

## **2025 Enrollment Request Form**

☐ AARP® Medicare Advantage from UHC OH-0016 (PPO) H8768-038-001

# 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 pri	nt in black or bl	ue ink)		
Last name	First name			Middle initial	
Birth date		Sex □ Male □	Femal	e	
Home phone number ( )	_	Mobile phone nu	ımber (	) —	
☐ 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	S	State	Zip code	
Mailing address (Only if it's different	t from above	e. You can give a	P.O. bo	x.)	
City		S	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)	nium (including any late enroll 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 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 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  No, not of Hispanic, Latino/a, or Spanish		
Yes, Mexican, Mexican American, o		
Yes, Puerto Rican	or Chicano/a	
Yes, Cuban	agnich avigin	
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	
<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>	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		
Enrollee nameAgent name/ID number		<del></del>
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If yes, please complete the following:	Ç
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 aren't limited to this list. You may go to any d	• • •
payment terms.	
You can find a list on the plan website or in the Pl	rovider Directory.
D : I DOD ( II	
Provider or PCP full name Provider/PCP number	(Please enter the number exactly as it appears on
Fronder/ FCF number	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 thi	s provider?
	ally enrolls you in paperless delivery for some of
your plan communications.	
You will get many of your required plan communi	
•	e: Explanation of Benefits or the Annual Notice of
Changes) are available online. You can access the computer, tablet or mobile phone.	ese communications through any device such as a
If you would rather have hard copies of require	d materials mailed to you, please check here:
	nard copies of required materials. Please note that
some communications are very large and may	not fit in all mailboxes. You can change your
preference for delivery at any time.	
Please read and sign  By completing this form, I agree to the followin	a.
	cal (Part B) to stay in UnitedHealthcare. I must keep
paying my Part B premium if I have one, unled	generally not covered under Medicare while out of
	r the U.S. border. This plan covers emergency and
urgent care outside of the U.S. See the Sum	,
☐ I understand that when my UnitedHealthcare	coverage begins, I must get all of my medical and
prescription drug benefits from UnitedHealth	care. Benefits and services authorized by
	dHealthcare "Evidence of Coverage" document
·	iber agreement) will be covered. Neither Medicare
nor UnitedHealthcare will pay for benefits or	services that are not covered.
Enrollee name	
Agent name/ID number	<del></del>
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<ul> <li>I understand that I can be enrolled in only or that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS),</li> </ul>	end my enrollment in ano	ther MA plan (exceptions
plans).  Release of information: By joining this Med will share my information with Medicare, who payments, and for other purposes allowed b information (see Privacy Act Statement below	o may use it to track my en y Federal law that authoriz w).	rollment, to make e the collection of this
<ul> <li>I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan.</li> </ul>	• •	•
<ul> <li>The information on this form is correct to the intentionally provide false information on this</li> <li>My response to this form is voluntary. However plan.</li> </ul>	s form I will be disenrolled	from the plan.
When I sign below, it means that I have read a	nd understand the inform	ation on this form
show written proof (power of attorney, guardians understand that I will need to submit written proof behalf of the member beyond this application. At received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizate Signature of applicant/member/authorized reposition.	of of this right, to the plan, iter this application has be Customer Service at the ricion information on file.  Coresentative Today	if I wish to take action on en approved and I have number on my r's date
If you are the authorized representative information below (*Not a Sales Agent)	, please sign above ar	nd complete the
Last name	First name	
Address		
City	State	Zip code
Phone number ( ) —	Relationship to applicar	nt
Enrollee name		
Agent name/ID numberY0066_ERFMA_2025_C		 AAOH25LP0220516_000

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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		Natio	onal F	Producer Number (A	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 form	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		

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 OH-0016 (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.

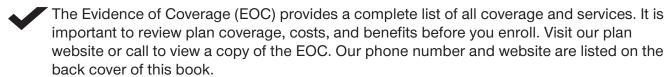
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

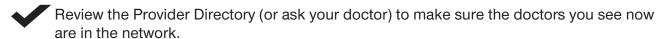
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

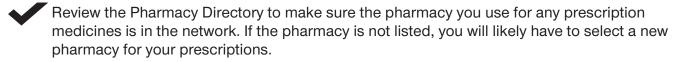
## **Enrollment checklist**

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**





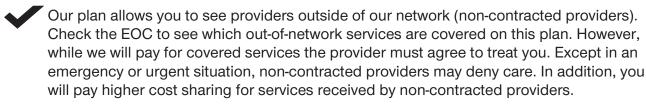


Review the Formulary to make sure your drugs are covered.

### **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.