

2025 Enrollment Request Form

☐ AARP® Medicare Advantage Essentials from UHC GA-7 (PPO) H1889-023-000

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 prin	nt in black or blue	ink)		
Last name	First name		1	Middle initial	
Birth date	Sex □ Male □		male	le	
Home phone number ()	 Mobile phone number 		er (() –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	num	ber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be co	•				
City	County		Э	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			^	ΔGΔ25I P0221138 .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)	nium (including any late enroll 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	u want to pay it:	
☐ You can pay it from you	r 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 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			
Y0066_ERFMA_2025_C		AAG	A25LP0221138_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 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	
 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		
auto liability, or Veterans benefits)		☐ Yes ☐ No
Enrollee name		
Agent name/ID number		
VOOCE EDEMA OOOF C	AAGA25LP0	221138_000

If yes, please complete the following:	
Name of health insurance company	
Member number	
7. Please give us the name of your prima	ary care provider (PCP), clinic or health center.
You aren't limited to this list. You may go to payment terms. You can find a list on the plan website or in	o any doctor who accepts Medicare and the plan's n the Provider 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 s	een this provider?
an email when new communications (For e	example: Explanation of Benefits or the Annual Notice of cess these communications through any device such as a
If you would rather have hard copies of r	required materials mailed to you, please check here:
	ail you hard copies of required materials. Please note that nd may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the fo	ollowing:
paying my Part B premium if I have or I understand that people with Medical the country, except for limited coverag urgent care outside of the U.S. See th I understand that when my UnitedHea prescription drug benefits from United UnitedHealthcare and contained in my	d Medical (Part B) to stay in UnitedHealthcare. I must keep ne, unless Medicaid or someone else pays for it. re are generally not covered under Medicare while out of ge near the U.S. border. This plan covers emergency and the Summary of Benefits for more information. Althcare coverage begins, I must get all of my medical and difficult the difficulty and services authorized by y UnitedHealthcare "Evidence of Coverage" document subscriber agreement) will be covered. Neither Medicare efits or services that are not covered.
Enrollee name	
Agent name/ID number	AAGA25LP0221138_000

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				
 I give UnitedHealthcare permission to sha or person(s) for permissible purposes und 	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 best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan. My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. 				
When I sign below, it means that I have read	d and understand the	e information on this form		
show written proof (power of attorney, guardia 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 If you are the authorized representation	proof of this right, to the control of this right, to the control of this application call Customer Service rization information on representative	ne plan, if I wish to take action on a has been approved and I have at the number on my file. Today's date		
information below (*Not a Sales Agent	-	•		
Last name	First name			
Address				
City	State	Zip code		
Phone number () —	Relationship to	Relationship to applicant		
For individuals helping enrollee with	completing this fo	orm only		
Enrollee name				
Agent name/ID numberY0066_ERFMA_2025_C		AAGA25LP0221138_000		

Complete this section members, or other thir	-		_		ounselors, family
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sales		agen	суι	ise only	
Licensed Sales representative/Writing ID			Initial receipt date		е
Licensed Sales representative/agent name				Proposed effective date	
Employer group name					
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees) ☐ OEP (Newly eligible) ☐ SEP (Chronic) ☐ SEP (SEP reason) _	☐ ICEP (MA enrollees) ☐ el 2i ☐ SEP (Dual LIS ☐ change of status) re ☐ SEP (Dual LIS ☐		enrol 2nd I □ SE resid □ AE	P (MA-PD lees eligible for EP) EP (Change in ence) EP (October 15- ember 7)	☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI
Enrollee name Agent name/ID number					
Y0066_ERFMA_2025_C					AAGA25LP0221138_000

Licensed Sales representative signature (optional)

Date

Please mail or fax this completed form 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

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 Essentials from UHC GA-7 (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.

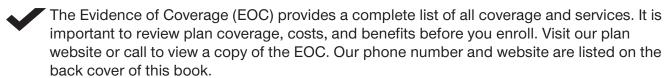
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

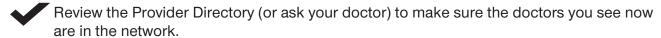
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

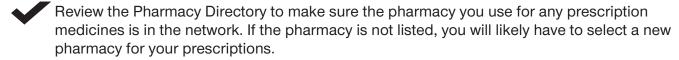
Enrollment checklist

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

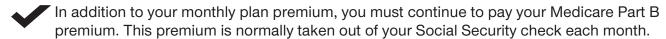


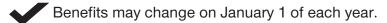


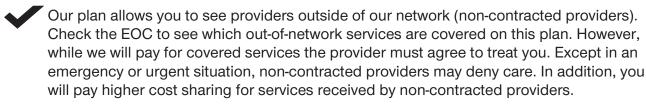


Review the Formulary to make sure your drugs are covered.

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.