

## **2025 Enrollment Request Form**

☐ AARP® Medicare Advantage from UHC IA-0003 (PPO) H8768-017-002

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 l	blue ink		
Last name	First name			Middle initial	
Birth date	Sex □ Male □		☐ Female		
Home phone number ( )	<ul><li>Mobile phone</li></ul>		number (	( ) —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			hone nui	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 nameAgent name/ID number					
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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 below, we'll send a bill each month to your mailing 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	• • •		
1. Would you prefer plan info	rmation in another language	or an accessible	format?
	rmation in another language of 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 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 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 in:	surance that will cover medical services?	
(Examples: Other employer group coverage		
auto liability, or Veterans benefits)		☐ Yes ☐ No
Enrollee name		
Enrollee nameAgent name/ID number		<del></del>
VOOCE EDEMA OOOF C		220535_000

If yes, please complete the following:	
Name of health insurance company	
Member number	
7. Please give us the name of your primary ca	re provider (PCP), clinic or health center.
You aren't limited to this list. You may go to any payment terms.	·
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 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 th	nis provider?
your plan communications.  You will get many of your required plan communications (For example)	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 requir	ed materials mailed to you, please check here:
	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 followi	ng:
paying my Part B premium if I have one, und I understand that people with Medicare are the country, except for limited coverage near urgent care outside of the U.S. See the Sun I understand that when my UnitedHealthcar prescription drug benefits from UnitedHealt UnitedHealthcare and contained in my United	generally not covered under Medicare while out of ar the U.S. border. This plan covers emergency and nmary of Benefits for more information. The coverage begins, I must get all of my medical and the care. Benefits and services authorized by edHealthcare "Evidence of Coverage" document criber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID numberY0066_ERFMA_2025_C	

<ul> <li>I understand that I can be enrolled in only o that enrollment in this plan will automatically</li> </ul>	y end my enrollment in and	other MA plan (exceptions
apply for MA Private Fee-for-Service (PFFS), plans).	, MA Medicare Medical Sa	vings Account (MSA)
<ul> <li>□ Release of information: By joining this Med will share my information with Medicare, who payments, and for other purposes allowed k information (see Privacy Act Statement below I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan.</li> </ul>	no may use it to track my e by Federal law that authori bw). my protected health infor	nrollment, to make ze the collection of this mation with organizations
<ul> <li>The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. Howe plan.</li> </ul>	s form I will be disenrolled	from the plan.
When I sign below, it means that I have read a	and understand the inform	nation on this form
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 authorizations.  Signature of applicant/member/authorized received my authorized my authorized received my authorized received my authorized received my authorized received my authorized my authorized received my authorized my autho	Ifter this application has been all Customer Service at the ation information on file.  Perpendicular to the presentative Toda	een 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 a	na complete the
Last name	First name	
Address		
City	State	Zip code
Phone number ( ) —	Relationship to applicant	
Enrollee name		
Agent name/ID number		A A E Y 251 P 0 2 2 0 5 3 5 0 0 0

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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	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-0003 (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.

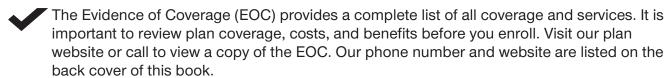
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

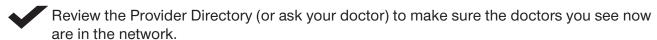
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

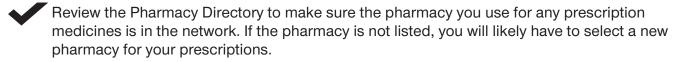
## **Enrollment checklist**

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**





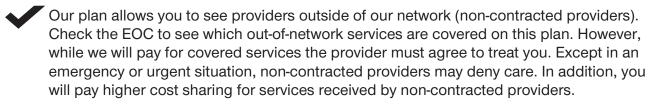


Review the Formulary to make sure your drugs are covered.

## **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.