

## **2025 Enrollment Request Form**

☐ AARP® Medicare Advantage from UHC IA-0002 (HMO-POS) H5253-108-004

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 pri	nt in black or blue	e ink)		
Last name	First name			Middle initial	
Birth date	Sex □ Male □ Fema		emale	e	
Home phone number ( )	<ul> <li>Mobile phone number (</li> </ul>		nber (	( ) –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		=	ne nun	nber(s) I have provided	
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		ate	Zip code	
Mailing address (Only if it's different from above. You can give a P.O. box.)					
City		ate	Zip code		
Email address (optional)		'			
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C				AAIA25HP0220680_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	nium (including any late enroll c deduction from your Social S	Security or Railroa	d Retirement
Electronic Funds Transfer (EFT	.).		, and the second
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	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			
Y0066_ERFMA_2025_C		AAI	A25HP0220680_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	<del></del>	
Vietnamese	White	
Other Asian	I choose not to answer	
Member/Citizen of a federal or state  4. 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	e, LTD coverage, Workers' Compensation,	
auto liability, or Veterans benefits)		☐ Yes ☐ No
Enrollee name		
Agent name/ID number		
Y0066_ERFMA_2025_C		220680_000

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 can find a list on the plan website or in the P	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 th	is provider? ☐ Yes ☐ No
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	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 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 amary of Benefits for more information. It is coverage begins, I must get all of my medical and incare. Benefits and services authorized by adHealthcare "Evidence of Coverage" document riber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID numberY0066_ERFMA_2025_C	AAIA25HP0220680_000

<ul> <li>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)</li> </ul>	ly end my enrollment in ano	ther MA plan (exceptions
<ul> <li>Palease of information: By joining this Me will 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.</li> <li>The information on this form is correct to the intentionally provide false information on the My response to this form is voluntary. Howen plan.</li> </ul>	no may use it to track my en by Federal law that authoriz ow). e my protected health inform er applicable law as required ne best of my knowledge. I ut his 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.
When I sign below, it means that I have read	and understand the inform	nation on this form
show written proof (power of attorney, guardian understand that I will need to submit written probehalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can can UnitedHealthcare UCard to update my authorized Signature of applicant/member/authorized relative If you are the authorized representative	oof of this right, to the plan, After this application has be all Customer Service at the ration information on file.  epresentative Today	if I wish to take action on en approved and I have number on my y's date
information below (*Not a Sales Agent) Last name	First name	
Address		
City	State	Zip code
Phone number ( ) —	Relationship to applicant	
Enrollee name		
Agent name/ID numberY0066_ERFMA_2025_C		AAIA25HP0220680_000

For individuals hel	ping enrollee with	cor	nple	eting this form o	nly
Complete this section	if vou're an individual	(i.e. a	adent	ts, brokers, SHIP co	ounselors, family
members, or other thir	•	•	_		, , ,
Name	a paraso) respirig arri			ship to enrollee	
Name		1 1016	ation	ship to emonee	
0:		NI-4	• 1	Dua dua an Manada an	/ A t / D t t )
Signature		INat	ionai	Producer Number	(Agents/Brokers only)
For Licensed Sales	s Representative/	ageı	ncy	use only	
Licensed Sales repres	entative/Writing ID			Initial receipt date	е
Linemand Colon warran				Duanas and offer atio	
Licensed Sales repres	entative/agent name			Proposed effective	ve date
Employer group name				•	
1 7 0 1					
Employer group ID			١,	Pranch ID	
Employer group ID			'	Branch ID	
Agent must complete	<b>)</b>		I		
☐ IEP (MA-PD	☐ ICEP (MA enrolle	es)		EP (MA-PD	☐ OEP (Jan 1 -
enrollees)	L 1021 (W// Official)	00)		ollees eligible for	Mar 31)
emonees)				IEP)	iviai 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					
Y0066_ERFMA_2025_C					AAIA25HP0220680_000

☐ SEP (SEP reason)	
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 from UHC IA-0002 (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.

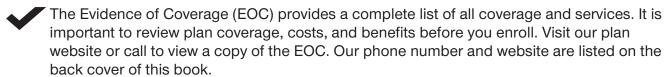
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

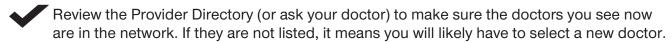
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

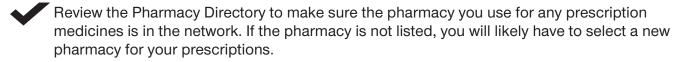
## **Enrollment checklist**

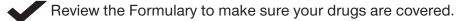
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the benefits



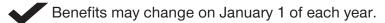


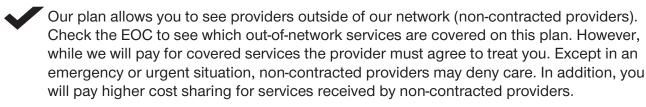




## **Understanding important rules**







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.