

## **2025 Enrollment Request Form**

☐ AARP® Medicare Advantage from UHC NC-0016 (PPO) H2406-034-000

Information about you (Please	type or pri	nt in black or b	lue ink)	
Last name	First name			Middle initial
		Γ		
Birth date		Sex □ Male □	] Femal	е
Home phone number ( )	_	Mobile phone n	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 homelessness, a PO Box may be co	•			
City	County		State	Zip code
Mailing address (Only if it's differen	t from above	e. You can give a	P.O. bo	x.)
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 vour mailir	na 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 you	r SS cneck		
☐ Medicare can bill you			
	t Board (RRB) can bill you		
☐ I want to pay from my Social	Security check		
☐ I want to pay from my Railro	ad Retirement Board (RRB) ch	neck	
☐ 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 vour plan		
1. Would you prefer plan info	• • •	or an accessible	format?
	rmation in another language or Braille		•
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, 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	
<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) 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:	
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 le 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	AANC25LP0220982_000

<ul> <li>I understand that I can be enrolled in only of that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS)</li> </ul>	y end my enrollment in ano	ther MA plan (exceptions
<ul> <li>Release of information: By joining this Medwill share my information with Medicare, who payments, and for other purposes allowed linformation (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</li> </ul>	no may use it to track my erectory Federal law that authorized w). The my protected health inform applicable law as required to best of my knowledge. It	rollment, to make the collection of this mation with organizations d to administer my health understand that if I
<ul><li>intentionally provide false information on th</li><li>My response to this form is voluntary. Howen plan.</li></ul>		•
When I sign below, it means that I have read a	and understand the inform	nation on this form
show written proof (power of attorney, guardians understand that I will need to submit written probehalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can ca UnitedHealthcare UCard to update my authorization.  Signature of applicant/member/authorized received my authorized my authorized received my authorized my aut	of of this right, to the plan, after this application has be Il Customer Service at the ration information on file.  Epresentative Today	if I wish to take action on en approved and I have number on my y's date
information below (*Not a Sales Agent)	e, piease sign above ai	id complete the
Last name	First name	
Address		
City	State	Zip code
Phone number ( ) —	Relationship to applicar	nt
Enrollee name		
Agent name/ID number Y0066_ERFMA_2025_C		 AANC25LP0220982_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 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)	, , , , , , , , , , , , , , , , , , ,	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 form	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		

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-0016 (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.

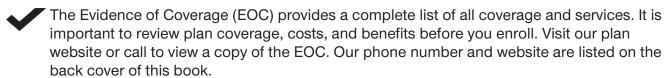
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

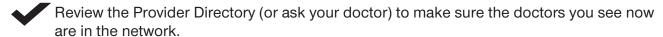
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

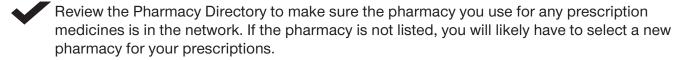
## **Enrollment checklist**

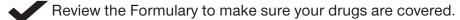
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the benefits





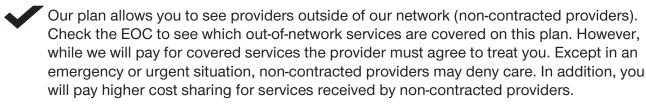




## **Understanding important rules**







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.