

## **2025 Enrollment Request Form**

☐ AARP® Medicare Advantage from UHC IA-0001 (HMO-POS) H5253-107-001

Information about you (Discos		اماید بام ماما میشاد	اداما: مادا		
Information about you (Please	T	nt in black or bi	iue ink)		
Last name	First name			Middle initial	
Birth date		Sex □ Male □	Femal	e	
Home phone number ( )	<ul> <li>Mobile phone number</li> </ul>		umber (		
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	one nur	mber(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	5	State	Zip code	
Mailing address (Only if it's different from above. You can give a P.O. box.)					
City		5	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 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 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	A25HP0220686_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, or Chicano/a Yes, Puerto Rican			
Yes, Cuban	agnich arigin		
Yes, another Hispanic, Latino, or Sp	banish ongin		
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		
<ul><li> Member/Citizen of a federal or state</li><li>4. What is your gender? Select one.</li><li> Woman</li><li> Man</li></ul>	e 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			
Enrollee nameAgent name/ID number		<del></del>	
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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 care	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 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 thi	s provider?
Providing your email address above automatic your plan communications.	ally enrolls you in paperless delivery for some of
an email when new communications (For example	cations delivered electronically. We will send you e: Explanation of Benefits or the Annual Notice of ese communications through any device such as a
If you would rather have hard copies of require	d materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you I some communications are very large and may preference for delivery at any time.	nard 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	g:
paying my Part B premium if I have one, unled I understand that people with Medicare are of the country, except for limited coverage neadurgent 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 r the U.S. border. This plan covers emergency and mary of Benefits for more information. coverage begins, I must get all of my medical and licare. Benefits and services authorized by dHealthcare "Evidence of Coverage" document liber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	

	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 information (see Privacy Act Statement below).				
	I give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health				
	intentionally provide false information on this form I will be disenrolled from the plan.				
Wh	en I sign below, it means that I have read an	d understand the inform	ation on this form		
und beh rece Unit	w written proof (power of attorney, guardiansh lerstand that I will need to submit written proof all of the member beyond this application. Afterived my UnitedHealthcare UCard®, I can call the dHealthcare UCard to update my authorization atture of applicant/member/authorized representative,	of this right, to the plan, is er this application has been customer Service at the non information on file.  resentative Today	f I wish to take action on en approved and I have umber on my 's date		
_	ormation below (*Not a Sales Agent)	,			
Las	t name	First name			
Add	dress				
City	,	State	Zip code		
Pho	one number ( ) —	Relationship to applican	t		
	llee name				
_	nt name/ID number 6_ERFMA_2025_C		 AAIA25HP0220686_000		
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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 represe	-			Initial receipt date	
Licensed Sales represe	entative/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, 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-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.

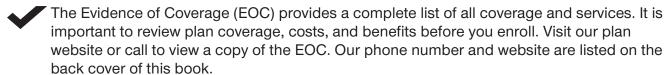
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

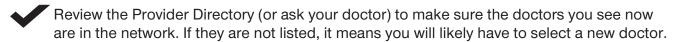
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

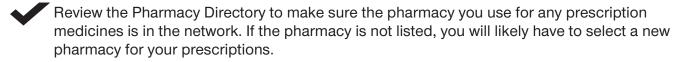
## **Enrollment checklist**

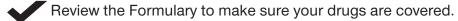
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the benefits





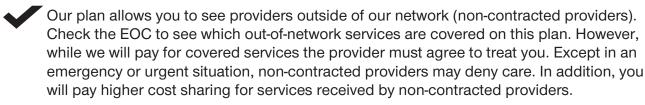




## **Understanding important rules**







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.