

# **2025 Enrollment Request Form**

☐ AARP® Medicare Advantage Patriot No Rx TX-MA03 (HMO-POS) H0609-056-000

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 □	] Femal	е	
Home phone number ( ) —		Mobile phone number ( ) —			
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	none nur	mber(s) I have provided	
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)					
City	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)		<u>'</u>			
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.

low 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.
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
. 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 <b>1-844-723-6473</b> , TTY <b>711</b> , 8 a.m8 p.m. local time, 7 days a week. Or visit <b>AARPMedicarePlans.com</b> 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	anish 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	I don't know
Bisexual	I choose not to answer
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	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	
	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
You will get many of your required plan communications (For example Changes) are available online. You can access the computer, tablet or mobile phone.	-
If you would rather have hard copies of required	d materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you h some communications are very large and may preference for delivery at any time.	ard 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, unle I understand that people with Medicare are g the country, except for limited coverage near urgent care outside of the U.S. See the Sumr I understand that when my UnitedHealthcare benefits from UnitedHealthcare. Benefits and	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and mary of Benefits for more information. coverage begins, I must get all of my medical services authorized by UnitedHealthcare and
contract or subscriber agreement) will be cover pay for benefits or services that are not cover I understand that I can be enrolled in only one that enrollment in this plan will automatically enrolled in the cover that enrollment in this plan will automatically enrolled in the coverage of the coverage	of Coverage" document (also known as a member vered. Neither Medicare nor UnitedHealthcare will red.  e Medicare Advantage (MA) plan at a time – and end my enrollment in another MA plan (exceptions MA Medicare Medical Savings Account (MSA)
<ul> <li>Release of information: By joining this Medicare, who 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 ror person(s) for permissible purposes under a</li> </ul>	Federal law that authorize the collection of this
Enrollee name	

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<ul> <li>The information on this form is correct to intentionally provide false information or</li> <li>My response to this form is voluntary. He plan.</li> </ul>	n this form I will be disenro	lled from the plan.			
When I sign below, it means that I have read and understand the information on this form  If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file.  Signature of applicant/member/authorized representative  Today's date					
If you are the authorized representative, please sign above and complete the information below (*Not a Sales Agent)					
Last name	First name				
Address					
City	State	Zip code			
Phone number ( ) —	Relationship to app	licant			
For individuals helping enrollee with completing this form only  Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.  Name  Relationship to enrollee					
Signature	National Producer Number (Agents/Brokers only)				
For Licensed Sales Representative/a  Enrollee name  Agent name/ID number	agency use only				
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Licensed Sales representative/Writing ID		Initial receipt date				
Licensed Sales representative/agent name			Proposed effective date			
Employer group name						
Employer group ID		[	Branch ID			
Agent must complete						
☐ IEP (MA-PD	☐ ICEP (MA enrollees)		EP (MA-PD	□ OEP (Jan 1 -		
enrollees)			nrollees eligible for Mar 31) nd IEP)			
☐ OEP (Newly	☐ SEP (Dual LIS	☐ SEP (Change in		☐ SEP (Loss of		
eligible)	change of status)	resid	dence)	EGHP coverage)		
☐ SEP (Chronic)	☐ SEP (Dual LIS	ΠА	EP (October 15-	□ OEPI		
	maintaining)	Dec	ember 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. 1-000-950-1170						

#### 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 TX-MA03 (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.

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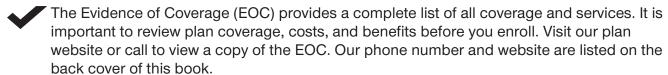
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

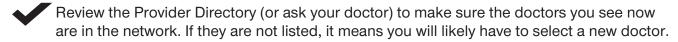
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

## **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.