

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC KC-0002 (HMO-POS) H2802-032-000

| Information about you (Place | type or pri | nt in black or l | oluo ink | 1 | |
|--|----------------------------------|------------------|-----------|-------------------------|--|
| Last name | type or print in black or blue i | | Dide Ilik | Middle initial | |
| Last Hamo | T il ot Hamo | | | Wilder Willer | |
| Birth date | | Sex □ Male [| □ Femal | е | |
| Home phone number () | _ | Mobile phone | number (| () – | |
| ☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord | | | hone nur | mber(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 differen | t from above | e. You can give | a P.O. bo | ox.) | |
| City | | | State | Zip code | |
| Email address (optional) | | l | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Enrollee name | | | | | |
| Agent name/ID number | | | | | |
| Y0066_ERFMA_2025_C | | | | AAEX25HP0220871_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 | 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-II | RMAA), | |
| Social Security (SS) will send y | ou a letter and ask you how yo | u 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 Railro | ad Retirement Board (RRB) ch | neck | | |
| ☐ I want to pay directly from a | ☐ I want to pay directly from a bank account | | | |
| Account type ☐ Checking [| ☐ Savings | | | |
| Account holder name: | | | | |
| Bank routing number/, | /_/_/_/_/_ | | | |
| Bank account number/_ | <i> _ _ _ _</i> | | | |
| | | | | |
| 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 | | | X25HP0220871_000 | |
| 10000_LI 11 IVIA_2023_O | | AAE | ALUITI ULLUU1 1_UUU | |

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 Non-binary | I choose not to answer | |
| 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 in | surance that will cover medical services? | |
| (Examples: Other employer group coverage | | |
| auto liability, or Veterans benefits) | s, 1.2 develage, tremele dempendation, | ☐ Yes ☐ No |
| ,,, | | - 133 - 1.0 |
| Enrollee name | | |
| Agent name/ID number | | |
| Y0066_ERFMA_2025_C | AAEX25HP0 | 220871_000 |

| 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 | |

| I understand that I can be enrolled in only that enrollment in this plan will automatic | | |
|--|--|---|
| apply for MA Private Fee-for-Service (PFF | S), MA Medicare Me | edical Savings Account (MSA) |
| plans). Release of information: By joining this N will share my information with Medicare, payments, and for other purposes allowe information (see Privacy Act Statement b I give UnitedHealthcare permission to shor person(s) for permissible purposes un plan. The information on this form is correct to | who may use it to traced by Federal law that selow). are my protected header applicable law a | ack my enrollment, to make t authorize the collection of this alth information with organizations s required to administer my health |
| intentionally provide false information on My response to this form is voluntary. Ho plan. | this form I will be dis | senrolled from the plan. |
| When I sign below, it means that I have rea | d and understand tl | ne information on this form |
| understand that I will need to submit written pehalf of the member beyond this application received my UnitedHealthcare UCard®, I can UnitedHealthcare UCard to update my author Signature of applicant/member/authorized | n. After this application call Customer Service rization information of the control of the contr | on has been approved and I have be at the number on my on file. Today's date |
| If you are the authorized representation information below (*Not a Sales Agen | | above and complete the |
| Last name | First name | |
| Address | | |
| City | State | Zip code |
| Phone number () — | mber () — Relationship to applicant | |
| Enrollee name | | |
| Agent name/ID number | | |
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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 for | m to: | |
| UnitedHealthcare | | |
| P.O. Box 30770 | | |
| Salt Lake City, UT 84130-0770 | | |
| Fax: 1-888-950-1170 | | |
| Fay the front and back of each page | Δ | |

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 KC-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.

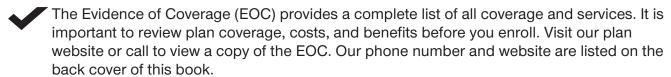
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

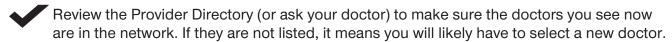
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

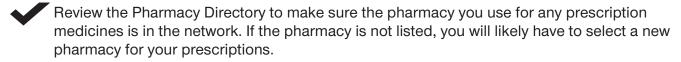
Enrollment checklist

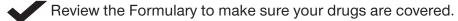
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits









Understanding important rules

