

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC GA-0006 (HMO-POS) H5322-042-000

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 homelessness, a PO Box may be co	-			
City	County		State	Zip code
Mailing address (Only if it's differen	t from above	e. You can give a	P.O. bo	x.)
City			State	Zip code
Email address (optional)				,
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C				AAGA25HP0220583_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			
		Γ	
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 automation 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-I	RMAA),
Social Security (SS) will send y	ou a letter and ask you how yo	ou want to pay it:	
☐ You can pay it from you	r 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	
\square 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		AAG	A25HP0220583_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 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		ı
auto liability, or Veterans benefits)		☐ Yes ☐ No
Enrollee name		
Agent name/ID number		
Y0066_ERFMA_2025_C	AAGA25HP0	220583_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 can find a list on the plan website or in the I	Provider Directory.
Provider or PCP full name	
Provider/PCP number	(Please enter the number exactly as it appears or 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 the	nis provider?
Providing your email address above automatic your plan communications.	cally enrolls you in paperless delivery for some of
an email when new communications (For examp	nications delivered electronically. We will send you ole: Explanation of Benefits or the Annual Notice of these communications through any device such as a
If you would rather have hard copies of requir	red 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 following	ng:
paying my Part B premium if I have one, un I understand that people with Medicare are the country, except for limited coverage ne- 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 Unite	e generally not covered under Medicare while out of ar the U.S. border. This plan covers emergency and mmary of Benefits for more information. The coverage begins, I must get all of my medical and theore. Benefits and services authorized by edHealthcare "Evidence of Coverage" document criber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number	

I understand that I can be enrolled in only that enrollment in this plan will automatic apply for MA Private Fee-for-Service (PFF)	cally end my enrollme	ent in another MA plan (exce	ptions
plans). ☐ Release of information: By joining this N	Medicare Advantage	Plan, I acknowledge that the	-
will share my information with Medicare, payments, and for other purposes allowe information (see Privacy Act Statement b	ed by Federal law tha	•	this
I give UnitedHealthcare permission to she or person(s) for permissible purposes un plan.	are my protected he	_	
 The information on this form is correct to intentionally provide false information on 		•	
My response to this form is voluntary. Ho plan.	owever, failure to resp	oond may affect enrollment i	in the
When I sign below, it means that I have rea	d and understand tl	ne information on this form	1
understand that I will need to submit written p behalf of the member beyond this application received my UnitedHealthcare UCard®, I can UnitedHealthcare UCard to update my author Signature of applicant/member/authorized	n. After this application call Customer Service rization information contraction contractions.	on has been approved and I be at the number on my	
If you are the authorized representation below (*Not a Sales Agen		above and complete the	e
Last name	First name		
Address			
City	State	Zip code	
Phone number () —	ne number () — Relationship to applicant		
Enrollee name			_
Agent name/ID number		ΔΔGΔ25HP0220583 0	_

			_		
For individuals hel	ping enrollee with	cor	nple	eting this form o	nly
Complete this section	if you're an individual	(i.e. a	agent	ts, brokers, SHIP co	ounselors, family
members, or other thir	d parties) helping an e	enroll	lee fil	ll out this form.	
Name	. ,	Rela	ation	ship to enrollee	
Signature		Nat	ional	Producer Number	(Agents/Brokers only)
Olgridiai		Ivat	ioriai	Troducci Number	(Agents) brokers only)
E. I. C. C. L. C. L.	- D /				
For Licensed Sale	• •	agei	ncy		
Licensed Sales repres	entative/Writing ID			Initial receipt dat	е
Licensed Sales repres	entative/agent name			Proposed effecti	ve date
Licerised daies repres	critative, agent name			1 Toposca checti	ve date
Employer group name					
Employer group ID			١,	Branch ID	
Employer group ib			'	Dianonib	
Agent must complete)				
☐ IEP (MA-PD	☐ ICEP (MA enrolle	es)		EP (MA-PD	□ OEP (Jan 1 –
enrollees)	,	,		ollees eligible for	Mar 31)
0111 0110 00)				IEP)	ma. 01)
☐ 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					AAGA25HP0220583_000

☐ SEP (SEP reason)		
Licensed Sales representative signature (optional)	Date	
Please mail or fax this completed form	:0:	
UnitedHealthcare		
P.O. Box 30769		
Salt Lake City, UT 84130-0769		
Fax: 1-888-950-1169		
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 GA-0006 (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.

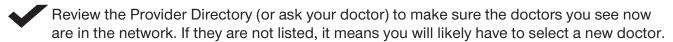
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

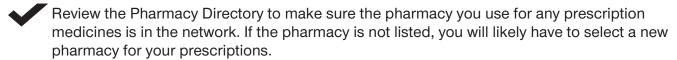
Enrollment checklist

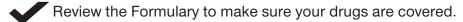
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





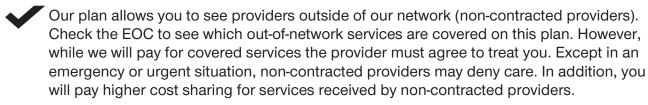




Understanding important rules







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.