

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC NM-0006 (PPO) H2406-091-000

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 bl	ue ink)		
Last name	First name			Middle initial	
Birth date	Sex □ Male □ Fe		Female	ale	
Home phone number ()	_	Mobile phone nu	ımber () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		=	one nur	nber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be co	•				
City	County	S	State	Zip code	
Mailing address (Only if it's different	t from above	e. You can give a	P.O. bo	x.)	
City		S	State	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C			A	AANM25LP0220928_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	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 below, we'll send a bill each month to your mailing address.			
If you must pay a Part D-Incom	e Related Monthly Adjustment	Amount (Part D-II	RMAA),
Social Security (SS) will send y	ou a letter and ask you how yo	u 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 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 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			
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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 Sp.		
Yes, Mexican, Mexican American, o	r Chicano/a	
Yes, Puerto Rican		
Yes, Cuban		
Yes, another Hispanic, Latino, or Sp	panish 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		ı
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 primary care	e provider (PCP), clinic or health center.
You aren't limited to this list. You may go to any do payment terms.	octor who accepts Medicare and the plan's
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 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 required	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 following	g:
paying my Part B premium if I have one, unle I understand that people with Medicare are g the country, except for limited coverage near urgent care outside of the U.S. See the Sumr I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcure UnitedHealthcare and contained in my United	enerally 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 ber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number	

I understand that I can be enrolled in only one that enrollment in this plan will automatically e apply for MA Private Fee-for-Service (PFFS), N plans).	end my enrollment in anot	ther MA plan (exceptions		
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 en Federal law that authoriz	rollment, to make		
-	or person(s) for permissible purposes under applicable law as required to administer my health			
 The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan. My response to this form is voluntary. However, failure to respond may affect enrollment in the 				
plan.	or, randro to respond may			
When I sign below, it means that I have read an	d understand the inform	ation on this form		
show written proof (power of attorney, guardiansh understand that I will need to submit written proof behalf of the member beyond this application. Aftereceived my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorization Signature of applicant/member/authorized rep	of this right, to the plan, if of this application has been customer Service at the non information on file. Today	f I wish to take action on en approved and I have umber on my 's date		
If you are the authorized representative, information below (*Not a Sales Agent)	please sign above ar	id complete the		
Last name	First name			
Address				
City	State	Zip code		
Phone number () —	Relationship to applicar	t		
Phone number () —	Relationship to applicar	t		
Phone number () — Enrollee name		t		

For individuals hel	ping enrollee with	cor	mple	eting this form o	only
Complete this section	if you're an individual	(i.e. a	agen	its, brokers, SHIP c	ounselors, family
members, or other thir	•	•	_		, ,
Name	1 / 1 5			ship to enrollee	
ranio		1101	atioi	iomp to omonoo	
Signature		Not	iona	I Droducor Numbor	(Agents/Brokers only)
Signature		Ival	iona	i Fioducei Number	(Agents/ brokers only)
E 11 10 1	D 111 /			•	
For Licensed Sales	•	age	ncy		
Licensed Sales repres	entative/Writing ID		Initial receipt date		te
Licensed Sales repres	entative/agent name			Proposed effecti	ive date
Liconoca Calco reproc	ornanivo, agoni namo			Tropodod onooti	ivo dato
Employer group name					
Employer group ID				Branch ID	
Agent must complete					
☐ IEP (MA-PD	☐ ICEP (MA enrolle	es)		EP (MA-PD	□ OEP (Jan 1 -
enrollees)			enr	ollees eligible for	Mar 31)
			2nc	l IEP)	
☐ OEP (Newly	☐ SEP (Dual LIS			SEP (Change in	☐ SEP (Loss of
eligible)	change of status)		resi	idence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS			AEP (October 15-	
,	maintaining)			cember 7)	
				,	
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C					AANM25LP0220928_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 nad	ar.

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 NM-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.

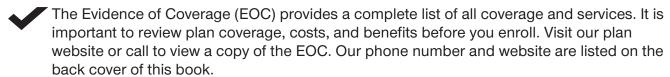
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

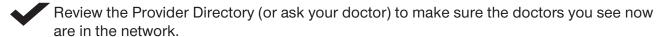
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

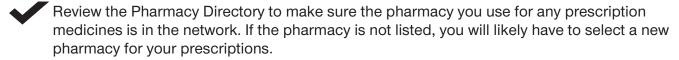
Enrollment checklist

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





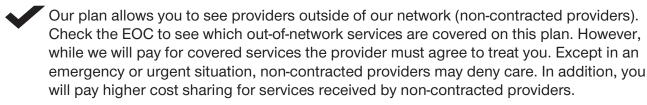


Review the Formulary to make sure your drugs are covered.

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.