

# **2025 Enrollment Request Form**

☐ AARP® Medicare Advantage from UHC IL-5 (PPO) H8768-010-000

# 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 blue ir | ık)   |                       |  |
| Last name  | First name       |                        | Mi    | Middle initial        |  |
| Birth date   | Sex □ Male □ Fer |                        | ale   | ale                   |  |
| Home phone number ( )  | _                | Mobile phone numbe     | r (   | ) —                   |  |
| ☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord |                  | •                      | iumbe | er(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. | box.) |                       |  |
| City   |                  | State                  |       | Zip code              |  |
| Email address (optional)   |                  | I                      |       |                       |  |
|  |                  |                        |       |                       |  |
| Enrollee name  |                  |                        |       |                       |  |
| Agent name/ID number   |                  |                        |       |                       |  |
| Y0066_ERFMA_2025_C   |                  |                        | AA    | AIL25LP0220541_000    |  |

| Do you have other insurance (Examples: Other private insura programs.) If yes, what is it?  |  | _                   | ☐ Yes ☐ No<br>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<br>pay your premium by automation<br>Board (RRB) benefit check each<br>Electronic Funds Transfer (EFT | c deduction from your Social S<br>ch month. You can also pay fro | Security or Railroa | nd 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-Income Related Monthly Adjustment Amount (Part D-IRMAA),   |  |                     |                                 |
| 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 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   |  |                     |                                 |
| 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  |  | AA                  | IL25LP0220541_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,                 | ı          |
| auto liability, or Veterans benefits)   |   | ☐ Yes ☐ No |
| Enrollee name   |   |            |
| Agent name/ID number  |   |            |
| Y0066_ERFMA_2025_C  |   | 220541_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 aren't limited to this list. You may go to any opayment terms.   |  |
| You can find a list on the plan website or in the P  | Tovider Directory.   |
| Provider or PCP full name  |  |
| Provider/PCP number  | (Please enter the number exactly as it appears on<br>the website or in the Provider Directory. It will be<br>10 to 12 digits. Don't include dashes.)   |
| Are you now seeing or have you recently seen th  | is provider? ☐ Yes ☐ No  |
| your plan communications.  You will get many of your required plan commun an email when new communications (For example)   | 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 get 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 at the U.S. border. This plan covers emergency and amary of Benefits for more information. The coverage begins, I must get all of my medical and ancare. 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   | AAIL25LP0220541_000  |

|                                  | I understand that I can be enrolled in only one that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS), Note 1979   | end my enrollment in anot   | ther MA plan (exceptions   |  |
|----------------------------------|--|---|--|--|
|                                  | plans).  Release of information: By joining this Medicare, who will share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below   | may use it to track my en<br>Federal law that authorize<br>().  | rollment, to make<br>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 intentionally provide false information on this My response to this form is voluntary. However plan.  | 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   |  |
| unc<br>beh<br>rece<br>Uni<br>Sig | w written proof (power of attorney, guardiansh lerstand that I will need to submit written proof all of the member beyond this application. Afteived my UnitedHealthcare UCard®, I can call tedHealthcare UCard to update my authorization nature of applicant/member/authorized rep | 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<br>en approved and I have<br>umber on my<br>'s date |  |
| _                                | ou are the authorized representative, ormation below (*Not a Sales Agent)  | please sign above an  | id complete the  |  |
| Las                              | t name   | First name  |  |  |
| Add                              | dress  |   |  |  |
| City                             | 1  | State   | Zip code   |  |
| Pho                              | one number ( ) —   | Relationship to applican  | t  |  |
|                                  |  |   |  |  |
|                                  | llee name  |   |  |  |
|                                  | nt name/ID number<br>6_ERFMA_2025_C  |   | AAIL25LP0220541_000  |  |
|                                  | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  |   |  |  |

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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 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) | ,<br>,<br>,<br>,<br>, | enrol<br>2nd I<br>□ SE<br>resid<br>□ AE | P (MA-PD<br>lees eligible for<br>EP)<br>EP (Change in<br>ence)<br>EP (October 15-<br>mber 7) | ☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI |
| Enrollee name  |  |                       |   |  |   |

Y0066\_ERFMA\_2025\_C

| ☐ 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                | 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-5 (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.

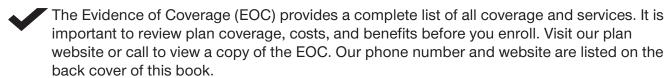
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

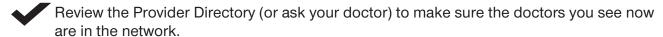
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

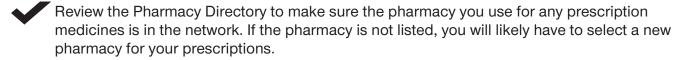
## **Enrollment checklist**

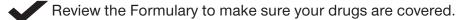
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

### **Understanding the benefits**





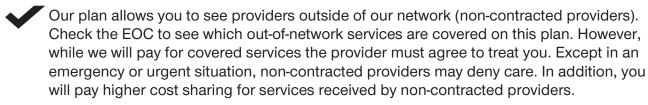




### **Understanding important rules**







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.