

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC OR-0001 (PPO) H2406-042-000

Information about you (Please	type or pri	nt in black or b	olue ink)
Last name	First name			Middle initial
Birth date		Sex □ Male [☐ Femal	e
Home phone number ()	_	Mobile phone r	number (() –
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	hone nur	mber(s) I have provided
Medicare number				
Permanent residence street address homelessness, a PO Box may be co	-			
City	County		State	Zip code
Mailing address (Only if it's differen	t from above	e. You can give a	a P.O. bo	ox.)
City			State	Zip code
Email address (optional)				
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C				AAOR25LP0220974_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 you	r 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 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		•
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 Spa		
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 ins	surance that will cover medical services?	
(Examples: Other employer group coverage	e, LTD coverage, Workers' Compensation,	ı
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 aren't limited to this list. You may go to any depayment terms. You can find a list on the plan website or in the Property of the plan website.			
Provider or PCP full name	Tovidor Billoctory.		
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 thi	s provider?		
an email when new communications (For exampl	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 licare. Benefits and services authorized by dHealthcare "Evidence of Coverage" document liber agreement) will be covered. Neither Medicare		
Enrollee name			
Agent name/ID number Y0066_ERFMA_2025_C	AAOR25LP0220974_000		

 I understand that I can be enrolled in only of that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS), 	end my enrollment in ano	ther MA plan (exceptions		
plans). Release of information: By joining this Medwill share my information with Medicare, when payments, and for other purposes allowed be information (see Privacy Act Statement below I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan. The information on this form is correct to the intentionally provide false information on this	o may use it to track my ency Federal law that authorized). my protected health information applicable law as required to best of my knowledge. It is form I will be disenrolled	rollment, to make the collection of this mation with organizations d to administer my health understand that if I 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	nd 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 cal UnitedHealthcare UCard to update my authorization. Signature of applicant/member/authorized re	of of this right, to the plan, fter this application has be I Customer Service at the ration information on file. presentative 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)	, piease sign above ar	na 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		 AAOR25LP0220974_000		

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For individuals helping enrollee with completing this form only						
Complete this section	if you're an individual	(i.e.	ager	nts	, brokers, SHIP cou	unselors, 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 representative/Writing ID			•		Initial receipt date	
Licensed Sales representative/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		☐ SEP (Loss of
eligible)	change of status)				` •	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS			☐ AEP (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 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-0001 (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.

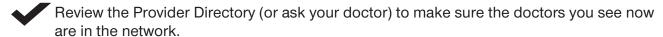
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

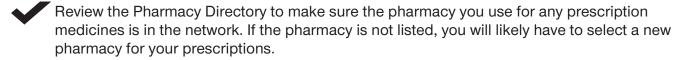
Enrollment checklist

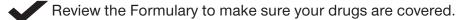
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





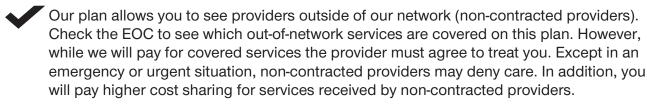




Understanding important rules







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.