

## **2025 Enrollment Request Form**

☐ AARP® Medicare Advantage from UHC NM-0002 (PPO) H2406-055-000

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 r	number (	( ) —
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			hone 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 different from above. You can give a P.O. box.)				
City			State	Zip code
Email address (optional)		1		
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C				AANM25LP0220962_000

	•	☐ Yes ☐ No a benefits or state	
Group number	RxBin	RxPCN (optional)	
Answering these questions is your choice. You can't be denied coverage because you don't fill them out.			
mium (including any late enroll	. , ,	, , ,	
• •	m a bank accour	nt through	
below, we'll send a bill each mo	onth to your maili	ng address.	
ne Related Monthly Adjustment	Amount (Part D-I	RMAA),	
ou a letter and ask you how yo	ou want to pay it:		
ur SS check			
nt Board (RRB) can bill you			
, ,			
oad 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_/_/_/_/_/_//			
us manage your plan			
ormation in another language	or an accessible	format?	
9 9		•	
Enrollee name			
	Group number  S your choice. You can't be desemble of the second of the	s your choice. You can't be denied coverage by the semium (including any late enrollment penalty you can deduction from your Social Security or Railroad the month. You can also pay from a bank account T).  below, we'll send a bill each month to your mailing the Related Monthly Adjustment Amount (Part Delayou a letter and ask you how you want to pay it: our SS check  and Board (RRB) can bill you all Security check to bank account Savings  Sa	

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	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 state 4. What is your gender? Select one.	recognized Tribe (name of Tribe)	
Woman	I use a different term:	
Man		
Non-binary	I choose not to answer	
5. Which of the following best represents	how you think of yourself? Select one.	
Lesbian or gay	I use a different term:	
Straight, that is, not gay or lesbian	I don't know	
Bisexual	I choose not to answer	
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		
auto liability, or Veterans benefits)	z, ETD Goverage, Workers Compensation,	☐ Yes ☐ No
acto hability, or votorario borionto,		_ 100 _ 100
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 prima	ary care provider (PCP), clinic or health center.
You aren't limited to this list. You may go t payment terms. You can find a list on the plan website or i	n 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 recently s	seen this provider?
an email when new communications (For	example: Explanation of Benefits or the Annual Notice of ecess these communications through any device such as a
If you would rather have hard copies of	required materials mailed to you, please check here:
	ail you hard copies of required materials. Please note that nd may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the f	ollowing:
paying my Part B premium if I have on I understand that people with Medica the country, except for limited covera urgent care outside of the U.S. See the I understand that when my UnitedHeat prescription drug benefits from United UnitedHealthcare and contained in medical serious prescription.	d Medical (Part B) to stay in UnitedHealthcare. I must keep ne, unless Medicaid or someone else pays for it. are are generally not covered under Medicare while out of age near the U.S. border. This plan covers emergency and ne Summary of Benefits for more information. althcare coverage begins, I must get all of my medical and dHealthcare. Benefits and services authorized by y UnitedHealthcare "Evidence of Coverage" document subscriber agreement) will be covered. Neither Medicare efits or services that are not covered.
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	AANM25LP0220962_000

<ul> <li>I understand that I can be enrolled in only that enrollment in this plan will automatica apply for MA Private Fee-for-Service (PFFS)</li> </ul>	lly end my enrollment in an	other MA plan (exceptions	
<ul> <li>Palease of information: By joining this Mewill share my information with Medicare, we payments, and for other purposes allowed information (see Privacy Act Statement be I give UnitedHealthcare permission to share or person(s) for permissible purposes und plan.</li> <li>The information on this form is correct to the intentionally provide false information on the My response to this form is voluntary. How plan.</li> </ul>	who may use it to track my end by Federal law that author elow).  The my protected health information as required the best of my knowledge. The form I will be disenrolled.	enrollment, to make rize the collection of this rmation with organizations ed to administer my health I understand that if I d from the plan.	
When I sign below, it means that I have read	and understand the infor	mation on this form	
show written proof (power of attorney, guardian understand that I will need to submit written probehalf of the member beyond this application. received my UnitedHealthcare UCard®, I can continuedHealthcare UCard to update my authorized signature of applicant/member/authorized in the submit of th	After this right, to the plant After this application has be all Customer Service at the zation information on file.  Today  Te, please sign above a	a, if I wish to take action on seen approved and I have number on my ay's date	
information below (*Not a Sales Agent) Last name	First name		
Address			
City	State	Zip code	
Phone number ( ) —	Relationship to applicant		
Enrollee name Agent name/ID number			
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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		National Producer Number (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 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, 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-0002 (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.

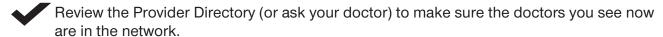
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

## **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





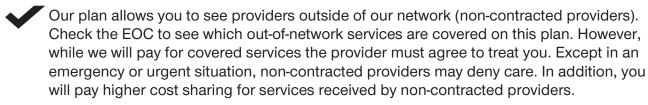


Review the Formulary to make sure your drugs are covered.

## **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.