

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC NC-0010 (HMO-POS) H5253-102-000

Information about you (Please	type or pri	nt in black or b	olue ink)
Last name	First name			Middle initial
Birth date		Sex □ Male [□ Femal	e
Home phone number ()	_	Mobile phone	number (() –
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	hone nui	mber(s) I have provided
Medicare number				
Permanent residence street address homelessness, a PO Box may be co	-			
City	County	County		Zip code
Mailing address (Only if it's differen	t from above	e. You can give	a P.O. bo	ox.)
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 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	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				
1. Would you prefer plan info				
	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 Spa			
Yes, Mexican, Mexican American, or Yes, Puerto Rican	i Cilicano/a		
Yes, Cuban	aniah aviain		
Yes, another Hispanic, Latino, or Sp	anish 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	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	
Enrollog namo			
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 primary care	e provider (PCP), clinic or health center.
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 or 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 require	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 followin	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 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 iber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number	
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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)					
 plans). Release of information: By joining this M will share my information with Medicare, payments, and for other purposes allower information (see Privacy Act Statement but I give UnitedHealthcare permission to share or person(s) for permissible purposes un plan. The information on this form is correct to intentionally provide false information on My response to this form is voluntary. How plan. 	who may use it to traced by Federal law that below). are my protected heal oder applicable law as the best of my knowled this form I will be dise	k my enrollment, to make authorize the collection of this th information with organizations required to administer my health edge. I understand that if I enrolled from the plan.			
When I sign below, it means that I have rea	d and understand the	e information on this form			
If I sign as an authorized representative, it me show written proof (power of attorney, guardiunderstand that I will need to submit written pehalf of the member beyond this application received my UnitedHealthcare UCard®, I can UnitedHealthcare UCard to update my author Signature of applicant/member/authorized If you are the authorized representation	anship, etc.) of this rigoroof of this right, to the After this application call Customer Service rization information on I representative	ht if Medicare asks for it. I 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 Sales Agen		ove and complete the			
Last name	First name	First name			
Address					
City	State	Zip code			
Phone number () —	Relationship to applicant				
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C		 AANC25HP0220690_000			
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For individuals helping enrollee with completing this form only						
Complete this section	if you're an individual	(i.e.	ager	nts	, brokers, SHIP cou	unselors, family
members, or other thir	d parties) helping an e	enrol	lee f	ill	out this form.	
Name		Rel	atio	nsł	nip to enrollee	
Signature		Nat	tiona	ıl F	Producer Number (A	Agents/Brokers only)
For Licensed Sales	s Representative/	age	ncv	u	se only	
Licensed Sales represe			•		Initial receipt date	
Licensed Sales representative/agent name					Proposed effective	e date
Employer group name						
Employer group ID				Ві	ranch ID	
Agent must complete ☐ IEP (MA-PD		00)			P (MA-PD	☐ OEP (Jan 1 –
enrollees)	☐ ICEP (MA enrolled	U S)			ees eligible for	Mar 31)
Crirolices)					•	Wai OT)
☐ OEP (Newly	☐ SEP (Dual LIS			2nd IEP) □ SEP (Change in □ SEP (Loss of		
eligible)	change of status)				EGHP coverage)	
☐ SEP (Chronic)	☐ SEP (Dual LIS			☐ AEP (October 15- ☐ OEPI		
_ = (=: (=:::=)	maintaining)				mber 7)	
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Enrollee name						
Agent name/ID number	•					

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☐ 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, 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 NC-0010 (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.

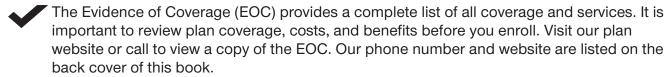
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

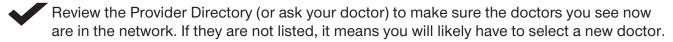
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

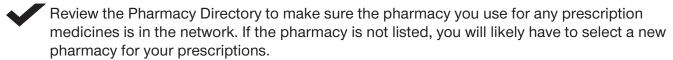
Enrollment checklist

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





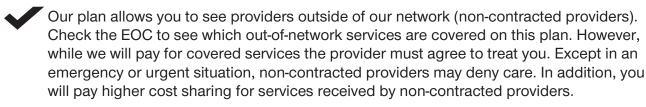


Review the Formulary to make sure your drugs are covered.

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.