

## **2025 Enrollment Request Form**

☐ AARP® Medicare Advantage from UHC CA-021P (HMO-POS) H0543-220-000

Information about you (Diagon	type or pri	nt in block or b	عاما مباد	
Information about you (Please		TIL III DIACK OF L	nue Irik	
Last name	First name			Middle initial
			_	
Birth date		Sex   Male	」 Femal	e 
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	•			
homelessness, a PO Box may be co	onsiaerea ya	our permanent r	esidence	e address)
City	County		State	Zip code
Mailing address (Only if it's different	t from above	e. You can give a	a P.O. bo	ex.)
City			State	Zip code
Email address (optional)		1		-
Enrollee name				
Agent name/ID number Y0066_ERFMA_2025_C				 AACA25HP0221329_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 Electronic Funds Transfer (EFT	c deduction from your Social S ch month. You can also pay fro	Security or Railroa	d Retirement	
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 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	• • •			
1. Would you prefer plan info	rmation in another language	or an accessible	format?	
	rmation in another language or Braille		•	
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C		AAC	A25HP0221329_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 Sp.		
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 Woman Man	recognized Tribe (name of Tribe)	
Non-binary	I choose not to answer	
5. Which of the following best represents Lesbian or gay Straight, that is, not gay or lesbian Bisexual	I use a different term:	
6. Do you or your spouse work?		☐ Yes ☐ No
Do you or your spouse have other health in:	surance that will cover medical services?	
(Examples: Other employer group coverage		ı
auto liability, or Veterans benefits)		☐ Yes ☐ No
Enrollee name		
Agent name/ID number		
Y0066_ERFMA_2025_C	AACA25HP0	221329_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 or 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	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 communications (For example Changes) are available online. You can access the computer, tablet or mobile phone.	j
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 some communications are very large and may 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 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 care. Benefits and services authorized by dHealthcare "Evidence of Coverage" document ber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	

that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS).	y end my enrollment in ano	
plans).	,	,
Release of information: By joining this Med will share my information with Medicare, who payments, and for other purposes allowed by the control of the cont	no may use it to track my en by Federal law that authoriz	rollment, to make
<ul> <li>information (see Privacy Act Statement below</li> <li>I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan.</li> </ul>	e my protected health inforn	_
☐ The information on this form is correct to the		
<ul> <li>intentionally provide false information on this</li> <li>My response to this form is voluntary. Howe plan.</li> </ul>		•
When I sign below, it means that I have read a	and understand the inform	ation on this form
understand that I will need to submit written pro behalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can cal UnitedHealthcare UCard to update my authoriza Signature of applicant/member/authorized re	ofter this application has be Il Customer Service at the r ation information on file.	en approved and I have
	presentative Today	's date
If you are the authorized representative		
If you are the authorized representative information below (*Not a Sales Agent)	e, please sign above ar	
If you are the authorized representative information below (*Not a Sales Agent) Last name	e, please sign above ar	
If you are the authorized representative information below (*Not a Sales Agent) Last name Address	e, please sign above ar	Zip code
If you are the authorized representative information below (*Not a Sales Agent) Last name Address City	First name  State	Zip code
If you are the authorized representative information below (*Not a Sales Agent) Last name Address City	First name  State  Relationship to applicar	Zip code

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For individuals help	ping enrollee with	com	plet	ing this form on	ly
Complete this section i	_		_	_	_
members, or other third	•		_		
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sales	Representative/a	agen	cv u	se only	
Licensed Sales representative/Writing ID				Initial receipt date	
Licensed Sales representative/agent name				Proposed effective	e date
Employer group name					
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees) ☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ ICEP (MA enrolled ☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	, , , , , , , , , , , , , , , , , , ,	enrol 2nd I □ SE resid □ AE	P (MA-PD lees eligible for EP) EP (Change in ence) EP (October 15- mber 7)	☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI
Enrollee name					

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☐ 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 CA-021P (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.

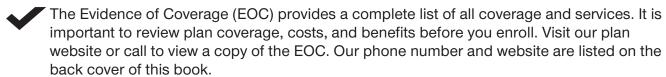
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

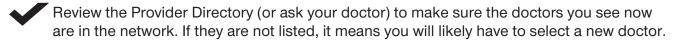
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

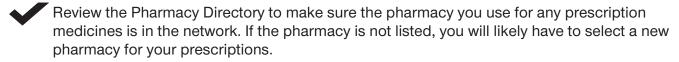
## **Enrollment checklist**

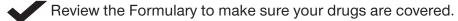
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the benefits





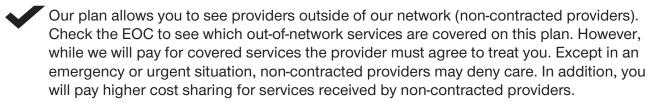




## **Understanding important rules**







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.