AAIL25HP0220860_000



Y0066_ERFMA_2025_C

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC IL-0002 (HMO-POS) H2802-054-000

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 b	lue ink	
Last name	First name			Middle initial
Birth date		Sex □ Male □] Femal	е
Home phone number ()	Mobile phone number () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		-	hone nur	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 different	t from above	e. You can give a	P.O. bo	x.)
City			State	Zip code
Email address (optional)		'		
Enrollee name				
Agent name/ID number				

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 automati 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 b	pelow, we'll send a bill each mo	onth to your mailir	ng address.	
If you must pay a Part D-Incom	e Related Monthly Adjustment	: Amount (Part D-I	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	ıs manage your plan			
1. Would you prefer plan info	rmation in another language	or an accessible	format?	
	rmation in another language of Braille		•	
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C		AAI	L25HP0220860_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, o Yes, Puerto Rican	of Chicano/a	
Yes, Cuban	aniah aviain	
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 ins	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 care	
You can find a list on the plan website or in the Pr	ovider 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 this	s provider?
Providing your email address above automatications.	ally enrolls you in paperless delivery for some of
You will get many of your required plan communications (For example Changes) are available online. You can access the computer, tablet or mobile phone.	•
If you would rather have hard copies of required	d materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you h 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, unle I understand that people with Medicare are g the country, except for limited coverage near urgent care outside of the U.S. See the Sumr I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealthc	enerally not covered under Medicare while out of 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 care. Benefits and services authorized by dHealthcare "Evidence of Coverage" document ber 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 or that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS), 	end my enrollment in ano	ther MA plan (exceptions		
plans). Release of information: By joining this Medwill share my information with Medicare, who payments, and for other purposes allowed be information (see Privacy Act Statement below	o may use it to track my en y Federal law that authoriz w).	rollment, to make e the collection of this		
 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 				
 plan. The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan. My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. 				
When I sign below, it means that I have read a	nd understand the inform	ation on this form		
show written proof (power of attorney, guardians understand that I will need to submit written produced behalf of the member beyond this application. As received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizate Signature of applicant/member/authorized reports.	of of this right, to the plan, ifter this application has be Customer Service at the rition information on file. presentative Today	if I wish to take action on en approved and I have number on my r's date		
If you are the authorized representative information below (*Not a Sales Agent)	, please sign above ar	nd complete the		
Last name	First name			
Address				
City	State	Zip code		
Phone number () —	Relationship to applicar	nt		
Enrollee name				
Agent name/ID numberY0066_ERFMA_2025_C		AAIL25HP0220860_000		

For individuals hel	ping enrollee with	cor	nple	ting 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	<u>a parazo, respirig an a</u>			ship to enrollee	
Name		1101	ation	ship to emonee	
0:		N1 - 43	· I	Due due en Manele en	/ A t / D t t)
Signature		INati	National Producer Number (Agents/Brokers only)		
For Licensed Sales	s Representative/	ager	ncy	use only	
Licensed Sales repres	entative/Writing ID			Initial receipt date	е
Linemand Colon warran				Dua is a said officiation	
Licensed Sales repres	entative/agent name			Proposed effective	ve date
Employer group name					
1 7 0 1					
Employer group ID			١,	Branch ID	
Employer group ID			'	Sianchid	
Agent must complete)				
☐ IEP (MA-PD	☐ ICEP (MA enrolled	es)		EP (MA-PD	□ OEP (Jan 1 -
enrollees)	L 1021 (WIX OTHORIO	00)		ollees eligible for	Mar 31)
emonees)				IEP)	iviai 51)
				,	
☐ 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	<u> </u>				
Y0066_ERFMA_2025_C					AAIL25HP0220860_000

☐ 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 nad	ar.

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 IL-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.

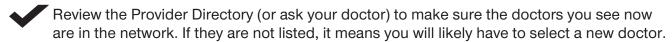
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

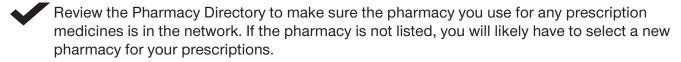
Enrollment checklist

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





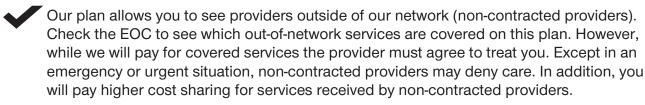




Understanding important rules







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.