

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC IN-0006 (PPO) H2406-066-000

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 blu	ue ink)		
Last name	First name			Middle initial	
Birth date	Sex □ Male □ Fe		Female	ale	
Home phone number ()	 Mobile phone number 		mber (() –	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	one nur	nber(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	S	tate	Zip code	
Mailing address (Only if it's different from above. You can give a P.O. box.)					
City		S	tate	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C				AAIN25LP0220952_000	

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 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 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 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 Braille		•
Enrollee name			
Agent name/ID number Y0066_ERFMA_2025_C			 N25LP0220952_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 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		
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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 prima	ary care provider (PCP), clinic or health center.
You aren't limited to this list. You may go to payment terms. You can find a list on the plan website or in	any doctor who accepts Medicare and the plan's the Provider 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 se	een this provider? ☐ Yes ☐ No
an email when new communications (For ecchanges) are available online. You can accomputer, tablet or mobile phone.	mmunications delivered electronically. We will send you example: Explanation of Benefits or the Annual Notice of cess these communications through any device such as a
If you would rather have hard copies of r	required materials mailed to you, please check here:
• •	nil you hard copies of required materials. Please note that and may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the fo	ollowing:
paying my Part B premium if I have on I understand that people with Medicar the country, except for limited coverage urgent care outside of the U.S. See the I understand that when my UnitedHeat prescription drug benefits from United UnitedHealthcare and contained in my	d Medical (Part B) to stay in UnitedHealthcare. I must keep ne, unless Medicaid or someone else pays for it. The are generally not covered under Medicare while out of genear the U.S. border. This plan covers emergency and e Summary of Benefits for more information. It was coverage begins, I must get all of my medical and although the although the although the although the coverage of Coverage document subscriber agreement) will be covered. Neither Medicare efits or services that are not covered.
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	AAIN25LP0220952_000

□ I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and 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)				
 Release of information: By joining this Medwill share my information with Medicare, when payments, and for other purposes allowed by information (see Privacy Act Statement belowed 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 this My response to this form is voluntary. Howe plan. 	o may use it to track my ency Federal law that authorized). my protected health information applicable law as required best of my knowledge. It is form I will be disenrolled	rollment, to make e 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		-1' 11'- 6		
show written proof (power of attorney, guardians understand that I will need to submit written produced behalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can cal UnitedHealthcare UCard to update my authorizations. Signature of applicant/member/authorized religions are the authorized representative information below (*Not a Sales Agent)	of of this right, to the plan, fter this application has be I 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		
Last name	First name			
Address				
City	State	Zip code		
Phone number () —	Relationship to applicant			
Enrollee name				
Agent name/ID number		<u></u>		
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For individuals hel	ping enrollee with	cor	nple	eting this form o	nly	
Complete this section	if you're an individual	(i.e. a	agent	ts, brokers, SHIP co	ounselors, family	
members, or other thir	d parties) helping an e	enroll	lee fil	I out this form.	•	
Name	, , ,			ship to enrollee		
110.1110						
Signature		Nati	National Producer Number (Agents/Brokers only)			
Olgitataro		INGL	ΙΟΠαι	Troducci Namber	(/ tgento/ brokers only)	
For Licensed Solo	. Donrocontativo/	000	2011	uoo only		
For Licensed Sales	•	agei	iiCy i			
Licensed Sales repres	entative/Writing ID		Initial receipt date		е	
Licensed Sales repres	entative/agent name			Proposed effecti	ve date	
	omani o, agom mamo					
Employer group name						
Employer group ID			E	Branch ID		
Agent must complete						
☐ IEP (MA-PD	☐ ICEP (MA enrolle	es)		EP (MA-PD	☐ OEP (Jan 1 -	
enrollees)			enro	ollees eligible for	Mar 31)	
			2nd	IEP)		
☐ OEP (Newly	☐ SEP (Dual LIS		□S	EP (Change in	☐ SEP (Loss of	
eligible)	change of status)		resid	dence)	EGHP coverage)	
☐ SEP (Chronic)	☐ SEP (Dual LIS		ΠА	EP (October 15-	□ OEPI	
,	maintaining)			ember 7)		
Enrollee name						
Agent name/ID number						
Y0066_ERFMA_2025_C		·			AAIN25LP0220952_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 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 IN-0006 (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.

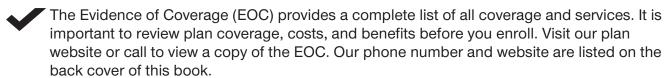
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

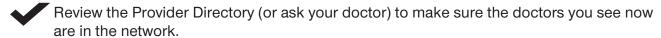
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

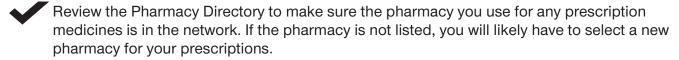
Enrollment checklist

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



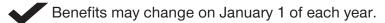


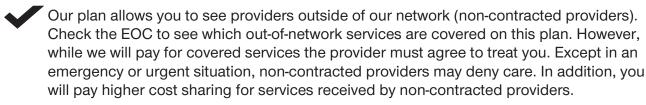


Review the Formulary to make sure your drugs are covered.

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.