

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC NC-0019 (PPO) H2406-115-000

Information about you (Please	type or pri	nt in black or bl	ue ink)	
Last name	First name			Middle initial
Birth date		Sex □ Male □	Female	•
Home phone number ()	_	Mobile phone nu	ımber () –
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		· ·	one nun	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		State	Zip code
Mailing address (Only if it's different from above. You can give a P.O. box.)				
City		S	State	Zip code
Email address (optional)		,		,
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C			A	AANC25LP0220906_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 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 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				

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 ins	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 p	rimary care provider (PCP), clinic or health center.
You aren't limited to this list. You may payment terms. You can find a list on the plan website	go to any doctor who accepts Medicare and the plan's or in 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 recen	tly seen this provider? ☐ Yes ☐ No
an email when new communications (F	n communications delivered electronically. We will send you For example: Explanation of Benefits or the Annual Notice of access these communications through any device such as a
If you would rather have hard copies	of required materials mailed to you, please check here:
	Il mail you hard copies of required materials. Please note that e and may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the	ne following:
paying my Part B premium if I have I understand that people with Med the country, except for limited covering urgent care outside of the U.S. See I understand that when my United prescription drug benefits from UrunitedHealthcare and contained in (also known as a member contract.)	and Medical (Part B) to stay in UnitedHealthcare. I must keep to one, unless Medicaid or someone else pays for it. dicare are generally not covered under Medicare while out of verage near the U.S. border. This plan covers emergency and see the Summary of Benefits for more information. Healthcare coverage begins, I must get all of my medical and nitedHealthcare. Benefits and services authorized by n my UnitedHealthcare "Evidence of Coverage" document at or subscriber agreement) will be covered. Neither Medicare benefits or services that are not covered.
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	

	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 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 end Federal law that authorized).	rollment, to make 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 t	from the plan.			
Wh	en I sign below, it means that I have read an	d understand the informa	ation on this form			
unc beh rec Uni Sig	show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file. Signature of applicant/member/authorized representative Today's date					
_	ormation below (*Not a Sales Agent)	please sign above an	d complete the			
Las	st name	First name				
Add	dress					
City	/	State	Zip code			
Pho	one number () —	Relationship to applican	t			
	ollee name					
Age	ollee name nt name/ID number 6_ERFMA_2025_C		AANC25LP0220906_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	-			Initial receipt date	
Licensed Sales represe	entative/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 fo	rm to:
UnitedHealthcare	
P.O. Box 30770	
Salt Lake City, UT 84130-0770	
Fax: 1-888-950-1170	
Fay the front and back of each na	α _Φ

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 NC-0019 (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.

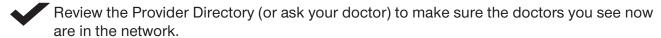
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

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



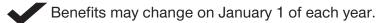


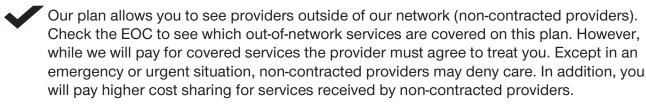


Review the Formulary to make sure your drugs are covered.

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.