

## **2025 Enrollment Request Form**

☐ AARP® Medicare Advantage CareFlex from UHC FL-32 (HMO-POS) H1045-057-000

Information about you (Please	type or pri	nt in black or b	lue ink	
Last name	First name		Middle initial	
		I		
Birth date		Sex □ Male □	] Femal	е
Home phone number ( )	_	Mobile phone n	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	-			
homelessness, a PO Box may be co	onsidered yo	our permanent re	esidence	e 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				AAFL25HP0221195_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 you a letter and ask you how you want to pay it:				
☐ You can pay it from you	r SS check			
☐ Medicare can bill you	□ 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	ieck		
☐ 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				
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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 Sp.	•	
Yes, Mexican, Mexican American, o	or Chicano/a	
Yes, Puerto Rican		
Yes, Cuban		
Yes, another Hispanic, Latino, or Sp	oanish origin	
I choose not to answer		
3. What's your race? Select all that apply		
or remark of your races consert an interapply.	•	
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	
<ul><li> Member/Citizen of a federal or state</li><li>4. What is your gender? Select one.</li><li> Woman</li><li> Man</li></ul>	e recognized Tribe (name of Tribe) 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)	,	☐ Yes ☐ No
22.2		
Enrollee name		<del></del>
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 primary car	e provider (PCP), clinic or health center.
You can find a list on the plan website or in the P	rovider Directory.
Provider or PCP full name	
Provider/PCP number	(Please enter the number exactly as it appears of 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	is provider? ☐ Yes ☐ No
Providing your email address above automatic your plan communications.	ally enrolls you in paperless delivery for some of
an email when new communications (For examp	ications delivered electronically. We will send you le: Explanation of Benefits or the Annual Notice of nese communications through any device such as a
If you would rather have hard copies of require	ed materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you some communications are very large and may preference for delivery at any time.	hard copies of required materials. Please note that not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the following	ng:
<ul> <li>paying my Part B premium if I have one, unled I understand that people with Medicare are at the country, except for limited coverage neadurgent care outside of the U.S. See the Sum</li> <li>I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealth UnitedHealthcare and contained in my United</li> </ul>	generally not covered under Medicare while out of at the U.S. border. This plan covers emergency and amary of Benefits for more information. The coverage begins, I must get all of my medical and acare. Benefits and services authorized by addHealthcare "Evidence of Coverage" document riber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	

	I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA) plans).						
	Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).						
	or person(s) for permissible purposes under applicable law as required to administer my health						
	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.				
	en I sign below, it means that I have read an sign as an authorized representative, it means						
und beh rece Unit	wwwritten proof (power of attorney, guardiansh derstand that I will need to submit written proof half of the member beyond this application. Aft eived my UnitedHealthcare UCard®, I can call tedHealthcare UCard to update my authorization nature of applicant/member/authorized rep	of this right, to the plan, is er this application has been customer Service at the non information on file.  resentative Today	f I wish to take action on en approved and I have umber on my 's date				
_	or are the authorized representative, ormation below (*Not a Sales Agent)	please sign above an	d complete the				
Las	t name	First name					
Add	dress						
City	1	State	Zip code				
Pho	one number ( ) —	Relationship to applicant					
	llee name						
_	nt name/ID number 6_ERFMA_2025_C		 AAFL25HP0221195_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 represe	-			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 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 CareFlex from UHC FL-32 (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.

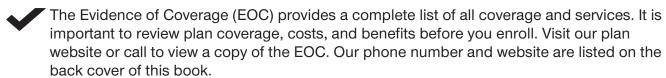
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

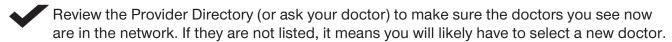
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

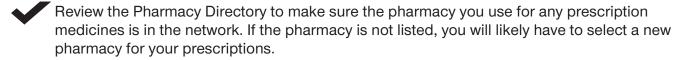
## **Enrollment checklist**

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





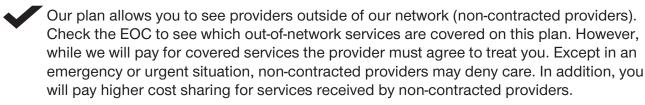




## **Understanding important rules**







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.