

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC SD-0001 (PPO) H1278-009-000

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 blu	ie ink)		
Last name	First name			Middle initial	
Birth date		Sex □ Male □	Female	•	
Home phone number ()	_	Mobile phone nur	mber () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			ne nun	nber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be co	-				
City	County	St	ate	Zip code	
Mailing address (Only if it's differen	t from above	e. You can give a P	.O. bo	x.)	
City		St	ate	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-Income Related Monthly Adjustment Amount (Part D-IRMAA),			
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			
Y0066_ERFMA_2025_C		AAS	D25LP0221181_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	or Chicano/a	
Yes, Cuban	aniah aviain	
Yes, another Hispanic, Latino, or Sp	banish ongin	
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	e 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		ı
auto liability, or Veterans benefits)		☐ Yes ☐ No
Enrollee name		
Enrollee nameAgent name/ID number		
VOOCE EDEMA COOF C		221181_000

If yes, please complete the following:	
Name of health insurance company	
Member number	
7. Please give us the name of your prima	ry care provider (PCP), clinic or health center.
You aren't limited to this list. You may go to payment terms. You can find a list on the plan website or in	any doctor who accepts Medicare and the plan's the Provider 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 se	een this provider?
an email when new communications (For e Changes) are available online. You can acc computer, tablet or mobile phone.	mmunications delivered electronically. We will send you example: Explanation of Benefits or the Annual Notice of eess these communications through any device such as a
If you would rather have hard copies of re	equired materials mailed to you, please check here:
• •	il you hard copies of required materials. Please note that d may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the fo	llowing:
paying my Part B premium if I have on I understand that people with Medicar the country, except for limited coverag urgent care outside of the U.S. See the I understand that when my UnitedHeal prescription drug benefits from United UnitedHealthcare and contained in my (also known as a member contract or s nor UnitedHealthcare will pay for bene	
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	AASD25LP0221181_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, wh payments, and for other purposes allowed by information (see Privacy Act Statement below).	o may use it to track my en by Federal law that authoriz w).	rollment, to make e the collection of this
 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 My response to this form is voluntary. Howe plan. 	s form I will be disenrolled	from the plan.
When I sign below, it means that I have read a	nd understand the inform	ation on this form
show written proof (power of attorney, guardians understand that I will need to submit written produced behalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can cal UnitedHealthcare UCard to update my authorizations. Signature of applicant/member/authorized remainders.	of of this right, to the plan, ifter this application has be I Customer Service at the rition information on file. presentative Today	if I wish to take action on en approved and I have number on my r's date
If you are the authorized representative information below (*Not a Sales Agent)	, please sign above ar	nd 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		 AASD25LP0221181_000

For individuals he	ping enrollee with	con	nple	eting this form o	only
Complete this section			_		-
members, or other thin	•	•	_		, ,
Name				ship to enrollee	
Signature		Nati	ional	Producer Number	r (Agents/Brokers only)
For Licensed Sale	s Representative/	ager	ıcv	use only	
Licensed Sales repres	• •	age.	,	Initial receipt da	te
Licensed Sales representative/agent name				Proposed effect	ive date
Employer group name	,				
Employer group ID				Branch ID	
Agent must complete)				
☐ IEP (MA-PD	☐ ICEP (MA enrolle	es)		EP (MA-PD	□ OEP (Jan 1 -
enrollees)			enro	ollees eligible for	Mar 31)
			2nd	IEP)	
☐ OEP (Newly	☐ SEP (Dual LIS			SEP (Change in	☐ SEP (Loss of
eligible)	change of status)			dence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS			EP (October 15-	□ OEPI
	maintaining)		Dec	ember 7)	
Enrollee name					
Agent name/ID numbe	r				
Y0066_ERFMA_2025_C					AASD25LP0221181_000

□ 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 from UHC SD-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.

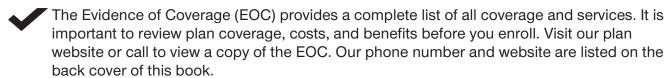
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

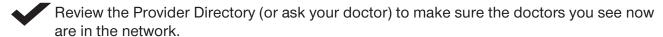
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

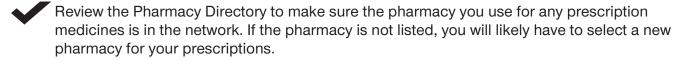
Enrollment checklist

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



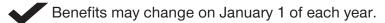


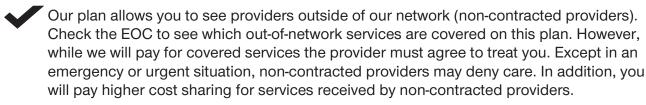




Understanding important rules







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.