

## **2025 Enrollment Request Form**

☐ AARP® Medicare Advantage Extras from UHC OH-13 (HMO-POS) H5253-134-000

| Information about you (Please   | type or pri | nt in black or b                        | lue ink        |                     |
|---|-------------|---|----------------|---------------------|
| Last name   | First name  |   | Middle initial |                     |
|   |             | I                                       |                |                     |
| Birth date  |             | Sex □ Male □                            | ] Femal        | е                   |
| Home phone number ( )   | _           | <ul> <li>Mobile phone number</li> </ul> |                | ) –                 |
| ☐ 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      | County                                  |                | 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)  |             | <u>'</u>                                |                |                     |
|   |             |   |                |                     |
| Enrollee nameAgent name/ID number   |             |   |                |                     |
| Y0066_ERFMA_2025_C  |             |   |                | AAEX25HP0220652_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 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<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-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 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   |                     | •                               |
| Enrollee name  |   |                     |                                 |
| Agent name/ID number   |   |                     |                                 |
| Y0066_ERFMA_2025_C   |   | AAE                 | X25HP0220652_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  | <del></del>   |            |
| 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                      | e 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 in:   | surance that will cover medical services?                 |            |
| (Examples: Other employer group coverage  | e, LTD coverage, Workers' Compensation,                   | ı          |
| auto liability, or Veterans benefits)   |   | ☐ Yes ☐ No |
| Enrollee name   |   |            |
| Agent name/ID number  |   |            |
| Y0066_ERFMA_2025_C  |   | 220652_000 |

| If yes, please complete the following:   |   |
|--|---|
| Name of health insurance company   |   |
| Member number  |   |
| 7. Please give us the name of your primary care You can find a list on the plan website or in the Pr   |   |
| Provider or PCP full name  |   |
| Provider/PCP number  | (Please enter the number exactly as it appears or<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 communications (For example Changes) are available online. You can access the computer, tablet or mobile phone.  | •   |
| If you would rather have hard copies of required   | 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, unle I understand that people with Medicare are g the country, except for limited coverage near urgent care outside of the U.S. See the Sumr I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcure UnitedHealthcare and contained in my United | renerally 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 nameAgent name/ID number  |   |

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|                            | 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 Medicare Advantage Plan, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). |   |  |  |  |  |
|                            | ☐ 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  |   |  |  |  |  |
|                            | intentionally provide false information on this form I will be disenrolled from the plan.  |   |  |  |  |  |
| Wh                         | en I sign below, it means that I have read an  | d understand the inform   | ation on this form   |  |  |  |
| und<br>beh<br>rece<br>Unit | w written proof (power of attorney, guardiansh lerstand that I will need to submit written proof all of the member beyond this application. Afterived my UnitedHealthcare UCard®, I can call the dHealthcare UCard to update my authorization atture of applicant/member/authorized representative,  | of this right, to the plan, is er this application has been customer Service at the non information on file.  resentative Today | f I wish to take action on<br>en approved and I have<br>umber on my<br>'s date |  |  |  |
| _                          | ormation below (*Not a Sales Agent)  | produce eight discrete  |  |  |  |  |
| Las                        | t name   | First name  |  |  |  |  |
| Add                        | dress  |   |  |  |  |  |
| City                       | ,  | State   | Zip code   |  |  |  |
| Pho                        | one number ( ) —   | Relationship to applican  | t  |  |  |  |
|                            |  |   |  |  |  |  |
| Enro                       | llee name  |   | <del></del>  |  |  |  |
| _                          | nt name/ID number<br>6_ERFMA_2025_C  |   | <br>AAEX25HP0220652_000  |  |  |  |
| . 5000                     | o (_LoLoo  | ,   | ,oi ii ooooooo   |  |  |  |

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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 represe   | -  |                                       |   | 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<br>2nd I<br>□ SE<br>resid<br>□ AE | P (MA-PD<br>lees eligible for<br>EP)<br>EP (Change in<br>ence)<br>EP (October 15-<br>mber 7) | ☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI |
| Enrollee name  |  |                                       |   |  |   |

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| ☐ SEP (SEP reason)                                 | <del>-</del>   |
|--|----------------|
| 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                                |                |
| Fay the front and back of each na                  | α <sub>Φ</sub> |

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 Extras from UHC OH-13 (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.

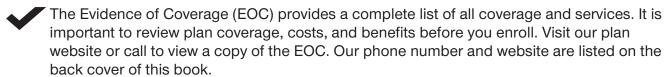
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

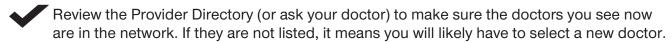
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

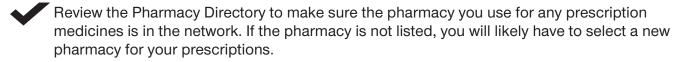
## **Enrollment checklist**

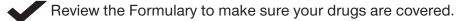
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the benefits



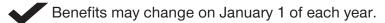


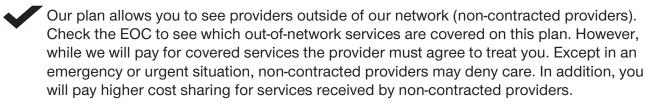




## **Understanding important rules**







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.