

2025 Enrollment Request Form

☐ AARP® Medicare Advantage Essentials from UHC KC-4 (PPO) H8768-023-000

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 prii	nt in black or b	lue ink		
Last name	First name		Middle initial		
Birth date	Sex □ Male □ Fema] Femal	le	
Home phone number ()	 Mobile phone number 		umber () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			none nur	mber(s) I have provided	
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		State	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)					
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C				AAEX25LP0220528_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	pelow, 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 Retiremen	t 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	• • •		
1. Would you prefer plan info			
	rmation in another language or Braille □ Large print □ Audi		•
Enrollee name			
Agent name/ID number Y0066_ERFMA_2025_C			
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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 Spanish		
Yes, Mexican, Mexican American, o Yes, Puerto Rican	of Chicano/a	
Yes, Cuban	aniah aviain	
Yes, another Hispanic, Latino, or Sp	oanish 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 state4. 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 in:	surance that will cover medical services?	
(Examples: Other employer group coverage		
auto liability, or Veterans benefits)		☐ Yes ☐ No
Enrollee name		
Agent name/ID number		
VOOCE EDEMA OOOF C		220528_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	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	following:
paying my Part B premium if I have o I understand that people with Medica the country, except for limited covera urgent care outside of the U.S. See th I understand that when my UnitedHea prescription drug benefits from United UnitedHealthcare and contained in m (also known as a member contract or nor UnitedHealthcare will pay for ben	
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	AAEX25LP0220528_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 enrollmen	t 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 intentionally provide false information on the My response to this form is voluntary. How	who may use it to traced by Federal law that a elow). The my protected health der applicable law as the best of my knowled this form I will be dise	k my enrollment, to make authorize the collection of this th information with organizations required to administer my health edge. I understand that if I nrolled from the plan.
plan. When I sign below, it means that I have read		
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 If you are the authorized representative.	After this application call Customer Service zation information on representative	has been approved and I have at the number on my file. Today's date
<pre>information below (*Not a Sales Agent) Last name</pre>) First name	
Last Harris	T ilot riamo	
Address		
City	State	Zip code
Phone number () —	Relationship to a	applicant
Enrollee name		
Agent name/ID numberY0066_ERFMA_2025_C		AAEX25LP0220528_000

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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		J		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	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 Essentials from UHC KC-4 (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.

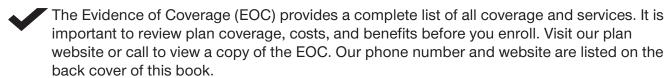
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

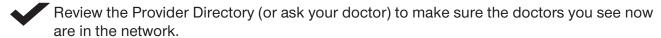
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

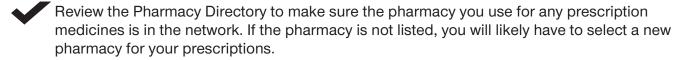
Enrollment checklist

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





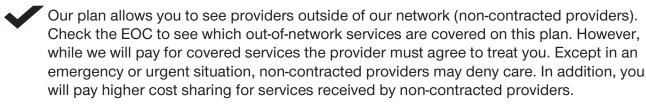


Review the Formulary to make sure your drugs are covered.

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.