

2025 Enrollment Request Form

☐ AARP® Medicare Advantage Essentials from UHC SC-3 (PPO) H2001-092-000

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	lue ink)		
Last name	First name		Middle initial		
Birth date	Sex ☐ Male ☐ Fem		Femal	le	
Home phone number ()	 Mobile phone number 		umber (() –	
☐ 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	5	State	Zip code	
Mailing address (Only if it's different	t from above	e. You can give a	P.O. bo	x.)	
City		3	State	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number					
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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 fill them out.	your choice. You can't be de	enied coverage b	ecause you don't
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 y	ou a letter and ask you how yo	u want to pay it:	
☐ You can pay it from your 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 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	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 Spanish		
Yes, Mexican, Mexican American, o Yes, Puerto Rican	of Chicano/a	
Yes, Cuban	aniah aviain	
Yes, another Hispanic, Latino, or Sp	oanish 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 state4. 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		
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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 pri	imary care provider (PCP), clinic or health center.
You aren't limited to this list. You may g payment terms. You can find a list on the plan website of	o to any doctor who accepts Medicare and the plan's
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 recent	ly seen this provider? ☐ Yes ☐ No
an email when new communications (F	communications delivered electronically. We will send you or example: Explanation of Benefits or the Annual Notice of access these communications through any device such as a
	of required materials mailed to you, please check here:
	mail you hard copies of required materials. Please note that e and may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to th	e following:
paying my Part B premium if I have I understand that people with Med the country, except for limited cove urgent care outside of the U.S. See I understand that when my UnitedI prescription drug benefits from Un UnitedHealthcare and contained in (also known as a member contract	and Medical (Part B) to stay in UnitedHealthcare. I must keep e one, unless Medicaid or someone else pays for it. icare are generally not covered under Medicare while out of erage near the U.S. border. This plan covers emergency and e the Summary of Benefits for more information. Healthcare coverage begins, I must get all of my medical and itedHealthcare. Benefits and services authorized by my UnitedHealthcare "Evidence of Coverage" document or subscriber agreement) will be covered. Neither Medicare enefits or services that are not covered.
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	

th ap	understand that I can be enrolled in only one pat enrollment in this plan will automatically opply for MA Private Fee-for-Service (PFFS), N	end my enrollment in anot	ther MA plan (exceptions
R W pa in l q or pl TI	elease of information: By joining this Medicial share my information with Medicare, who ayments, and for other purposes allowed by formation (see Privacy Act Statement below give UnitedHealthcare permission to share reperson(s) for permissible purposes under a lan. The information on this form is correct to the tentionally provide false information on this ly response to this form is voluntary. However,	may use it to track my energed Federal law that authorized). ny protected health informapplicable law as required best of my knowledge. I use form I will be disenrolled to the second	rollment, to make e the collection of this nation with organizations I to administer my health understand that if I from the plan.
pl	an.		
When	I sign below, it means that I have read an	d understand the inform	ation on this form
under	written proof (power of attorney, guardiansh stand that I will need to submit written proof fof the member beyond this application. Aft	of this right, to the plan, i	f I wish to take action on
United	ed my UnitedHealthcare UCard®, I can call of the last the last three of applicant/member/authorized rep	on information on file.	umber on my 's date
Signate of the state of the sta	Healthcare UCard to update my authorizati	on information on file. resentative Today	's date
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If you information and the control of the control o	Healthcare UCard to update my authorization ture of applicant/member/authorized reparative, are the authorized representative, mation below (*Not a Sales Agent) ame	resentative Today please sign above an First name State	z's date
If you information information Last number City Phone	Healthcare UCard to update my authorization ture of applicant/member/authorized representative, mation below (*Not a Sales Agent) ame e number () — e name	please sign above and First name State Relationship to applicant	z's date
If you information information and the control information information and the control information and the control information information and the control information and	Healthcare UCard to update my authorization ture of applicant/member/authorized reparative, mation below (*Not a Sales Agent) ame e number () —	please sign above and First name State Relationship to applicant	z's date

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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				hip to enrollee	
Signature		Natio	onal F	Producer Number (A	Agents/Brokers only)
For Licensed Sales	Representative/a	agen	cv u	se only	
Licensed Sales represe	-			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 for	m 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	Δ

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 SC-3 (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.

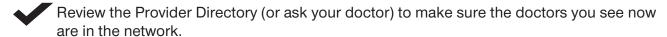
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

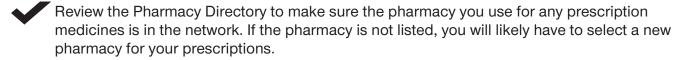
Enrollment checklist

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





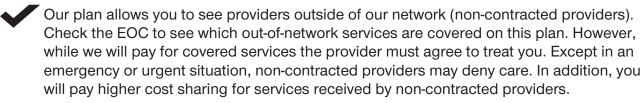


Review the Formulary to make sure your drugs are covered.

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.