

2025 Enrollment Request Form

☐ AARP® Medicare Advantage Access from UHC TN-7 (PPO) H2001-086-000

			Middle initial
	Sex □ Male □	Femal	le
_	Mobile phone number (() –
nd its affili voice tec	•	one nui	mber(s) I have provided
	r a P.O. box. Note our permanent re		dividuals experiencing e address)
ounty	S	State	Zip code
om above	e. You can give a	P.O. bo	ox.)
	S	State	Zip code

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 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 Railro	ad Retirement Board (RRB) ch	neck	
☐ I want to pay directly from a	bank account		
Account type ☐ Checking I	☐ 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		AAT	N25LP0221051_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 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	e, LTD coverage, Workers' Compensation,	,
auto liability, or Veterans benefits)		☐ Yes ☐ No
Enrollee name		
Agent name/ID number		
Y0066_ERFMA_2025_C		 0221051_000

If yes, please complete the following:	
Name of health insurance company	
Member number	
7. Please give us the name of your primary ca	are provider (PCP), clinic or health center.
You aren't limited to this list. You may go to any payment terms. You can find a list on the plan website or in the	
·	Trovider 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 to	his provider? ☐ Yes ☐ No
an email when new communications (For example Changes) are available online. You can access to computer, tablet or mobile phone.	nications delivered electronically. We will send you ple: Explanation of Benefits or the Annual Notice of these communications through any device such as a
If you would rather have hard copies of requi	red materials mailed to you, please check here:
• •	u hard copies of required materials. Please note that ay not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the follow	ing:
paying my Part B premium if I have one, un I understand that people with Medicare are the country, except for limited coverage ne urgent care outside of the U.S. See the Sur I understand that when my UnitedHealthcar prescription drug benefits from UnitedHeal UnitedHealthcare and contained in my Unite	e generally not covered under Medicare while out of ear the U.S. border. This plan covers emergency and mmary of Benefits for more information. re coverage begins, I must get all of my medical and thcare. Benefits and services authorized by tedHealthcare "Evidence of Coverage" document criber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	

 I understand that I can be enrolled in only that enrollment in this plan will automatica apply for MA Private Fee-for-Service (PFFS) 	ally end my enrollment	in another MA plan (exceptions
 plans). Release of information: By joining this M will share my information with Medicare, we payments, and for other purposes allowed information (see Privacy Act Statement be I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan. The information on this form is correct to 	who may use it to tracl d by Federal law that a elow). are my protected healt der applicable law as r	k my enrollment, to make authorize the collection of this h information with organizations equired to administer my health
intentionally provide false information on the state of the st		•
When I sign below, it means that I have read	d and understand the	information on this form
show written proof (power of attorney, guardia understand that I will need to submit written powerly behalf of the member beyond this application. The received my UnitedHealthcare UCard®, I can be unitedHealthcare UCard to update my authority Signature of applicant/member/authorized If you are the authorized representation.	roof of this right, to the After this application call Customer Service ization information on representative	e plan, if I wish to take action on has been approved and I have at the number on my file. Today's date
information below (*Not a Sales Agent		
Last name	First name	
Address		
City	State	Zip code
Phone number () —	Relationship to a	pplicant
Enrollee name		
Agent name/ID number Y0066_ERFMA_2025_C		AATN25LP0221051_000
10000_EHH MA_2020_O		AATINESEL SEE 1031_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	(Agents/Brokers only)
For Licensed Sale	s Representative/	ager	ncv	use only	
Licensed Sales repres	• •			Initial receipt da	te
Licensed Sales repres	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					AATN25LP0221051_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		
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 Access from UHC TN-7 (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.

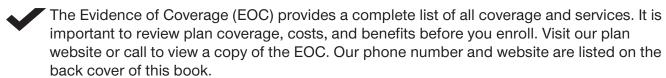
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

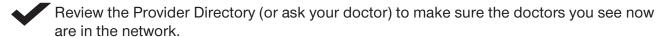
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

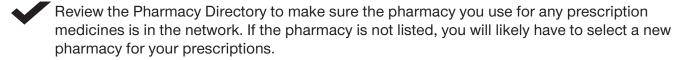
Enrollment checklist

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

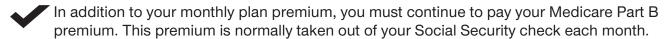


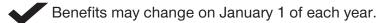


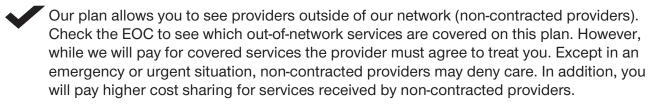




Understanding important rules







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.