

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC HI-0002 (PPO) H2406-058-000

Information about you (Please	type or pri	nt in black or b	olue ink)
Last name	First name			Middle initial
Birth date		Sex □ Male [□ Femal	e
Home phone number ()	_	Mobile phone	number (() –
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	hone nui	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	ox.)
City			State	Zip code
Email address (optional)				
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 your choice. You can't be denied coverage because you don't fill them out.				
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-Incom	e Related Monthly Adjustment	Amount (Part D-II	RMAA),	
Social Security (SS) will send you a letter and ask you how you want to pay it:				
□ You can pay it from your 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 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 Spanish		
Yes, Mexican, Mexican American, o		
Yes, Puerto Rican	of Chicano/a	
Yes, Cuban	agnich arigin	
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		
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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 pr	imary care provider (PCP), clinic or health center.
You aren't limited to this list. You may go payment terms. You can find a list on the plan website of	go to any doctor who accepts Medicare and the plan's or in 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 recent	ly seen this provider?
an email when new communications (F	communications delivered electronically. We will send you for example: Explanation of Benefits or the Annual Notice of access these communications through any device such as a
	of required materials mailed to you, please check here:
• •	mail you hard copies of required materials. Please note that e and may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to th	e following:
paying my Part B premium if I have I understand that people with Med the country, except for limited cov urgent care outside of the U.S. See I understand that when my Unitedle prescription drug benefits from Un UnitedHealthcare and contained in (also known as a member contract	and Medical (Part B) to stay in UnitedHealthcare. I must keep e one, unless Medicaid or someone else pays for it. licare are generally not covered under Medicare while out of erage near the U.S. border. This plan covers emergency and e the Summary of Benefits for more information. Healthcare coverage begins, I must get all of my medical and litedHealthcare. Benefits and services authorized by my UnitedHealthcare "Evidence of Coverage" document to r subscriber agreement) will be covered. Neither Medicare benefits or services that are not covered.
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	

□ 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)					
will share my information with Me payments, and for other purposes information (see Privacy Act State I give UnitedHealthcare permission or person(s) for permissible purpoplan. The information on this form is continued intentionally provide false information.	ng this Medicare Advantage Plan, I acknowledge that the plan edicare, who may use it to track my enrollment, to make is allowed by Federal law that authorize the collection of this ement below). On to share my protected health information with organizations oses under applicable law as required to administer my health correct to the best of my knowledge. I understand that if I ation on this form I will be disenrolled from the plan. I tary. However, failure to respond may affect enrollment in the				
plan.					
When I sign below, it means that I ha	ave read and understand the information on this form				
understand that I will need to submit verbehalf of the member beyond this app					
If you are the authorized represinformation below (*Not a Sales	sentative, please sign above and complete the s Agent)				
_					
information below (*Not a Sales	s Agent)				
information below (* Not a Sales Last name	s Agent)				
information below (* Not a Sales Last name Address	First name				
information below (* Not a Sales Last name Address City	State Zip code				
information below (* Not a Sales Last name Address City Phone number () — Enrollee name	State Zip code Relationship to applicant				
information below (* Not a Sales Last name Address City Phone number () —	State Zip code Relationship to applicant				

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For individuals helping enrollee with completing this form only					
Complete this section i	_		_	_	_
members, or other third	•		_		
Name		Relationship 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	rm 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	ge

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 from UHC HI-0002 (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.

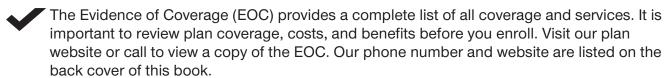
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

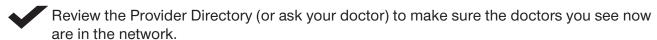
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

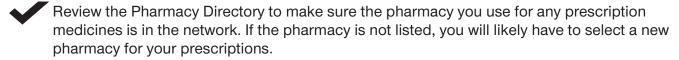
Enrollment checklist

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





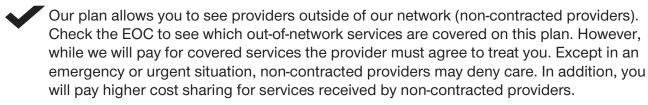


Review the Formulary to make sure your drugs are covered.

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.