

2025 Enrollment Request Form

☐ AARP® Medicare Advantage Extras from UHC KC-5 (PPO) H8768-039-000

| Information about you (Please | type or pri | nt in black or | blue ink) | |
|--|--------------|-----------------|----------------|-------------------------|
| Last name | First name | | Middle initial | |
| Birth date | | Sex □ Male | ☐ Female | Э |
| Home phone number () | _ | Mobile phone | number (|) – |
| ☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord | | - | ohone 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 differen | t from above | e. You can give | a P.O. bo | x.) |
| City | | | State | Zip code |
| Email address (optional) | | | ı | - |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Enrollee name | | | | |
| Agent name/ID number | | | | |
| Y0066_ERFMA_2025_C | | | | AAEX25LP0220514_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) | 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 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 Braille | | • |
| Enrollee name | | | |
| Agent name/ID number | | | |
| Y0066_ERFMA_2025_C | | AAE | X25LP0220514_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 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 Man | I use a different term: | |
| 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) | ,, 2.2 develage, tremere dempendation, | ☐ Yes ☐ No |
| ,, | | |
| Enrollee name | | |
| Agent name/ID number | | |
| Y0066_ERFMA_2025_C | AAEX25LP0 | 220514_000 |

| If yes, please complete the following: | |
|---|---|
| Name of health insurance company | |
| Member number | |
| 7. Please give us the name of your prima | ary care provider (PCP), clinic or health center. |
| You aren't limited to this list. You may go t payment terms. You can find a list on the plan website or i | o any doctor who accepts Medicare and the plan's n the Provider 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 s | seen this provider? |
| an email when new communications (For Changes) are available online. You can accomputer, tablet or mobile phone. | example: Explanation of Benefits or the Annual Notice of cess these communications through any device such as a |
| If you would rather have hard copies of | required materials mailed to you, please check here: |
| | ail you hard copies of required materials. Please note that nd may not fit in all mailboxes. You can change your |
| Please read and sign | |
| By completing this form, I agree to the f | ollowing: |
| paying my Part B premium if I have on I understand that people with Medica the country, except for limited covera urgent care outside of the U.S. See the I understand that when my UnitedHeat prescription drug benefits from United UnitedHealthcare and contained in medical contained | d Medical (Part B) to stay in UnitedHealthcare. I must keep ne, unless Medicaid or someone else pays for it. are are generally not covered under Medicare while out of age near the U.S. border. This plan covers emergency and ne Summary of Benefits for more information. Althcare coverage begins, I must get all of my medical and dHealthcare. Benefits and services authorized by y UnitedHealthcare "Evidence of Coverage" document subscriber agreement) will be covered. Neither Medicare efits or services that are not covered. |
| Enrollee name | |
| Agent name/ID number Y0066_ERFMA_2025_C | AAEX25LP0220514_000 |

| I understand that I can be enrolled in only that enrollment in this plan will automatica apply for MA Private Fee-for-Service (PFFS) | ally end my enrollment | in another MA plan (exceptions |
|--|---|---|
| plans). Release of information: By joining this M will share my information with Medicare, w payments, and for other purposes allowed information (see Privacy Act Statement be I give UnitedHealthcare permission to sha or person(s) for permissible purposes uno plan. The information on this form is correct to the intentionally provide false information on the My response to this form is voluntary. How | who may use it to tracked by Federal law that a elow). The my protected health der applicable law as rette best of my knowle this form I will be diser | my enrollment, to make uthorize the collection of this information with organizations equired to administer my health dge. I understand that if I inrolled from the plan. |
| plan. | | |
| When I sign below, it means that I have read | and understand the | information on this form |
| show written proof (power of attorney, guardia understand that I will need to submit written probehalf of the member beyond this application. received my UnitedHealthcare UCard®, I can of UnitedHealthcare UCard to update my authorized Signature of applicant/member/authorized | roof of this right, to the After this application call Customer Service zation information on | e plan, if I wish to take action on has been approved and I have at the number on my |
| If you are the authorized representative information below (*Not a Sales Agent) | | ove and complete the |
| Last name | First name | |
| Address | | |
| City | State | Zip code |
| Phone number () — | Relationship to a | pplicant |
| | 1 | |
| Enrollee name | | |
| Agent name/ID number | | |
| Y0066_ERFMA_2025_C | | AAEX25LP0220514_000 |

AAEX25LP0220514_000

| 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 represe | entative/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 | | | | | |

Y0066_ERFMA_2025_C

| ☐ SEP (SEP reason) | - |
|--|--------------|
| 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 | |
| Fax the front and back of each pa | 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, 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 KC-5 (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.

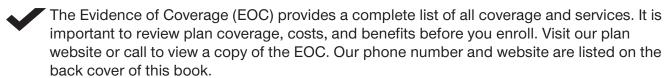
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

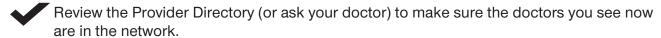
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

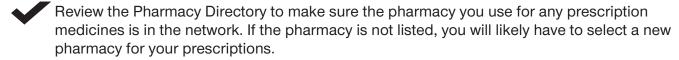
Enrollment checklist

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





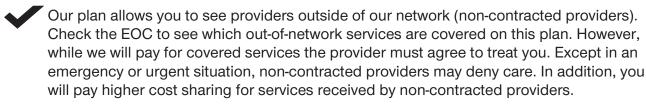


Review the Formulary to make sure your drugs are covered.

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.