

## **2025 Enrollment Request Form**

☐ AARP® Medicare Advantage Extras from UHC IN-17 (HMO-POS) H2802-056-000

| Information about you (Please   | type or pri                         | nt in black or l | blue ink   | )                      |
|---|-------------------------------------|------------------|------------|------------------------|
| Last name   | First name                          |                  |            | Middle initial         |
|   |                                     | Γ                |            |                        |
| Birth date  |                                     | Sex □ Male I     | □ Femal    | е                      |
| Home phone number ( )   | <ul> <li>Mobile phone nu</li> </ul> |                  | number (   | ( ) –                  |
| ☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology. |                                     |                  |            |                        |
| Medicare number   |                                     |                  |            |                        |
| Permanent residence street address  | (Don't enter                        | a P.O. box. No   | te: For in | dividuals experiencing |
| homelessness, a PO Box may be co  | onsidered yo                        | our permanent r  | esidence   | e address)             |
| 00  |                                     | 1                | 01.1       | 7                      |
| City  | County                              |                  | State      | Zip code               |
| Mailing address (Only if it's different from above. You can give a P.O. box.)   |                                     |                  |            |                        |
| City  |                                     |                  | State      | Zip code               |
| Email address (optional)  |                                     | '                |            | ,                      |
|   |                                     |                  |            |                        |
|   |                                     |                  |            |                        |
|   |                                     |                  |            |                        |
|   |                                     |                  |            |                        |
|   |                                     |                  |            |                        |
|   |                                     |                  |            |                        |
|   |                                     |                  |            |                        |
|   |                                     |                  |            |                        |
| Enrollee name   |                                     |                  |            |                        |
| Agent name/ID number  |                                     |                  |            |                        |
| Y0066_ERFMA_2025_C  |                                     |                  |            | AAIN25HP0220858_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 your choice. You can't be denied coverage because you don't fill them out.                              |  |                     |                                 |
| How do you want to pay?  |  |                     |                                 |
| If you have a monthly plan prer<br>pay your premium by automatic<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 | 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 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  | s manage your plan   |                     |                                 |
| 1. Would you prefer plan info  | rmation in another language                                      | or an accessible    | format?                         |
|  | rmation in another language or<br>Braille                        |                     | •                               |
| Enrollee name  |  |                     |                                 |
| Agent name/ID number   |  |                     |                                 |
| Y0066_ERFMA_2025_C   |  | AAII                | N25HP0220858_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 Spa   |   |            |
| Yes, Mexican, Mexican American, o<br>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                                      |            |
| <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> | recognized Tribe (name of Tribe)<br>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  |   |            |
| VOOCE EDEMA COOF C  |   | 220858_000 |

| 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 Pr  | rovider 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 this   | s provider? ☐ Yes ☐ No   |
| Providing your email address above automatications.   | ally enrolls you in paperless delivery for some of   |
| •   | 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 have 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 go the country, except for limited coverage near urgent care outside of the U.S. See the Summary 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<br>r the U.S. border. This plan covers emergency and<br>mary of Benefits for more information.<br>coverage begins, I must get all of my medical and<br>locare. Benefits and services authorized by<br>dHealthcare "Evidence of Coverage" document<br>iber agreement) will be covered. Neither Medicare |
| Enrollee name   |  |
| Agent name/ID number<br>Y0066_ERFMA_2025_C  |  |

| <ul> <li>I understand that I can be enrolled in only of<br/>that enrollment in this plan will automaticall<br/>apply for MA Private Fee-for-Service (PFFS)</li> </ul>  | ly end my enrollment in ano  | ther MA plan (exceptions   |
|--|--|--|
| <ul> <li>plans).</li> <li>Release of information: By joining this Me will share my information with Medicare, whe 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<br>by Federal law that authoriz<br>ow).<br>e my protected health inform<br>er applicable law as required<br>ne best of my knowledge. I ut<br>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 a   | and understand the inform  | ation 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 cat UnitedHealthcare UCard to update my authorizated Signature of applicant/member/authorized relatives.   | oof of this right, to the plan, After this application has be all Customer Service at the relation information on file.  Expresentative Today  | if I wish to take action on<br>en approved and I have<br>number on my<br>y's date  |
| <pre>information below (*Not a Sales Agent) Last name</pre>  | First name   |  |
|  |  |  |
| Address  |  |  |
| City   | State  | Zip code   |
| Phone number ( ) —   | Relationship to applicant  |  |
|  |  |  |
| Enrollee name  |  |  |
| Agent name/ID numberY0066_ERFMA_2025_C   |  | <br>AAIN25HP0220858_000  |

AAIN25HP0220858\_000

| 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) | ,<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                | 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 Extras from UHC IN-17 (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.

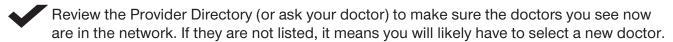
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

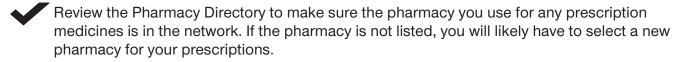
## **Enrollment checklist**

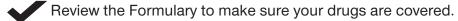
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the benefits





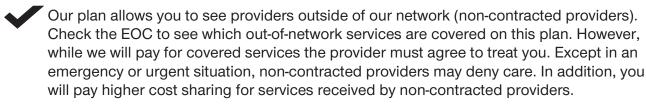




## **Understanding important rules**







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.