

2025 Enrollment Request Form

 \square AARP® Medicare Advantage from UHC IA-0002 (HMO-POS) H5253-108-002

Information about you (Please	type or pri	nt in black or bl	ue ink)		
Last name	First name			Middle initial	
Birth date		Sex □ Male □	Female	е	
Home phone number ()	_	Mobile phone nu	ımber () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	one nur	mber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be co	-				
City	County	S	State	Zip code	
Mailing address (Only if it's different from above. You can give a P.O. box.)					
City		S	State	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C				AAEX25HP0220682_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 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 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	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		AAE	X25HP0220682_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, or Chicano/a Yes, Puerto Rican				
Yes, Cuban	aniah aviain			
Yes, another Hispanic, Latino, or Sp	anish ongin			
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	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 ins	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				
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If yes, please complete the following:	
Name of health insurance company	
Member number	
7. Please give us the name of your primary car	re provider (PCP), clinic or health center.
You can find a list on the plan website or in the F	Provider 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 th	is provider? ☐ Yes ☐ No
Providing your email address above automatic your plan communications.	cally enrolls you in paperless delivery for some of
an email when new communications (For examp	nications delivered electronically. We will send you ble: Explanation of Benefits or the Annual Notice of hese communications through any device such as a
If you would rather have hard copies of require	ed materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you some communications are very large and may preference for delivery at any time.	hard copies of required materials. Please note that y not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the following	ng:
paying my Part B premium if I have one, unl I understand that people with Medicare are the country, except for limited coverage nea urgent care outside of the U.S. See the Sum I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealth UnitedHealthcare and contained in my United	generally not covered under Medicare while out of ar the U.S. border. This plan covers emergency and mary of Benefits for more information. e coverage begins, I must get all of my medical and hcare. Benefits and services authorized by edHealthcare "Evidence of Coverage" document briber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number	

□ 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) plans).					
Release of information: By joining this Med will share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below).	no may use it to track my er by Federal law that authoriz bw).	rollment, to make e the collection of this			
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					
 plan. The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. Howe plan. 	is form I will be disenrolled	from the plan.			
When I sign below, it means that I have read a	and understand the inform	ation on this form			
show written proof (power of attorney, guardians understand that I will need to submit written probehalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorization. Signature of applicant/member/authorized received my authorized my authorized received my authorized my a	of of this right, to the plan, after this application has be a control of the plan of the	if I wish to take action on en approved and I have number on my y's date			
If you are the authorized representative information below (*Not a Sales Agent)	e, piease sign above ar	id complete the			
Last name	First name				
Address					
City	State	Zip code			
Phone number () —	Relationship to applicar	nt			
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C		 AAEX25HP0220682_000			

For individuals he	ping enrollee with	con	nple	eti	ing this form o	nly
Complete this section			-		-	-
members, or other thin	•	•	_			,
Name					ip to enrollee	
Signature		Nati	iona	ΙP	roducer Number ((Agents/Brokers only)
For Licensed Sale	s Representative/	ager	ncv	us	se only	
For Licensed Sales Representative/a Licensed Sales representative/Writing ID			,	- 1	Initial receipt date	;
Licensed Sales representative/agent name				Proposed effecti		re date
Employer group name	,					
Employer group ID				Br	anch ID	
Agent must complete)					
☐ IEP (MA-PD	☐ ICEP (MA enrolle	es)		ΕP	(MA-PD	□ OEP (Jan 1 -
enrollees)			enr	olle	ees eligible for	Mar 31)
			2nd	d IE	EP)	
☐ OEP (Newly	☐ SEP (Dual LIS				P (Change in	☐ SEP (Loss of
eligible) _	change of status)				ence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS				P (October 15-	☐ OEPI
	maintaining)		Dec	cer	mber 7)	
Enrollee name						
Agent name/ID numbe	r					
Y0066_ERFMA_2025_C						AAEX25HP0220682_000

☐ 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 IA-0002 (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.

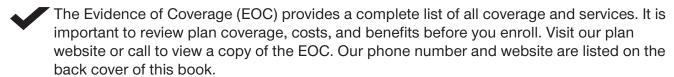
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

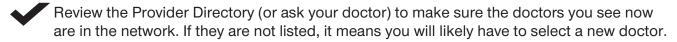
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

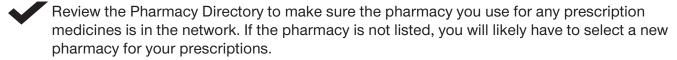
Enrollment checklist

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





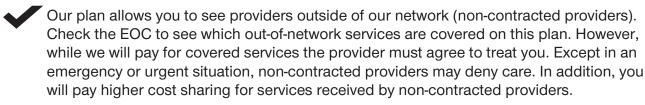


Review the Formulary to make sure your drugs are covered.

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.