

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC FG-0003 (PPO) H2001-120-000

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 blue	ink)		
Last name	First name			Middle initial	
Birth date		Sex □ Male □ Fe	emale	le	
Home phone number ()	_	Mobile phone numl	ber () —	
☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology.					
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	Stat	te	Zip code	
Mailing address (Only if it's different from above. You can give a P.O. box.)					
City		Stat	te	Zip code	
Email address (optional)					
Enrollee name				<u>.</u>	
Agent 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			<u> </u>	
			T	
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 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 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 of Braille		•	
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C AAEX25LP0221020_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 Sp.		
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 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	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 prim	nary care provider (PCP), clinic or health center.
You aren't limited to this list. You may go payment terms. You can find a list on the plan website or	to any doctor who accepts Medicare and the plan's
Provider or PCP full name	mane i revider Birectory.
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 provider? ☐ Yes ☐ No
an email when new communications (For	ommunications delivered electronically. We will send you example: Explanation of Benefits or the Annual Notice of ccess these communications through any device such as a
	required materials mailed to you, please check here:
	nail you hard copies of required materials. Please note that and may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the	following:
paying my Part B premium if I have of I understand that people with Medicathe country, except for limited covera urgent care outside of the U.S. See to I understand that when my UnitedHe prescription drug benefits from UnitedHealthcare and contained in many (also known as a member contract of	and Medical (Part B) to stay in UnitedHealthcare. I must keep one, 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 the Summary of Benefits for more information. Ealthcare coverage begins, I must get all of my medical and edHealthcare. Benefits and services authorized by my UnitedHealthcare "Evidence of Coverage" document or subscriber agreement) will be covered. Neither Medicare nefits or services that are not covered.
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	

	I understand that I can be enrolled in only one that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS), N	end my enrollment in ano	ther MA plan (exceptions
	plans). Release of information: By joining this Medi will share my information with Medicare, who payments, and for other purposes allowed by	may use it to track my en	rollment, to make
	I give UnitedHealthcare permission to share ror person(s) for permissible purposes under a	my protected health inform	· ·
	plan. The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. However plan.	form I will be disenrolled	from the plan.
Wh	en I sign below, it means that I have read an	d understand the inform	ation on this form
beh rece Uni Sig	lerstand that I will need to submit written proof all of the member beyond this application. Afterived my UnitedHealthcare UCard®, I can call tedHealthcare UCard to update my authorization nature of applicant/member/authorized reprovate the authorized representative,	er this application has been customer Service at the mon information on file. resentative Today	en approved and I have number on my 's date
info	ormation below (*Not a Sales Agent)		·
Las	t name	First name	
Add	dress		
City	,	State	Zip code
Pho	one number () —	Relationship to applicar	it
Enro	llee name		
	nt name/ID number 6 ERFMA 2025 C		AAFV0ELD0001000 000
YUUD	n EBENJA ZUZO U		AAFX25LP0221020 000

For individuals hel	ping enrollee with	or cor	mple	eting this form o	nly
Complete this section	if you're an individual	(i.e. a	agen [.]	ts, brokers, SHIP co	ounselors, family
members, or other thir	•	•	_		•
Name	<u>- - </u>			ship to enrollee	
Name		1101	ation	Ship to chilolice	
0:		NI - 4	1	Dua du casa Massala au	/ A t / D t t)
Signature		INat	ionai	Producer Number	(Agents/Brokers only)
For Licensed Sale	s Representative/	agei	ncy	use only	
Licensed Sales repres	entative/Writing ID		_	Initial receipt date	е
	- ···· · · · · · · · · · · · · · · · ·				
Licensed Sales repres	entative/agent name			Proposed effective	ve date
Francisco de autorio de autorio					
Employer group name					
Employer group ID				Branch ID	
Agent must complete)				
☐ IEP (MA-PD	☐ ICEP (MA enrolle	es)		EP (MA-PD	□ OEP (Jan 1 -
enrollees)	`	,		ollees eligible for	Mar 31)
				IEP)	
☐ OEP (Newly	☐ SEP (Dual LIS			EP (Change in	☐ SEP (Loss of
, ,				` •	•
eligible)	change of status)			dence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS			EP (October 15-	□ OEPI
	maintaining)		Dec	ember 7)	
Enrollee name					
Agent name/ID number	r				
Y0066_ERFMA_2025_C					AAEX25LP0221020_000

☐ 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, 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 FG-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.

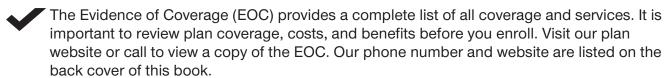
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

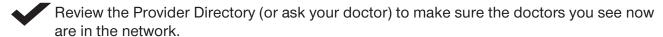
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

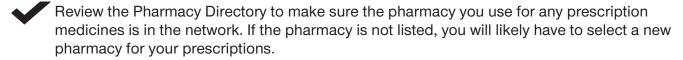
Enrollment checklist

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

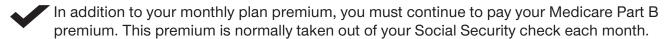


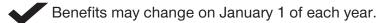


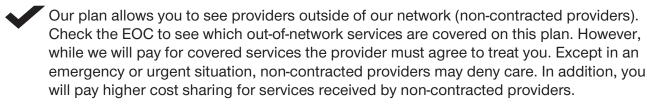




Understanding important rules







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.