AANV25HP0221291_000



Y0066_ERFMA_2025_C

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC NV-0006 (HMO-POS) H0609-040-000

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 print in black or blue ink)					
Last name	First name			Middle initial	
Birth date	Sex □ Male □ Female		е		
Home phone number ()	Mobile phone number () –) —		
☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology.				mber(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			State	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number					

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 Retiremen	t 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 Spanish origin				
Yes, Mexican, Mexican American, or Chicano/a Yes, Puerto Rican				
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 state 4. 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				
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 You can find a list on the plan website or in the Pr	
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 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	renerally 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 nameAgent name/ID number	

□ 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 I will share my information with Medicare, payments, and for other purposes allower information (see Privacy Act Statement & I give UnitedHealthcare permission to short person(s) for permissible purposes under the permission in the permission in the permissible purposes under the permissible permissible purposes under the permissible purposes under the permissible permissible pe	who may use it to traced by Federal law that below). nare my protected heal	k my enrollment, to make authorize the collection of the the thick the information with organization with organization.	nis		
 plan. The information on this form is correct to intentionally provide false information on My response to this form is voluntary. Ho plan. 	this form I will be dise	nrolled from the plan.	ı the		
When I sign below, it means that I have rea	d and understand the	information on this form			
If I sign as an authorized representative, it meshow 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 authorized Signature of applicant/member/authorized	ianship, etc.) of this rig proof of this right, to the n. After this application call Customer Service rization information on d representative	ht if Medicare asks for it. I e plan, if I wish to take action has been approved and I h at the number on my file. Today's date	on on		
If you are the authorized representation below (*Not a Sales Agen	-	ove and complete the			
Last name	First name				
Address					
City	State	Zip code			
Phone number () —	Relationship to	applicant			
Enrollee name			-		
Agent name/ID number Y0066_ERFMA_2025_C		AANV25HP0221291_00			
			_		

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For individuals helping enrollee with completing this form only					
Complete this section			_	_	_
members, or other thir	•	•	_		•
Name		Rela	tions	ship to enrollee	
Signature		Natio	onal	Producer Number	(Agents/Brokers only)
For Licensed Sales	s Representative/	agen	CV I	use only	
For Licensed Sales Representative/a Licensed Sales representative/Writing ID				Initial receipt date)
Licensed Sales representative/agent name				Proposed effective	ve date
Employer group name				•	
Employer group ID			E	Branch ID	
Agent must complete	•				
☐ IEP (MA-PD	☐ ICEP (MA enrolle	es) l		EP (MA-PD	□ OEP (Jan 1 -
enrollees)		(enro	llees eligible for	Mar 31)
		2	2nd	IEP)	
☐ OEP (Newly	☐ SEP (Dual LIS		□S	EP (Change in	☐ SEP (Loss of
eligible)	change of status)	I	resid	dence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)			EP (October 15- ember 7)	□ OEPI
	O,			•	
Enrollee name					
Agent name/ID number	「 <u></u>				

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□ SEP (SEP reason)	
Licensed Sales representative signature (optional)	Date
Please mail or fax this completed for	orm to:
UnitedHealthcare	
P.O. Box 30770	
Salt Lake City, UT 84130-0770	
Fax: 1-888-950-1170	
Fay the front and back of each pa	ane

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 NV-0006 (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.

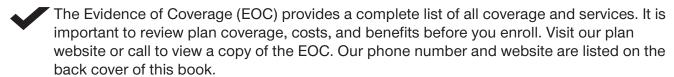
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

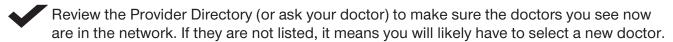
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

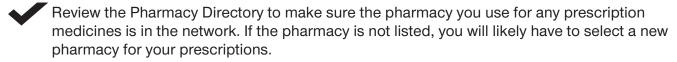
Enrollment checklist

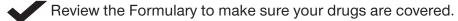
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





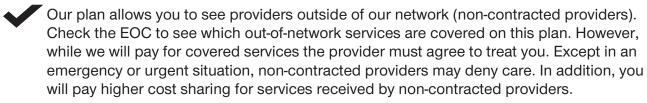




Understanding important rules







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.