

## **2025 Enrollment Request Form**

 $\Box$  AARP® Medicare Advantage Essentials from UHC OH-5 (HMO-POS) H5253-144-002

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 prii	nt in black or blu	e ink)	
Last name	First name			Middle initial
Birth date	Sex □ Male □ Femal		Female	9
Home phone number ( )	<ul> <li>Mobile phone number</li> </ul>		nber (	) —
☐ 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.				
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	Sta	ate	Zip code
Mailing address (Only if it's different from above. You can give a P.O. box.)				
City		ate	Zip code	
Email address (optional)				
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C			P	AAOH25HP0220646_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 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 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 of 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 Spanish		
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 primary care	e 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? ☐ Yes ☐ No
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 number Y0066_ERFMA_2025_C	AAOH25HP0220646_000

<ul> <li>I understand that I can be enrolled in onle that enrollment in this plan will automatic apply for MA Private Fee-for-Service (PFI)</li> </ul>	cally end my enrollme	nt in another MA plan (exceptions	
plans).  Release of information: By joining this I will share my information with Medicare, payments, and for other purposes allowed.	who may use it to tra ed by Federal law that	ck my enrollment, to make	
<ul> <li>information (see Privacy Act Statement below).</li> <li>I give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health</li> </ul>			
<ul> <li>plan.</li> <li>The information on this form is correct to intentionally provide false information on</li> <li>My response to this form is voluntary. Ho plan.</li> </ul>	this form I will be dis	enrolled from the plan.	
When I sign below, it means that I have rea	d and understand th	e information on this form	
understand 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 autho  Signature of applicant/member/authorized  If you are the authorized representate	n. After this application call Customer Service rization information of the representative	n has been approved and I have e at the number on my n file.  Today's date	
information below (*Not a Sales Agen	• •	·	
Last name	First name	First name	
Address			
City	State	Zip code	
Phone number ( ) —	Relationship to	Relationship to applicant	
Enrollee name			
Agent name/ID numberY0066 ERFMA 2025 C			

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For individuals helping enrollee with completing this form only				
Complete this section if you're an indi	vidual (i.e.	. agent	s, brokers, SHIP co	ounselors, family
members, or other third parties) helpin	ng an enro	ollee fil	I out this form.	•
Name	Re	elation	ship to enrollee	
Signature	Na	National Producer Number (Agents/Brokers only)		
For Licensed Sales Representa	ative/age	ency	use only	
Licensed Sales representative/Writing ID		•	Initial receipt dat	е
Licensed Sales representative/agent name			Proposed effecti	ve date
Employer group name				
Employer group ID		ŀ	Branch ID	
Agent must complete ☐ IEP (MA-PD ☐ ICEP (MA €	enrollees)		EP (MA-PD	☐ OEP (Jan 1 –
enrollees)			llees eligible for	Mar 31)
☐ OEP (Newly ☐ SEP (Dual	LIS		2nd IEP)  ☐ SEP (Change in ☐ SEP (Loss of	
eligible) change of sta				EGHP coverage)
☐ SEP (Chronic) ☐ SEP (Dual I	•	☐ AEP (October 15- ☐ OEPI		• ,
maintaining)			ember 7)	
•			,	
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 Essentials from UHC OH-5 (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.

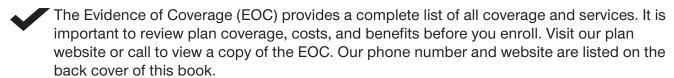
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

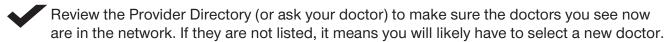
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

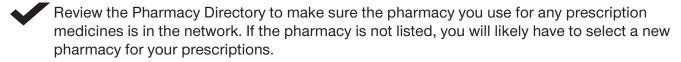
## **Enrollment checklist**

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**





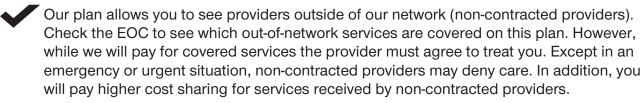




## **Understanding important rules**







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.