

2025 Enrollment Request Form

☐ AARP® Medicare Advantage Extras from UHC GA-8 (PPO) H1889-027-000

Information about you (Places	type or pri	nt in block or h	علما مباد	1
Information about you (Please		III III black of t	nue irik	
Last name	First name			Middle initial
			_	
Birth date		Sex Male	☐ Femal	e
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	onsidered yo	our permanent r	esidence	e address)
City	County		State	Zip code
City	Oddity		Otato	210 0000
Mailing address (Only if it's differen	t from above	e. You can give a	a P.O. bo	ox.)
City			State	Zip code
Email address (optional)		I		
Enrollee name				
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			
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 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	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	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		
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If yes, please complete the following:	5		
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 d	octor who accepts Medicare and the plan's		
payment terms.			
You can find a list on the plan website or in the Plan	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 thi	s provider?		
Providing your email address above automatic	ally enrolls you in paperless delivery for some of		
your plan communications.			
You will get many of your required plan communi	cations delivered electronically. We will send you		
	e: Explanation of Benefits or the Annual Notice of		
Changes) are available online. You can access these communications through any device such as a			
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 hard copies of required materials. Please note that			
some communications are very large and may not fit in all mailboxes. You can change your			
preference for delivery at any time.			
Please read and sign			
By completing this form, I agree to the following	g:		
	cal (Part B) to stay in UnitedHealthcare. I must keep		
paying my Part B premium if I have one, unless Medicaid or someone else pays for it.			
 I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and 			
urgent care outside of the U.S. See the Summary of Benefits for more information.			
☐ I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and			
prescription drug benefits from UnitedHealthcare. Benefits and services authorized by			
	UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document		
(also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.			
nor ormedication will pay for benefits of	oo, video that are not oovered.		
Enrollee name			
Agent name/ID number			
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 I understand that I can be enrolled in only of that enrollment in this plan will automaticall apply for MA Private Fee-for-Service (PFFS) 	y end my enrollment in ano	ther MA plan (exceptions
 plans). Release of information: By joining this Mewill share my information with Medicare, who payments, and for other purposes allowed information (see Privacy Act Statement below I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan. The information on this form is correct to the intentionally provide false information on the My response to this form is voluntary. However, 	no may use it to track my end by Federal law that authorized by). The my protected health informer applicable law as required the best of my knowledge. It is form I will be disenrolled	rollment, to make the collection of this mation with organizations d to administer my health understand that if I from the plan.
plan.		
When I sign below, it means that I have read a lf I sign as an authorized representative, it mean		
understand that I will need to submit written probehalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can cau UnitedHealthcare UCard to update my authorization. Signature of applicant/member/authorized received.	After this application has be Il Customer Service at the ration information on file.	en approved and I have
If you are the authorized representative information below (*Not a Sales Agent)	e, please sign above a	nd complete the
Last name	First name	
Address		
City	State	Zip code
Phone number () —	Relationship to applicar	nt
Enrollee name		
Agent name/ID number		A A O A O E I DO O O A A C E A C O C O
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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 for	m 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	IA.

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, 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 Extras from UHC GA-8 (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.

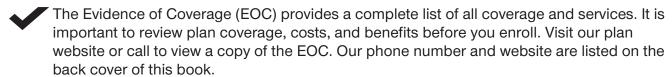
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

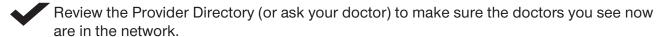
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

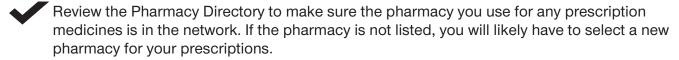
Enrollment checklist

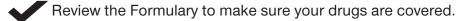
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits



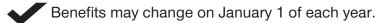


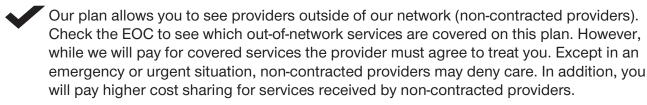




Understanding important rules







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.