

## 2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC PA-0008 (PPO) H2406-047-000

Information about you (Please	type or pri	nt in black or bl	lue ink)	
Last name	First name			Middle initial
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 differen	t from above	e. You can give a	P.O. bo	x.)
City		5	State	Zip code
Email address (optional)				1
Enrollee name				
Agent name/ID number				A A P A 251 P D 220 Q 60 000

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 premium (including any late enrollment penalty you may owe), you can pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT).  If you don't choose an option below, we'll send a bill each month to your mailing address.			
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If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA),			
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 us manage your plan			
1. Would you prefer plan information in another language or an accessible format?			
If you would prefer plan information in another language or accessible format, please check what you'd like: ☐ Spanish ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD			
Enrollee name			
Agent name/ID number			

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		
auto liability, or Veterans benefits)		☐ Yes ☐ No
Enrollee name		
Agent name/ID number		
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If yes, please complete the following:	5			
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 de	octor who accepts Medicare and the plan's			
payment terms.				
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 automatica	ally enrolls you in paperless delivery for some of			
your plan communications.	,			
You will get many of your required plan communic	cations delivered electronically. We will send you			
an email when new communications (For example	-			
Changes) are available online. You can access the	ese communications through any device such as a			
computer, tablet or mobile phone.				
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 h	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 following	g:			
	cal (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.			
· · · · · · · · · · · · · · · · · · ·	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and			
urgent care outside of the U.S. See the Sumr				
	coverage begins, I must get all of my medical and			
prescription drug benefits from UnitedHealth				
-	dHealthcare "Evidence of Coverage" document			
nor UnitedHealthcare will pay for benefits or	iber agreement) will be covered. Neither Medicare			
nor ormeditioally will pay for beliefits of s	solvisos that are not obvered.			
Enrollee name				
Agent name/ID number Y0066_ERFMA_2025_C				
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□ 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)					
<ul> <li>plans).</li> <li>Release of information: By joining this Me will share my information with Medicare, where payments, and for other purposes allowed information (see Privacy Act Statement below I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan.</li> <li>The information on this form is correct to the</li> </ul>	no may use it to track my er by Federal law that authoriz ow). e my protected health inforr er applicable law as required	rollment, to make the collection of this mation with organizations d to administer my health			
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, guardian 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 references to the submit of the submit o	of of this right, to the plan, After this application has be Il Customer Service at the ration information on file.  Expresentative Today	if I wish to take action on een approved and I have number on my y's date			
information below (*Not a Sales Agent)	, <b>,</b> , , , , , , , , , , , , , , , , ,				
Last name	First name				
Address					
City	State	Zip code			
Phone number ( ) —	Relationship to applicant				
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C					
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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		Relationship to enrollee				
Signature		Natio	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						

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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 from UHC PA-0008 (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.

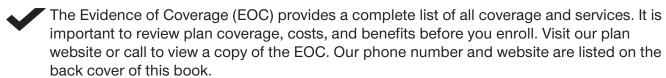
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

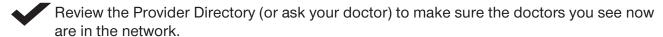
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

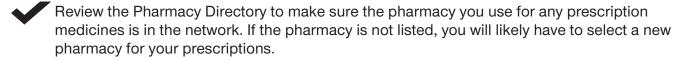
## **Enrollment checklist**

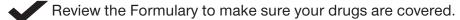
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the benefits





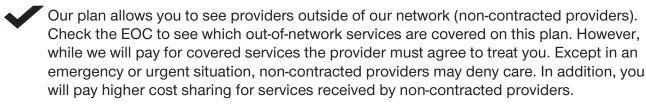




## **Understanding important rules**







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.