

2025 Enrollment Request Form

☐ AARP® Medicare Advantage Patriot No Rx RI-MA01 (HMO-POS) H5253-149-000

Information about you (Please	type or pri	nt in black or b	lue ink		
Last name	First name		Middle initial		
		I			
Birth date	Sex □ Male □] Female		
Home phone number ()	_	 Mobile phone number 		() —	
☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology.					
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)				
nomelessiess, at 6 Box may be or	onoluci cu ye	our permanent re	Jordonoc	, addi cooj	
City	County	County State		Zip code	
Mailing address (Only if it's different from above. You can give a P.O. box.)					
City			State	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number					
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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?
f 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).
f you don't choose an option below, we'll send a bill each month to your mailing address.
f 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
I. 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
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.m8 p.m. local time, 7 days a week. Or visit AARPMedicarePlans.com for online help.
2. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply. No, not of Hispanic, Latino/a, or Spanish origin Yes, Mexican, Mexican American, or Chicano/a Yes, Puerto Rican Yes, Cuban

Enrollee name _____

Agent name/ID number _____

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Yes, another Hispanic, Latino, or Sp I choose not to answer	panish origin
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	recognized Tribe (name of Tribe)
4. What is your gender? Select one.	
Woman	I use a different term:
Man	
Non-binary	I choose not to answer
5. Which of the following best represents	how you think of yourself? Select one.
Lesbian or gay	I use a different term:
Straight, that is, not gay or lesbian	
Bisexual	I choose not to answer
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	e, LTD coverage, Workers' Compensation,
auto liability, or Veterans benefits)	☐ Yes ☐ No
If yes, please complete the following:	
Name of health insurance company	
Member number	
7 Please give us the name of your primar	ry care provider (PCP), clinic or health center.
You can find a list on the plan website or in	the Provider Directory.
Enrollee name	
Agent name/ID number	
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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 this	s provider?
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 gothe country, except for limited coverage near urgent care outside of the U.S. See the Summare I understand that when my UnitedHealthcare benefits from UnitedHealthcare. Benefits and contained in my UnitedHealthcare "Evidence contract or subscriber agreement) will be compay for benefits or services that are not cover I understand that I can be enrolled in only on that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS), I plans). Release of information: By joining this Mediwill share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below I give UnitedHealthcare permission to share in	generally not covered under Medicare while out of rethe U.S. border. This plan covers emergency and mary of Benefits for more information. I coverage begins, I must get all of my medical discretices authorized by UnitedHealthcare and e of Coverage" document (also known as a member vered. Neither Medicare nor UnitedHealthcare will red. I e Medicare Advantage (MA) plan at a time – and end my enrollment in another MA plan (exceptions MA Medicare Medical Savings Account (MSA) I care Advantage Plan, I acknowledge that the plan may use it to track my enrollment, to make y Federal law that authorize the collection of this
Enrollee nameAgent name/ID number	
Y0066_ERFMA_2025_C	AARI25HP0220641_000

 The information on this form is correct intentionally provide false information of the second of the	on this t	form I will be disenro	lled fro	m the plan.
When I sign below, it means that I have re	ead and	d understand the inf	ormati	on on this form
If I sign as an authorized representative, it reshow written proof (power of attorney, guarunderstand that I will need to submit written behalf of the member beyond this application received my UnitedHealthcare UCard®, I card UnitedHealthcare UCard to update my authorized Signature of applicant/member/authorized	rdianshin proof ion. Afte an call C norizatio	ip, etc.) of this right if of this right, to the pler this application has Customer Service at ton information on file	Medic lan, if I v s been the num	are asks for it. I wish to take action on approved and I have ber on my
If you are the authorized representa	ative,	please sign abov	e and	complete the
information below (*Not a Sales Age	ent)			
Last name		First name		
Address				
City		State	Z	lip code
Phone number () —		Relationship to applicant		
For individuals helping enrollee wit Complete this section if you're an individua members, or other third parties) helping an Name	al (i.e. aç n enrolle	gents, brokers, SHIP	_	elors, family
Signature	Natio	National Producer Number (Agents/Brokers only)		
For Licensed Sales Representative				
Enrollee name				
Agent name/ID number				

Licensed Sales representative/Writing ID		Initial receipt date			
Licensed Sales representative/agent name			Proposed effective date		
Employer group name					
Employer group ID		ı	Branch ID		
Agent must complete					
☐ IEP (MA-PD	☐ ICEP (MA enrollees)		EP (MA-PD	□ OEP (Jan 1 -	
enrollees)			ollees eligible for IEP)	Mar 31)	
☐ OEP (Newly	☐ SEP (Dual LIS	□S	EP (Change in	☐ SEP (Loss of	
eligible)	change of status)	resid	dence)	EGHP coverage)	
☐ SEP (Chronic)	☐ SEP (Dual LIS	\square A	EP (October 15-	□ OEPI	
	maintaining)	Dec	December 7)		
☐ 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 Patriot No Rx RI-MA01 (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.

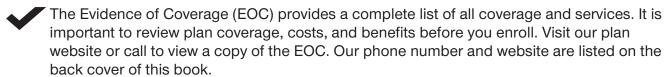
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

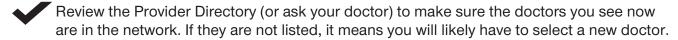
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

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

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits may change on January 1 of each year.
- Our plan allows you to see providers outside of our network (non-contracted providers). Check the EOC to see which out-of-network services are covered on this plan. However, while we will pay for covered services the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay higher cost sharing for services received by non-contracted providers.
- 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.