

2025 Enrollment Request Form

 \square AARP® Medicare Advantage Essentials from UHC OR-4 (HMO-POS) H3805-039-002

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 pri	nt in black or bl	ue ink)		
Last name	First name			Middle initial	
Birth date		Sex □ Male □	Female	е	
Home phone number ()	_	Mobile phone nu	ımber () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	one nur	nber(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 l	P.O. bo	x.)	
City		S	State	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C			A	AAOR25HP0220790_000	

Do you have other insurance (Examples: Other private insurance programs.) If yes, what is it?		_	☐ Yes ☐ No a 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	pecause you don't	
How do you want to pay?				
If you have a monthly plan prer pay your premium by automati 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	ad Retirement	
If you don't choose an option b	pelow, we'll send a bill each mo	onth to your mailir	ng address.	
If you must pay a Part D-Incom	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	ou want to pay it:		
☐ You can pay it from you	r SS check			
☐ Medicare can bill you				
☐ The Railroad Retiremen	nt Board (RRB) can bill you			
☐ I want to pay from my Socia	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				
1. Would you prefer plan info				
	rmation in another language o Braille □ Large print □ Aud		•	
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C		AAO	R25HP0220790_000	

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 Sp.		
Yes, Mexican, Mexican American, o	r Chicano/a	
Yes, Puerto Rican		
Yes, Cuban		
Yes, another Hispanic, Latino, or Sp	panish 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 in:	surance that will cover medical services?	
(Examples: Other employer group coverage		ı
auto liability, or Veterans benefits)		☐ Yes ☐ No
Enrollee name		
Agent name/ID number		
Y0066_ERFMA_2025_C	AAOR25HP0	220790_000

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 P	rovider Directory.
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 thi	s provider? ☐ Yes ☐ No
Providing your email address above automatications.	ally enrolls you in paperless delivery for some of
	cations delivered electronically. We will send you e: Explanation of Benefits or the Annual Notice of 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:
☐ Instead of paperless delivery, we will mail you have 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 of 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 UnitedHealth UnitedHealthcare and contained in my United	generally not covered under Medicare while out of r 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 locare. 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	

	olled in only one Medicare Advar I automatically end my enrollmer	ntage (MA) plan at a time – and nt in another MA plan (exceptions
	ervice (PFFS), MA Medicare Med	dical Savings Account (MSA)
will share my information with payments, and for other purport information (see Privacy Act State I give UnitedHealthcare permited or person(s) for permissible purplan. The information on this form is intentionally provide false information.	ssion to share my protected heal	ck my enrollment, to make authorize the collection of this of the collection of this of the information with organizations required to administer my health edge. I understand that if I enrolled from the plan.
plan.	,	,
When I sign below, it means that	I have read and understand the	e information on this form
understand that I will need to submobehalf of the member beyond this received my UnitedHealthcare UCard to update UnitedHealthcare uCard to update Signature of applicant/member/	application. After this application ard®, I can call Customer Service my authorization information on	n has been approved and I have at the number on my
If you are the authorized repinformation below (*Not a Sa	•	pove and complete the
Last name	First name	
Address		
City	State	Zip code
Phone number () —	. Relationship to	applicant
Fanalla		
Enrollee nameAgent name/ID number		
V0066 EREMA 2025 C		AAOR25HP0220790_000

For individuals hal	ning onrollog with		nnla	ating this form o	nhv.
For individuals hell Complete this section			_		_
members, or other thir	•	•	_		Juliselors, lairilly
Name	a partice) neiping and			ship to enrollee	
				p	
Signature		Natio	ional	Producer Number	(Agents/Brokers only)
For Licensed Sale	s Representative/	agen	псу	use only	
Licensed Sales repres	entative/Writing ID			Initial receipt dat	е
Licensed Sales repres	entative/agent name			Proposed effecti	ve date
Employer group name					
Employer group ID			ı	Branch ID	
Agent must complete)				
☐ IEP (MA-PD	☐ ICEP (MA enrolle	-		EP (MA-PD	□ OEP (Jan 1 -
enrollees)				ollees eligible for	Mar 31)
☐ OEP (Newly	☐ SEP (Dual LIS			IEP) EP (Change in	☐ SEP (Loss of
eligible)	change of status)			dence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS			EP (October 15-	□ OEPI
()	maintaining)			ember 7)	
	<i>5.</i>			,	
Enrollee name					
Agent name/ID number	r				
Y0066_ERFMA_2025_C					AAOR25HP0220790_000

☐ 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 Essentials from UHC OR-4 (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.

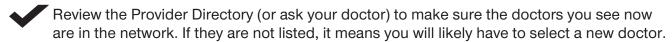
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

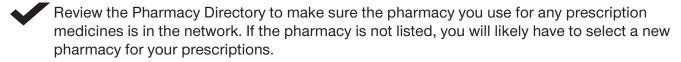
Enrollment checklist

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





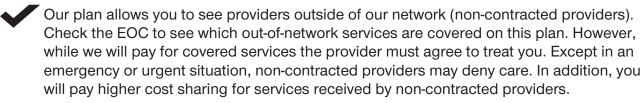




Understanding important rules







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.