

## **2025** Enrollment Request Form

☐ AARP® Medicare Advantage Giveback from UHC TX-35 (HMO-POS) H4527-048-000

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 blue	e ink)	
Last name	First name			Middle initial
Birth date		Sex □ Male □ F	emal	е
Home phone number ( )	_	Mobile phone num	ıber (	) —
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			ie nur	nber(s) I have provided
Medicare number				
Permanent residence street address homelessness, a PO Box may be co	•			
City	County	Sta	ite	Zip code
Mailing address (Only if it's different	t from above	e. You can give a P.	O. bo	x.)
City		Sta	ite	Zip code
Email address (optional)				
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C				AATX25HP0220761_000

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			
Y0066_ERFMA_2025_C		AAT	X25HP0220761_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	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	
<ul><li> Member/Citizen of a federal or state</li><li>4. What is your gender? Select one.</li><li> Woman</li><li> Man</li></ul>	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 primary car	e provider (PCP), clinic or health center.
You can find a list on the plan website or in the P	rovider Directory.
Provider or PCP full name	
Provider/PCP number	(Please enter the number exactly as it appears of 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 thi	is provider? ☐ Yes ☐ No
Providing your email address above automatic your plan communications.	ally enrolls you in paperless delivery for some of
an email when new communications (For example	ications delivered electronically. We will send you le: Explanation of Benefits or the Annual Notice of lese communications through any device such as a
If you would rather have hard copies of require	ed materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you some communications are very large and may preference for delivery at any time.	hard 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	ng:
paying my Part B premium if I have one, unled I understand that people with Medicare are go the country, except for limited coverage neadurgent care outside of the U.S. See the Sum I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealth UnitedHealthcare and contained in my United	generally not covered under Medicare while out of r the U.S. border. This plan covers emergency and mary of Benefits for more information. e coverage begins, I must get all of my medical and neare. Benefits and services authorized by dHealthcare "Evidence of Coverage" document riber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	

<ul> <li>I understand that I can be enrolled in only o that enrollment in this plan will automatically</li> </ul>	y end my enrollment in and	other MA plan (exceptions
apply for MA Private Fee-for-Service (PFFS). plans).	, MA Medicare Medical Sa	vings Account (MSA)
Release of information: By joining this Med will 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 or person(s) for permissible purposes under	no may use it to track my e by Federal law that authori bw). e my protected health infor	nrollment, to make ze the collection of this mation with organizations
<ul> <li>plan.</li> <li>The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. Howe plan.</li> </ul>	is form I will be disenrolled	from the plan.
When I sign below, it means that I have read a	and understand the inforr	mation on this form
understand that I will need to submit written probehalf 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 received my authorized my authorized received my authorized my authorized received my authorized my au	After this application has be Il Customer Service at the ation information on file. Peresentative Toda	een approved and I have number on my  ay's date
If you are the authorized representative information below (*Not a Sales Agent)	e, please sign above a	and complete the
Last name	First name	
Address		
City	State	Zip code
Phone number ( ) —	Relationship to applicant	
Enrollee name		
Agent name/ID number		AATY25HD0220761 000

For individuals he	lping enrollee with	com	nple <sup>1</sup>	ting this form o	nly
Complete this section			-		-
•	rd parties) helping an e	•	_		•
Name		Rela	tions	hip to enrollee	
Signature		Natio	onal	Producer Number	(Agents/Brokers only)
For Licensed Sale	s Representative/	agen	CV I	ise only	
Licensed Sales repres	• •	ugo	ioy c	Initial receipt dat	е
Licensed Sales representative/agent name				Proposed effecti	ve date
Employer group name	•			1	
Employer group ID			Е	ranch ID	
Agent must complete	9		'		
☐ IEP (MA-PD enrollees)  ☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ ICEP (MA enrolled ☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	ŕ	enro 2nd   Seconds Seconds Se	P (MA-PD llees eligible for EP) EP (Change in ence) EP (October 15- ember 7)	☐ OEP (Jan 1 - Mar 31)  ☐ SEP (Loss of EGHP coverage) ☐ OEPI
Enrollee name					
Agent name/ID numbe					
Y0066_ERFMA_2025_C					AATX25HP0220761_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 Giveback from UHC TX-35 (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.

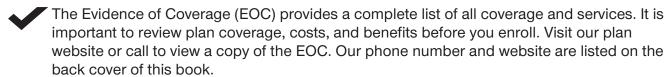
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

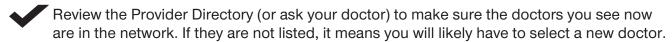
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

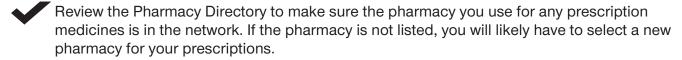
## **Enrollment checklist**

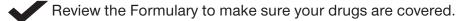
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## **Understanding the benefits**





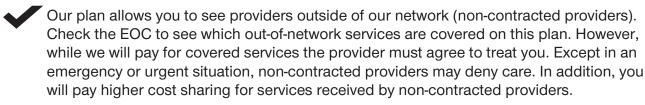




## **Understanding important rules**







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.