

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC OR-0002 (PPO) H2406-070-000

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 □ Fe | | Femal | ale | |
| Home phone number () | Mobile phone numb | | 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 (Don't enter a P.O. box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address) | | | | | |
| City | County | | 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 | | | | A A O D O E I D O O O O A O O O O | |
| Y0066_ERFMA_2025_C | | | | AAOR25LP0220948_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) | 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 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 Retirement Board (RRB) can bill you | | | |
| ☐ I want to pay from my Social Security check | | | |
| ☐ I want to pay from my Railroad Retirement Board (RRB) check | | | |
| ☐ 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 Large print Audi | | • |
| Enrollee name | | | |
| Agent name/ID number | | | |
| Y0066_ERFMA_2025_C | | AAO | R25LP0220948_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 Spanish | | |
|---|---|-----------------|
| | | |
| Yes, Mexican, Mexican American, o Yes, Puerto Rican | of Chicano/a | |
| | | |
| Yes, Cuban | aniah aviain | |
| Yes, another Hispanic, Latino, or Sp | banish 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 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 | | |
| VOOCE EDEMA OOOF C | AAOR25LP0 | 0220948_000 |

| If yes, please complete the following: | C | | | |
|---|--|--|--|--|
| 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 doctor who accepts Medicare and the plan's payment terms. | | | | |
| You can find a list on the plan website or in the Plan | rovider Directory. | | | |
| | | | | |
| Provider or PCP full name | T | | | |
| 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 easing or have you recently each thi | | | | |
| Are you now seeing or have you recently seen thi | s provider? — Lifes Li No | | | |
| Providing your email address above automatic | ally enrolls you in paperless delivery for some of | | | |
| your plan communications. | | | | |
| You will get many of your required plan communi | cations delivered electronically. We will send you | | | |
| | e: Explanation of Benefits or the Annual Notice of | | | |
| • | ese communications through any device such as a | | | |
| computer, tablet or mobile phone. | | | | |
| If you would rather have hard copies of required materials mailed to you, please check here: | | | | |
| ☐ Instead of paperless delivery, we will mail you h | nard copies of required materials. Please note that | | | |
| 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: | | | | |
| ☐ I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep | | | | |
| paying my Part B premium if I have one, unless Medicaid or someone else pays for it. | | | | |
| I understand that people with Medicare are generally not covered under Medicare while out of | | | | |
| the country, except for limited coverage near the U.S. border. This plan covers emergency and | | | | |
| urgent care outside of the U.S. See the Summary of Benefits for more information. | | | | |
| ☐ I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and | | | | |
| prescription drug benefits from UnitedHealthcare. Benefits and services authorized by | | | | |
| UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare | | | | |
| nor UnitedHealthcare will pay for benefits or services that are not covered. | | | | |
| | | | | |
| Enrollee name | | | | |
| Agent name/ID numberY0066_ERFMA_2025_C | AAOR25LP0220948_000 | | | |

| I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA) | | | | |
|---|--|---|--|--|
| plans). Release of information: By joining this Medwill share my information with Medicare, who payments, and for other purposes allowed information (see Privacy Act Statement belowed). | no may use it to track my er by Federal law that authoriz bw). | rollment, to make te the collection of this | | |
| ☐ 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 | | | | |
| plan. The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan. My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. | | | | |
| When I sign below, it means that I have read a | and understand the inform | nation 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 relation information on file. Expresentative Today | if I wish to take action on en approved and I have number on my y's date | | |
| If you are the authorized representative information below (*Not a Sales Agent) | e, piease sign above ai | na 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 | | AAOR25LP0220948_000 | | |

AAOR25LP0220948_000

| 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 | | National Producer Number (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 | | | | | |

Y0066_ERFMA_2025_C

| ☐ 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 from UHC OR-0002 (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.

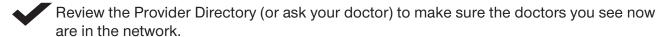
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

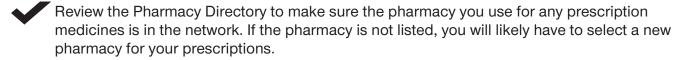
Enrollment checklist

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





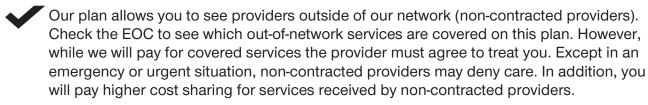


Review the Formulary to make sure your drugs are covered.

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.