

2025 Enrollment Request Form

☐ AARP® Medicare Advantage Extras from UHC OH-9 (HMO-POS) H5253-130-000

Information about you (Please	type or pri	nt in black or bl	lue ink)	
Last name	First name			Middle initial
		I		
Birth date		Sex □ Male □	Femal	е
Home phone number ()	_	Mobile phone nu	umber () —
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	one nur	mber(s) I have provided
Medicare number				
Permanent residence street address homelessness, a PO Box may be co	•			
City	County	5	State	Zip code
Mailing address (Only if it's different from above. You can give a P.O. box.)				
City		5	State	Zip code
Email address (optional)		'		
Enrollee name				
Agent name/ID number				
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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-Incom	e Related Monthly Adjustment	Amount (Part D-I	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 you	r 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		
Yes, Mexican, Mexican American, or Yes, Puerto Rican	Gnicanora	
Yes, Cuban	aniah arisin	
Yes, another Hispanic, Latino, or Spa	anish 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 representsLesbian or gayStraight, that is, not gay or lesbianBisexual	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
Enrollog namo		
Enrollee nameAgent 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	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 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.	·
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 UnitedHealthc	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 Y0066_ERFMA_2025_C	

t	understand that I can be enrolled in only one hat enrollment in this plan will automatically	end my enrollment in ano	ther MA plan (exceptions
	apply for MA Private Fee-for-Service (PFFS), Nolans).	MA Medicare Medical Sav	ings Account (MSA)
F	Release of information: By joining this Mediwill share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below give UnitedHealthcare permission to share represented for person(s) for permissible purposes under a plan.	may use it to track my engage Federal law that authorized). my protected health information applicable law as required	rollment, to make e the collection of this nation with organizations I to administer my health
iı D N	The information on this form is correct to the ntentionally provide false information on this My response to this form is voluntary. However the column is t	form I will be disenrolled	from the plan.
Wher	n I sign below, it means that I have read an	d understand the inform	ation on this form
beha receiv Unite Signa	erstand that I will need to submit written proof If of the member beyond this application. Aft wed my UnitedHealthcare UCard®, I can call edHealthcare UCard to update my authorizati ature of applicant/member/authorized rep	er this application has been customer Service at the non information on file. resentative Today	en approved and I have umber on my
_	rmation below (*Not a Sales Agent)	please sign above ar	id complete the
Last	name	First name	
Addr	ess		
City		State	Zip code
Phon	ne number () —	() — Relationship to applicant	
Enrolle	ee name		
Agent	name/ID number		
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For individuals helping enrollee with completing this form only						
Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, 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 represe			•		Initial receipt date	
Licensed Sales represe	entative/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)					•	Wai OT)
☐ OEP (Newly	☐ SEP (Dual LIS		2nd IEP) □ SEP (Change in		,	☐ SEP (Loss of
eligible)	change of status)				ence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS	□ AE			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 form	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		

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 Extras from UHC OH-9 (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.

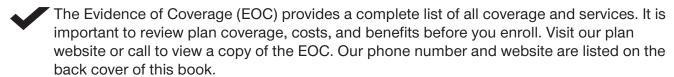
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

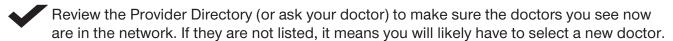
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

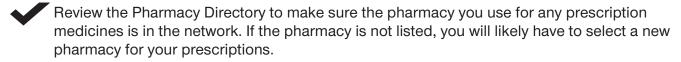
Enrollment checklist

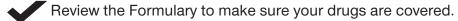
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





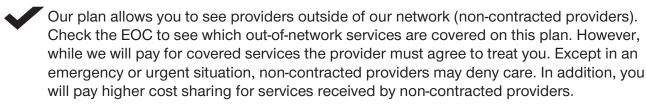




Understanding important rules







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.