

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC IA-0001 (HMO-POS) H5253-107-003

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 □ F	emale	Э	
Home phone number ()	_	Mobile phone num	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 homelessness, a PO Box may be co	•				
City	County	Sta	ate	Zip code	
Mailing address (Only if it's different from above. You can give a P.O. box.)					
City		Sta	ate	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 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	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 Retiremen	t 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 I	☐ 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	
•	recognized Tribe (name of Tribe)	
4. What is your gender? Select one.	Luca a different toward	
Woman	I use a different term:	
Man Non-binary	I choose not to answer	
5. Which of the following best represents		
Lesbian or gay	I use a different term:	
Straight, that is, not gay or lesbian		
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)	,	☐ 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 primary ca	are provider (PCP), clinic or health center.
You can find a list on the plan website or in the	Provider Directory.
Provider or PCP full name	
Provider/PCP number	(Please enter the number exactly as it appears or 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	this provider? ☐ Yes ☐ No
Providing your email address above automat your plan communications.	cically enrolls you in paperless delivery for some of
an email when new communications (For exam	unications delivered electronically. We will send you aple: Explanation of Benefits or the Annual Notice of these communications through any device such as a
If you would rather have hard copies of requi	ired materials mailed to you, please check here:
	u hard copies of required materials. Please note that ay not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the follow	/ing:
paying my Part B premium if I have one, up I understand that people with Medicare are the country, except for limited coverage ne urgent care outside of the U.S. See the Su I understand that when my UnitedHealthca prescription drug benefits from UnitedHealthcare and contained in my UnitedHealthcare and contained in my UnitedHealthcare.	are coverage begins, I must get all of my medical and althcare. Benefits and services authorized by itedHealthcare "Evidence of Coverage" document scriber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	

 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
 Palease of information: By joining this Me will share my information with Medicare, where 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. Howen plan. 	no may use it to track my entry 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.
When I sign below, it means that I have read a	and understand the inform	ation on this form
If I sign as an authorized representative, it means 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 residuals.	ship, etc.) of this right if Me of of this right, to the plan, after this application has be all Customer Service at the reation information on file. Expresentative Today	dicare asks for it. I if I wish to take action on en approved and I have number on my /'s date
information below (*Not a Sales Agent)	, picase sign above an	
Last name	First name	
Address		
City	State	Zip code
Phone number () —	B. I. I. I. I. I.	nt
	Relationship to applicar	
	Relationship to applicar	
Enrollee nameAgent name/ID number		

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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 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 form	to:	
UnitedHealthcare		
P.O. Box 30770		
Salt Lake City , UT 84130-0770		
Fax: 1-888-950-1170		
Fay 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, 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-0001 (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.

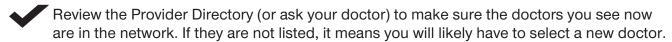
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

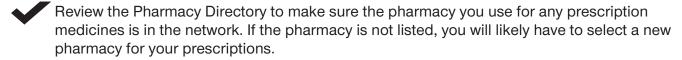
Enrollment checklist

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





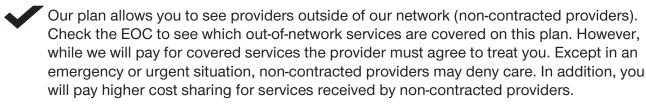




Understanding important rules







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.