

## **2025 Enrollment Request Form**

☐ AARP® Medicare Advantage from UHC ST-1P (HMO-POS) H2802-071-000

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	ue ink)	
Last name	First name			Middle initial
Birth date		Sex □ Male □	Female	е
Home phone number ( )	_	Mobile phone nu	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	3	State	Zip code
Mailing address (Only if it's different from above. You can give a P.O. box.)				
City		5	State	Zip code
Email address (optional)				
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C				AAEX25HP0220846_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 fill them out.	your choice. You can't be de	enied coverage b	ecause you don't	
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-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 you	r 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 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 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	<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	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	e, LTD coverage, Workers' Compensation,	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 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 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? ☐ Yes ☐ No
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 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 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 UnitedHealthc	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and nary of Benefits for more information. coverage begins, I must get all of my medical and care. Benefits and services authorized by dealthcare "Evidence of Coverage" document ber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID numberY0066_ERFMA_2025_C	

		•	intage (MA) plan at a time - ent in another MA plan (exc	
apply for MA P plans).	rivate Fee-for-Service	e (PFFS), MA Medicare Me	edical Savings Account (MS	SA)
□ Release of info will share my in payments, and information (se □ I give UnitedHe	nformation with Medi I for other purposes a ee Privacy Act Statem ealthcare permission	icare, who may use it to tra allowed by Federal law tha nent below). I to share my protected hea	Plan, I acknowledge that the lock my enrollment, to make the authorize the collection of alth information with organi	this zations
or person(s) to plan.	r permissible purpos	ses under applicable law a	s required to administer my	health
<ul><li>The informatio intentionally pr</li></ul>	rovide false informati	on on this form I will be dis	rledge. I understand that if senrolled from the plan. bond may affect enrollment	
<ul><li>My response to plan.</li></ul>	J this form is volunta	ry. However, failure to resp	ond may affect emoliment	iii tiie
When I sign below	ı, it means that I hav	ve read and understand th	ne information on this forr	n
received my United UnitedHealthcare U	Healthcare UCard®, JCard to update my a	cation. After this application I can call Customer Service authorization information corized representative		I have
-	uthorized represe ow (*Not a Sales /	-	bove and complete th	е
Last name		First name		
Address				
City		State	Zip code	
Phone number (	) –	Relationship to	applicant	
Enrollee name				
	nber			

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For individuals helping enrolled	e with co	mple	ting this form o	nly
Complete this section if you're an indi	vidual (i.e.	. agent	s, brokers, SHIP co	ounselors, family
members, or other third parties) helpii	ng an enro	ollee fil	I out this form.	•
Name	Re	elation	ship to enrollee	
Signature	Na	ational	Producer Number	(Agents/Brokers only)
For Licensed Sales Representa	ative/age	ency	use only	
Licensed Sales representative/Writing		•	Initial receipt dat	е
Licensed Sales representative/agent name			Proposed effecti	ve date
Employer group name				
Employer group ID		ŀ	Branch ID	
Agent must complete ☐ IEP (MA-PD ☐ ICEP (MA €	enrollees)		EP (MA-PD	☐ OEP (Jan 1 –
enrollees)	,	enro	ollees eligible for IEP)	Mar 31)
☐ OEP (Newly ☐ SEP (Dual	LIS		EP (Change in	☐ SEP (Loss of
eligible) change of sta			dence)	EGHP coverage)
☐ SEP (Chronic) ☐ SEP (Dual I	•		EP (October 15-	□ OEPI
maintaining)			ember 7)	
•			,	
Enrollee name				

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□ SEP (SEP reason)			
Licensed Sales representative signature (optional)	Date		
Please mail or fax this completed form	o:		
UnitedHealthcare			
P.O. Box 30770			
Salt Lake City, UT 84130-0770			
Fax: 1-888-950-1170			
Fax the front and back of each page			

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 ST-1P (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.

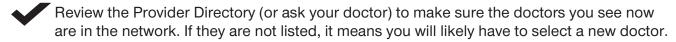
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

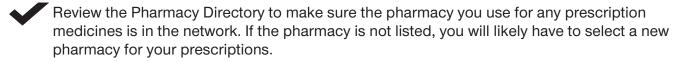
## **Enrollment checklist**

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



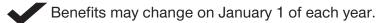


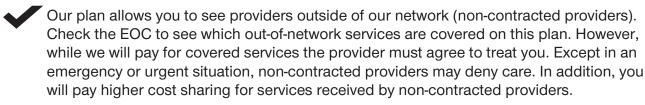




## **Understanding important rules**







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.