

2025 Enrollment Request Form

☐ AARP® Medicare Advantage Giveback from UHC MS-4 (PPO) H8768-040-000

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 print in black or blue ink)					
Last name	First name		Middle initial		
Birth date	Sex □ Male □ Fer] Femal	ale	
Home phone number ()	 Mobile phone number 		umber (
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			none 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		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					
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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	nium (including any late enroll c deduction from your Social S ch month. You can also pay fro	Security or Railroa	d Retirement
Electronic Funds Transfer (EFT If you don't choose an option be	•	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			
	1 33 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	• • •	or an accessible	format?
	rmation in another language or Braille □ Large print □ Audi		•
Enrollee name			
Agent name/ID number			
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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 Chicario/a	
Yes, Cuban	aniah aviain	
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	
 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:	5		
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 aren't limited to this list. You may go to any d	octor who accepts Medicare and the plan's		
payment terms.			
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		
	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 automatical	ally enrolls you in paperless delivery for some of		
your plan communications.			
You will get many of your required plan communi	cations delivered electronically. We will send you		
	e: Explanation of Benefits or the Annual Notice of		
Changes) are available online. You can access these communications through any device such as a			
computer, tablet or mobile phone.			
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 h	nard copies of required materials. Please note that		
some communications are very large and may	not fit in all mailboxes. You can change your		
preference for delivery at any time.			
Please read and sign			
By completing this form, I agree to the following	g:		
□ I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep			
paying my Part B premium if I have one, unless Medicaid or someone else pays for it.			
 I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and 			
urgent care outside of the U.S. See the Summary of Benefits for more information.			
☐ I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and			
prescription drug benefits from UnitedHealthcare. Benefits and services authorized by			
UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document			
(also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.			
ins. Similar radiations will pay for bottomb of	20230		
Enrollee name			
Agent name/ID number Y0066_ERFMA_2025_C	AAMS25LP0220513_000		
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 I understand that I can be enrolled that enrollment in this plan will a apply for MA Private Fee-for-Service 	utomatically end my enrollment	in another MA plan (exceptions
plans). Release of information: By joining will share my information with M payments, and for other purpose information (see Privacy Act State I give UnitedHealthcare permission or person(s) for permissible purpolan. The information on this form is continued intentionally provide false information of the plane.	ledicare, who may use it to trackes allowed by Federal law that a tement below). ion to share my protected health poses under applicable law as recorrect to the best of my knowled ation on this form I will be diser	my enrollment, to make authorize the collection of this h information with organizations equired to administer my health dge. I understand that if I hrolled from the plan.
plan. When I sign below, it means that I h		
show written proof (power of attorney understand that I will need to submit behalf of the member beyond this appreceived my UnitedHealthcare UCard UnitedHealthcare UCard to update m Signature of applicant/member/au If you are the authorized representations of the submit of the sub	written proof of this right, to the oplication. After this application d®, I can call Customer Service any authorization information on the other services are representative.	e plan, if I wish to take action on has been approved and I have at the number on my file. Today's date
information below (*Not a Sale Last name	First name	
Address		
City	State	Zip code
Phone number () —	Relationship to a	pplicant
	1	
Agent name/ID number Y0066_ERFMA_2025_C		AAMS25LP0220513_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	-	J		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)	, , , , ,	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	orm to:
UnitedHealthcare	
P.O. Box 30770	
Salt Lake City, UT 84130-0770	
Fax: 1-888-950-1170	
Fay the front and back of each no	ane

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 Giveback from UHC MS-4 (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.

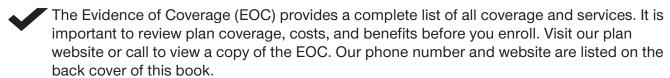
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

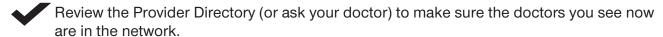
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

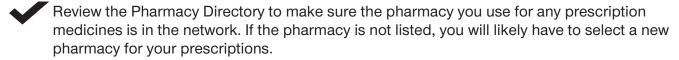
Enrollment checklist

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





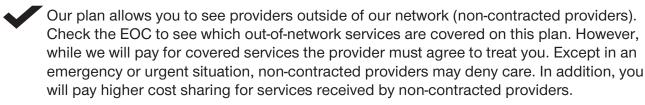


Review the Formulary to make sure your drugs are covered.

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.