

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC NY-0006 (HMO-POS) H3379-039-000

Last name	First name			Middle initial
Birth date		Sex □ Male □	l Femal	e
Home phone number ()	_	 Mobile phone number 		() –
☐ I give consent for UnitedHealthcausing an autodialer and/or prerecor		•	one nur	mber(s) I have provided
Medicare number				
Permanent residence street address homelessness, a PO Box may be o	•			
City	County		State	Zip code
Mailing address (Only if it's differe	nt from above	e. You can give a	P.O. bo	ox.)
City			State	Zip code
Email address (optional)		L		
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C				AANY25HP0220827_00

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 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 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	□ 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 Railro	ad Retirement Board (RRB) ch	ieck			
☐ I want to pay directly from a bank account					
Account type ☐ Checking I	□ 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		
Yes, Mexican, Mexican American, o		
Yes, Puerto Rican	or Chicano/a	
Yes, Cuban	aniah aviain	
Yes, another Hispanic, Latino, or Sp	banish ongin	
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	e 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		
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	provider (PCP), clinic or health center.
You can find a list on the plan website or in the Pr	ovider 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 require	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, unled I understand that people with Medicare are go the country, except for limited coverage near urgent care outside of the U.S. See the Summary I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealthcare and contained in my United	generally 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 iber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID numberY0066_ERFMA_2025_C	AANY25HP0220827_000

 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) 	y end my enrollment in ano	ther MA plan (exceptions
 plans). Release of information: By joining this Medwill share my information with Medicare, when payments, and for other purposes allowed information (see Privacy Act Statement below I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan. The information on this form is correct to the intentionally provide false information on the intention on the correct to the intentionally provide false information on the correct to the intentionally provide false information on the correct to the intentionally provide false information on the correct to the correct	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 the collection of this mation with organizations d to administer my health understand that if I
intentionally provide false information on thMy response to this form is voluntary. Howe plan.		•
When I sign below, it means that I have read a	and understand the inform	ation 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.	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 's date
If you are the authorized representative information below (*Not a Sales Agent)	e, please sign above a	nd 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		 AANY25HP0220827_000

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For individuals helping enrollee with completing this form only						
Complete this section	if you're an individual	(i.e.	ager	nts	, brokers, SHIP cou	unselors, family
members, or other thir	d parties) helping an e	enrol	lee f	ill	out this form.	
Name		Rel	atio	nsł	nip to enrollee	
Signature		Nat	tiona	ıl F	Producer Number (A	Agents/Brokers only)
For Licensed Sales	s Representative/	age	ncv	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				Ві	ranch ID	
Agent must complete ☐ IEP (MA-PD		00)			P (MA-PD	☐ OEP (Jan 1 –
enrollees)	☐ ICEP (MA enrolled	U S)			ees eligible for	Mar 31)
Crirolices)					EP)	Wai OT)
☐ OEP (Newly	☐ SEP (Dual LIS				P (Change in	☐ SEP (Loss of
eligible)	change of status)				ence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS	☐ AEF			P (October 15-	□ OEPI
_ = (=: (=:::=)	maintaining)				mber 7)	
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Enrollee name						
Agent name/ID number	•					

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

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 NY-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.

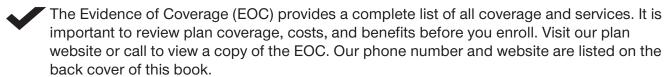
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

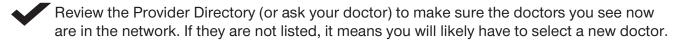
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

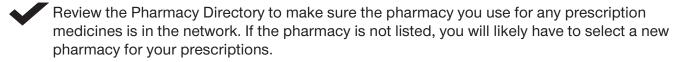
Enrollment checklist

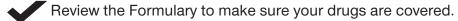
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





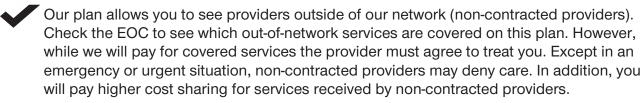




Understanding important rules







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.