

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC CO-0014 (PPO) H2406-105-000

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 bl	lue ink)		
Last name	First name			Middle initial	
Birth date	Sex □ Male □ Fema		Femal	le	
Home phone number ()	 Mobile phone number 		umber (() –	
☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology.					
Medicare number					
Permanent residence street address (Don't enter a P.O. box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address)					
City	County	3	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				AACO25LP0220914_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)	nium (including any late enroll 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 b	elow, we'll send a bill each mo	onth to your mailir	ng address.
If you must pay a Part D-Incom	e Related Monthly Adjustment	Amount (Part D-I	RMAA),
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 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	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	O25LP0220914_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 Spanish		
Yes, Mexican, Mexican American, o Yes, Puerto Rican	of Chicano/a	
Yes, Cuban	aniah aviain	
Yes, another Hispanic, Latino, or Sp	oanish 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 state4. What is your gender? Select one. Woman Man	recognized Tribe (name of Tribe) I use a different term:	
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 ins	surance that will cover medical services?	
(Examples: Other employer group coverage		
auto liability, or Veterans benefits)		☐ Yes ☐ No
Enrollee name		
Enrollee nameAgent name/ID number		
V0000 EDEMA 000E O	AACO25LP0	220914 000

If yes, please complete the following:	<u>g</u>			
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 aren't limited to this list. You may go to any d	loctor who accepts Medicare and the plan's			
payment terms.	·			
You can find a list on the plan website or in the P	rovider Directory.			
Provider or PCP full name				
Provider/PCP number	(Please enter the number exactly as it appears on			
1 Tovidely For Humber	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 thi	s provider?			
	ally enrolls you in paperless delivery for some of			
your plan communications.				
	ications delivered electronically. We will send you			
•	e: Explanation of Benefits or the Annual Notice of			
Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone.				
If you would rather have hard copies of required materials mailed to you, please check here:				
	hard copies of required materials. Please note that			
some communications are very large and may preference for delivery at any time.	not lit in all maliboxes. You can change your			
Please read and sign				
By completing this form, I agree to the following:				
I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.				
I understand that people with Medicare are generally not covered under Medicare while out of				
the country, except for limited coverage near the U.S. border. This plan covers emergency and				
urgent care outside of the U.S. See the Summary of Benefits for more information.				
☐ I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and				
prescription drug benefits from UnitedHealthcare. Benefits and services authorized by				
UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document				
(also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.				
nor ormedhealthcare will pay for benefits or	Services that are not covered.			
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C	AACO25LP0220914_000			

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)					
 Release of information: By joining this Med will share my information with Medicare, who payments, and for other purposes allowed be information (see Privacy Act Statement below I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan. The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. However plan. 	o may use it to track my ency Federal law that authorizw). my protected health informapplicable law as required best of my knowledge. It is form I will be disenrolled	rollment, to make e the collection of this nation with organizations d to administer my health understand that if I from the plan.			
When I sign below, it means that I have read a	nd understand the inform	ation on this form			
If I sign as an authorized representative, it means show written proof (power of attorney, guardians understand that I will need to submit written proof behalf of the member beyond this application. Af received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizat Signature of applicant/member/authorized reput If you are the authorized representative.	hip, etc.) of this right if Me of of this right, to the plan, iter this application has be Customer Service at the ricon information on file. Coresentative Today	dicare asks for it. I if I wish to take action on en approved and I have number on my v's date			
information below (*Not a Sales Agent)	, ,				
Last name	First name				
Address					
City	State Zip code				
Phone number () —	Relationship to applicant				
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C	,	AACO25LP0220914_000			

AACO25LP0220914_000

For individuals helping enrollee with completing this form only					
Complete this section			_		-
members, or other thir	d parties) helping an e	enroll	ee fil	l out this form.	•
Name		Rela	ations	ship to enrollee	
Signature		Nati	ional	Producer Number	(Agents/Brokers only)
For Licensed Sales	s Representative/	ager	тсу і	use only	
Licensed Sales representative/Writing ID			_	Initial receipt date	е
Licensed Sales repres	entative/agent name			Proposed effective	ve date
Employer group name					
Employer group ID			E	Branch ID	
Agent must complete	•				
☐ IEP (MA-PD	☐ ICEP (MA enrolle	es)		EP (MA-PD	□ OEP (Jan 1 -
enrollees)			enro	llees eligible for	Mar 31)
			2nd	,	
☐ 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					

Y0066_ERFMA_2025_C

☐ SEP (SEP reason)	-
Licensed Sales representative signature (optional)	Date
Please mail or fax this completed fo	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 pa	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 CO-0014 (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.

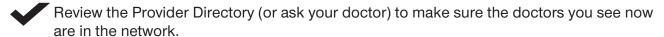
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

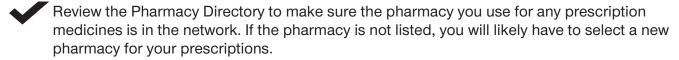
Enrollment checklist

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

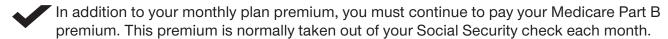


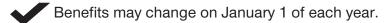


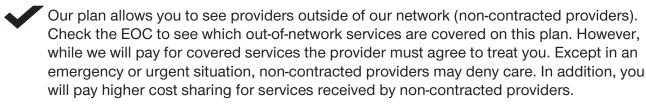


Review the Formulary to make sure your drugs are covered.

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.