

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC HI-5 (PPO) H2406-131-000

Information about you (Please	type or pri	nt in black or	blue ink)	
Last name	First name			Middle initial	
Birth date		Sex □ Male	□ Femal	e	
Home phone number ()	_	Mobile phone	number (() –	
☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology.					
Medicare number					
Permanent residence street address (Don't enter a P.O. box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence 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)				1	
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C				AAHI25LP0220899_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-Income Related Monthly Adjustment Amount (Part D-IRMAA),				
Social Security (SS) will send y You can pay it from you Medicare can bill you The Railroad Retiremen	r SS check	ou want to pay it:		
☐ The Railroad Retirement Board (RRB) can bill you ☐ I want to pay from my Social Security check				
. ,	•	neck		
☐ 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 Y0066_ERFMA_2025_C			 HI25LP0220899_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 state 4. What is your gender? Select one.	recognized Tribe (name of Tribe)	
Woman Man	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)	s, 1.2 develage, tremele dempendation,	☐ Yes ☐ No
,,,		- 133 - 1.0
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 car	e provider (PCP), clinic or health center.
You aren't limited to this list. You may go to any compayment terms. You can find a list on the plan website or in the P	
Provider or PCP full name	Tovidor Biroctory.
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 th	is provider? ☐ Yes ☐ No
an email when new communications (For example	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:
paying my Part B premium if I have one, unled I understand that people with Medicare are get the country, except for limited coverage near urgent care outside of the U.S. See the Sum I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealth UnitedHealthcare and contained in my United	generally not covered under Medicare while out of ar the U.S. border. This plan covers emergency and mary of Benefits for more information. Ecoverage begins, I must get all of my medical and neare. Benefits and services authorized by adHealthcare "Evidence of Coverage" document riber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	

apply for MA Private Fee-for-Serv	utomatically end my enrollment	age (MA) plan at a time – and in another MA plan (exceptions cal Savings Account (MSA)
plans). Release of information: By joini will share my information with Me payments, and for other purpose information (see Privacy Act State I give UnitedHealthcare permissi or person(s) for permissible purpolan. The information on this form is contentionally provide false inform My response to this form is voluring the same of the same	edicare, who may use it to track es allowed by Federal law that a tement below). ion to share my protected health poses under applicable law as recorrect to the best of my knowled pation on this form I will be diser	my enrollment, to make uthorize the collection of this information with organizations equired to administer my health dge. I understand that if I prolled from the plan.
plan.		
When I sign below, it means that I h	nave read and understand the	information on this form
show written proof (power of attorney understand that I will need to submit behalf of the member beyond this ap received my UnitedHealthcare UCard to update m	written proof of this right, to the pplication. After this application d®, I can call Customer Service a	plan, if I wish to take action on has been approved and I have at the number on my
Signature of applicant/member/au		Today's date
If you are the authorized representation below (*Not a Sale	esentative, please sign abo	
If you are the authorized repre	esentative, please sign abo	
If you are the authorized representation below (*Not a Sale	esentative, please sign abo es Agent)	
If you are the authorized representation below (*Not a Sale Last name	esentative, please sign abo es Agent)	
If you are the authorized representation below (*Not a Sale Last name	esentative, please sign aboves Agent) First name	ove and complete the Zip code
If you are the authorized representation below (*Not a Sales Last name Address City	esentative, please sign aboves Agent) First name State	ove and complete the Zip code
If you are the authorized representation below (* Not a Sales Last name Address City Phone number () — Enrollee name	esentative, please sign aboves Agent) First name State Relationship to a	Zip code
If you are the authorized representation below (*Not a Sales Last name Address City Phone number () —	esentative, please sign aboves Agent) First name State Relationship to a	Zip code

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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		National Producer Number (Agents/Brokers only)			
For Licensed Sales	Representative/a	agen	cv u	se only	
Licensed Sales representative/Writing ID				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	ie		

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 HI-5 (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.

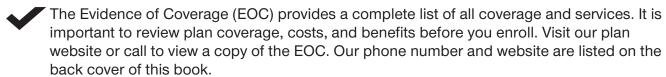
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

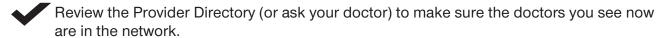
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

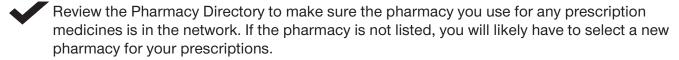
Enrollment checklist

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





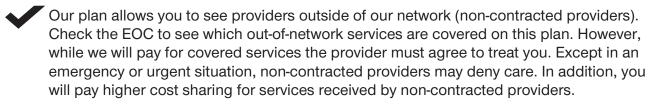


Review the Formulary to make sure your drugs are covered.

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.