

## 2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC FL-0021 (PPO) H2406-013-000

1.6					
Information about you (Please	type or pri	nt in black or b	olue ink		
Last name	First name			Middle initial	
		I			
Birth date		Sex □ Male □	☐ Femal	е	
Home phone number ( )	_	Mobile phone r	number (	( ) –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			hone nur	mber(s) I have provided	
Medicare number					
Permanent residence street address	(Don't enter	a P.O. box. Not	e: For in	dividuals experiencing	
homelessness, a PO Box may be co	•				
City	County		State	Zip code	
Mailing address (Only if it's different	t from above	e. You can give a	a P.O. bo	ox.)	
City			State	Zip code	
Email address (optional)		l			
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C				AAFL25LP0220991_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 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 y	ou a letter and ask you how yo	u want to pay it:		
☐ You can pay it from your SS check				
☐ Medicare can bill you				
☐ The Railroad Retiremen	☐ 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				
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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	
<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>	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 ins	surance that will cover medical services?	
(Examples: Other employer group coverage		
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 primary care	e provider (PCP), clinic or health center.
You aren't limited to this list. You may go to any depayment terms.	octor who accepts Medicare and the plan's
You can find a list on the plan website or in the Pr	rovider 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 this	s provider?
Providing your email address above automatications.	ally enrolls you in paperless delivery for some of
You will get many of your required plan communications (For example Changes) are available online. You can access the computer, tablet or mobile phone.	
If you would rather have hard copies of require	d materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you have some communications are very large and may preference for delivery at any time.	nard 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 followin	g:
paying my Part B premium if I have one, unled I understand that people with Medicare are go the country, except for limited coverage near urgent care outside of the U.S. See the Summary I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealth UnitedHealthcare and contained in my United	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and mary of Benefits for more information. coverage begins, I must get all of my medical and care. Benefits and services authorized by dHealthcare "Evidence of Coverage" document ber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number	

<ul> <li>I understand that I can be enrolled in only of that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS),</li> </ul>	end my enrollment in ano	ther MA plan (exceptions
plans).  Release of information: By joining this Medwill share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below).	o may use it to track my en by Federal law that authoriz w).	rollment, to make e the collection of this
<ul> <li>I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan.</li> </ul>	• •	· ·
<ul> <li>The information on this form is correct to the intentionally provide false information on thi</li> <li>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	nd understand the inform	ation on this form
show written proof (power of attorney, guardians understand that I will need to submit written proof behalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorization.  Signature of applicant/member/authorized re	of of this right, to the plan, ifter this application has be I Customer Service at the rition information on file.  presentative Today	of I wish to take action on en approved and I have number on my o's date
If you are the authorized representative information below (*Not a Sales Agent)	, piease sign above ar	id complete the
Last name	First name	
Address		
City	State	Zip code
Phone number ( ) —	Relationship to applicar	nt
Enrollee name		
Agent name/ID numberY0066_ERFMA_2025_C		AAFL25LP0220991_000

For individuals he	lping enrollee with	com	nple	ting this form o	nly
	if you're an individual		-	_	-
•	rd parties) helping an e	•	_		•
Name		Rela	tions	hip to enrollee	
Signature		Natio	onal I	Producer Number	(Agents/Brokers only)
For Licensed Sale	es Representative/	agen	CV I	ise only	
Licensed Sales repres	•	ugo	icy c	Initial receipt dat	e
Licensed Sales representative/agent name				Proposed effecti	ve date
Employer group name	)			<u>I</u>	
Employer group ID			В	ranch ID	
Agent must complete	е		•		
☐ IEP (MA-PD	☐ ICEP (MA enrolle	es)	□IE	P (MA-PD	□ OEP (Jan 1 -
enrollees)				lees eligible for	Mar 31)
☐ OEP (Newly eligible)	☐ SEP (Dual LIS change of status)		resid	EP (Change in ence)	☐ SEP (Loss of EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)			EP (October 15- ember 7)	□ OEPI
Enrollee name					
Agent name/ID numbe					
Y0066_ERFMA_2025_C					AAFL25LP0220991_000

□ SEP (SEP reason)			
Licensed Sales representative signature (optional)	Date		
Please mail or fax this completed for	m to:		
UnitedHealthcare			
P.O. Box 30770			
Salt Lake City, UT 84130-0770			
Fax: 1-888-950-1170			
Fay the front and back of each page	Δ		

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 FL-0021 (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.

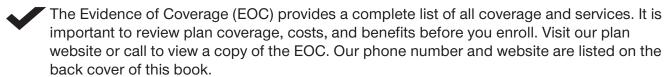
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

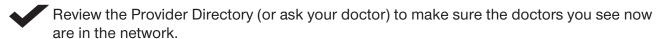
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

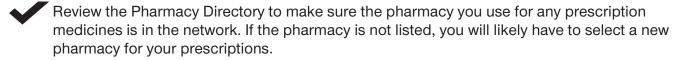
## **Enrollment checklist**

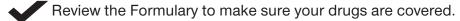
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the benefits





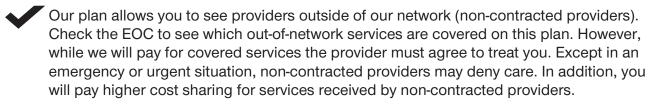




## **Understanding important rules**







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.