

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC CT-0004 (PPO) H8768-042-000

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 □		Female	ıle	
Home phone number ()	 Mobile phone number 		umber (() –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		=	one nur	nber(s) I have provided	
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					
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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			
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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	Laboratoria de la composição	
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)	s, 212 develage, werkere compensation,	☐ Yes ☐ No
acto hability, or votorano pononto,		0010
Enrollee name		
Agent name/ID number		
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If yes, please complete the following:	5		
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	octor who accepts Medicare and the plan's		
payment terms.			
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 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	s provider?		
Providing your email address above automatica	ally enrolls you in paperless delivery for some of		
your plan communications.			
You will get many of your required plan communi	cations delivered electronically. We will send you		
an email when new communications (For example	-		
•	ese communications through any device such as a		
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 hard copies of required materials. Please note that			
some communications are very large and may			
preference for delivery at any time.			
Please read and sign			
By completing this form, I agree to the followin	g:		
□ 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			
 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.			
Enrollee name			
Enrollee nameAgent name/ID number			
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 I understand that I can be enrolled in only or that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS), 	end my enrollment in ano	ther MA plan (exceptions
 Release of information: By joining this Medwill 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. Hower the intention is the intention of the intention of this form is voluntary. 	o may use it to track my ency Federal law that authorized). my protected health information applicable law as required best of my knowledge. It is form I will be disenrolled	rollment, to make the collection of this mation with organizations d to administer my health understand that if I from the plan.
plan. When I sign below, it means that I have read a		
show written proof (power of attorney, guardians understand that I will need to submit written produced behalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizated Signature of applicant/member/authorized remainder. If you are the authorized representative	of of this right, to the plan, fter this application has be 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
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 numberY0066_ERFMA_2025_C		AACT25LP0220512_000

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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				hip to enrollee	
Signature		Natio	onal F	Producer Number (A	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 fo	rm to:
UnitedHealthcare	
P.O. Box 30769	
Salt Lake City, UT 84130-0769	
Fax: 1-888-950-1169	
Fay the front and back of each na	no.

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, 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 CT-0004 (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.

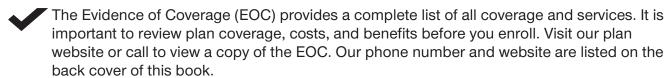
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

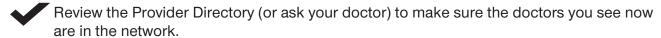
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

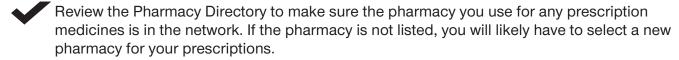
Enrollment checklist

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





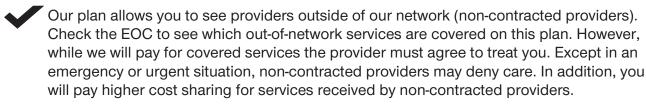


Review the Formulary to make sure your drugs are covered.

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.