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA),   |   |                     |                                 |
| Social Security (SS) will send y  | ou a letter and ask you how yo  | u 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 check   |   |                     |                                 |
| ☐ I want to pay from my Railro  | ad Retirement Board (RRB) ch  | neck                |                                 |
| ☐ 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   | rmation in another language   | or an accessible    | format?                         |
|   | rmation in another language or<br>Braille   Large print   Audi                                      |                     | •                               |
| Enrollee name   |   |                     |                                 |
| Agent name/ID number  |   |                     |                                 |
| Y0066_ERFMA_2025_C  |   | AAC                 | A25HP0221327_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                    |             |
| Member/Citizen of a federal or state 4. What is your gender? Select one. | recognized Tribe (name of Tribe)          |             |
| Woman  | 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  |
| Do you or your spouse have other health ins                              | surance that will cover medical services? |             |
| (Examples: Other employer group coverage                                 |   |             |
| auto liability, or Veterans benefits)                                    | , LTD coverage, workers compensation,     | ☐ Yes ☐ No  |
| acto hability, or veteralis beliefits)                                   |   | ⊔ 169 ⊔ INO |
| Enrollee name  |   |             |
| Agent name/ID number   |   |             |
| Y0066_ERFMA_2025_C   | AACA25HP0                                 | 221327_000  |

| If yes, please complete the following:   |  |
|--|--|
| Name of health insurance company   |  |
| Member number  |  |
| 7. Please give us the name of your primary care  | e provider (PCP), clinic or health center.   |
| You can find a list on the plan website or in the Pr   | ovider Directory.  |
| Provider or PCP full name  |  |
| Provider/PCP number  | (Please enter the number exactly as it appears of<br>the website or in the Provider Directory. It will be<br>10 to 12 digits. Don't include dashes.)   |
| Are you now seeing or have you recently seen this  | s provider?  |
| Providing your email address above automatications.  | ally enrolls you in paperless delivery for some of   |
| You will get many of your required plan communican email when new communications (For example Changes) are available online. You can access the computer, tablet or mobile phone.  | •  |
| If you would rather have hard copies of require  | d materials mailed to you, please check here:  |
| ☐ Instead of paperless delivery, we will mail you h<br>some communications are very large and may<br>preference for delivery at any time.  | nard copies of required materials. Please note that not fit in all mailboxes. You can change your  |
| Please read and sign   |  |
| By completing this form, I agree to the following  | g:   |
| paying my Part B premium if I have one, unled I understand that people with Medicare are go the country, except for limited coverage near urgent care outside of the U.S. See the Summary I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcare and contained in my United | enerally not covered under Medicare while out of<br>the U.S. border. This plan covers emergency and<br>mary of Benefits for more information.<br>coverage begins, I must get all of my medical and<br>care. Benefits and services authorized by<br>dHealthcare "Evidence of Coverage" document<br>ber agreement) will be covered. Neither Medicare |
| Enrollee name  |  |
| Agent name/ID number<br>Y0066_ERFMA_2025_C   |  |

| <ul> <li>I understand that I can be enrolled in only of<br/>that enrollment in this plan will automaticall</li> </ul>  | ly end my enrollment in and  | other MA plan (exceptions   |
|--|--|---|
| apply for MA Private Fee-for-Service (PFFS)  | ), MA Medicare Medical Sa  | vings Account (MSA)   |
| <ul> <li>plans).</li> <li>Release of information: By joining this Me will share my information with Medicare, who payments, and for other purposes allowed information (see Privacy Act Statement below I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan.</li> <li>The information on this form is correct to the source of the share of the share</li></ul>    | no may use it to track my end by Federal law that authorizow).  The my protected health inform applicable law as require the best of my knowledge. I | nrollment, to make ze the collection of this mation with organizations d to administer my health understand that if I |
| <ul><li>intentionally provide false information on the</li><li>My response to this form is voluntary. Howen</li><li>plan.</li></ul>  |  | -   |
| When I sign below, it means that I have read a   | and understand the inforn  | nation on this form   |
| understand that I will need to submit written probehalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can cat UnitedHealthcare UCard to update my authorization. Signature of applicant/member/authorized received my authorized my authoriz | After this application has be<br>all Customer Service at the<br>ation information on file.   | en approved and I have  |
| If you are the authorized representative information below (*Not a Sales Agent)  | e, please sign above a   | nd complete the   |
| Last name  | First name   |   |
| Address  |  |   |
| City   | State  | Zip code  |
| Phone number ( ) —   | Relationship to applicant  |   |
|  |  |   |
| Enrollee name  |  | <u>.</u>  |
| Agent name/ID number   |  | AACA25HP0221327 000   |

| For individuals he   | ping enrollee with | con     | nple                 | eting          | this form o     | nly                   |
|--|--------------------|---------|----------------------|----------------|-----------------|-----------------------|
| Complete this section  |                    |         | _                    | _              |                 | -                     |
| members, or other thin   | •                  | •       | _                    |                |                 | ,                     |
| Name   |                    |         |                      |                | to enrollee     |                       |
| Signature  |                    | Nati    | iona                 | l Proc         | ducer Number (  | (Agents/Brokers only) |
| For Licensed Sale  | s Representative/  | ager    | ncv                  | use            | only            |                       |
| For Licensed Sales Representative/a Licensed Sales representative/Writing ID |                    | <b></b> | Initial receipt date |                | -               | <b>)</b>              |
| Licensed Sales representative/agent name                                     |                    |         |                      | Pro            | oposed effectiv | re date               |
| Employer group name  | ,                  |         |                      |                |                 |                       |
| Employer group ID  |                    |         |                      | Brand          | ch ID           |                       |
| Agent must complete  | )                  |         |                      |                |                 |                       |
| ☐ IEP (MA-PD   | ☐ ICEP (MA enrolle | es)     |                      | EP (N          | /IA-PD          | □ OEP (Jan 1 -        |
| enrollees)   |                    |         | enre                 | ollees         | s eligible for  | Mar 31)               |
|  |                    |         | 2nd                  | l IEP)         |                 |                       |
| ☐ OEP (Newly   | ☐ SEP (Dual LIS    |         |                      | SEP (Change in |                 | ☐ SEP (Loss of        |
| eligible)  | change of status)  |         |                      | idenc          | ,               | EGHP coverage)        |
| ☐ SEP (Chronic)  | ☐ SEP (Dual LIS    |         |                      | •              | October 15-     | ☐ OEPI                |
|  | maintaining)       |         | Dec                  | cemb           | er 7)           |                       |
|  |                    |         |                      |                |                 |                       |
|  |                    |         |                      |                |                 |                       |
|  |                    |         |                      |                |                 |                       |
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| En un II a a   |                    |         |                      |                |                 |                       |
| Enrollee name  |                    |         |                      |                |                 |                       |
| Agent name/ID numbe Y0066_ERFMA_2025_C                                       | r                  |         |                      |                |                 | AACA25HP0221327_000   |
| 10000_EMFIVIA_2025_C   |                    |         |                      |                |                 | MMUMZUMPUZZ 13Z1_UUU  |

| ☐ 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                | ar.    |

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 CA-023P (HMO-POS) 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.

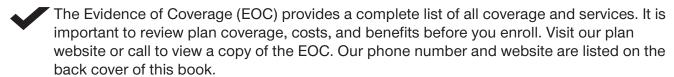
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

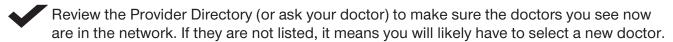
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

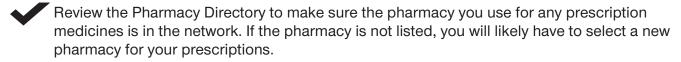
## **Enrollment checklist**

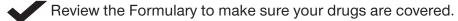
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

#### **Understanding the benefits**



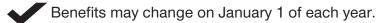


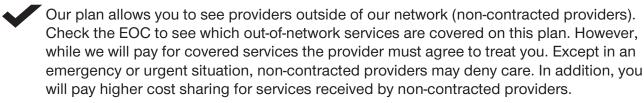




### **Understanding important rules**







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.