

# **2025 Enrollment Request Form**

☐ AARP® Medicare Advantage from UHC TX-0007 (PPO) H1278-015-000

# 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 | ue ink) |                         |  |
| Last name   | First name                              |                    |         | Middle initial          |  |
| Birth date  |   | Sex □ Male □       | Female  | Э                       |  |
| Home phone number ( )   | <ul> <li>Mobile phone number</li> </ul> |                    | mber (  | ( ) –                   |  |
| ☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord  |   | •                  | one nun | nber(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                                  | S                  | tate    | Zip code                |  |
| Mailing address (Only if it's different from above. You can give a P.O. box.)   |   |                    |         |                         |  |
| City  |   | S                  | tate    | Zip code                |  |
| Email address (optional)  |   |                    |         |                         |  |
|   |   |                    |         |                         |  |
| Enrollee name   |   |                    |         |                         |  |
| Agent name/ID number  |   |                    |         |                         |  |
| Y0066_ERFMA_2025_C  |   |                    |         | AATX25LP0221177_000     |  |

| Do you have other insurance (Examples: Other private insura programs.) If yes, what is it?  |   | •                   | ☐ Yes ☐ No<br>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<br>c deduction from your Social S<br>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 □ 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<br>Braille   |                     | •                               |  |
| Enrollee name   |   |                     |                                 |  |
| Agent name/ID number  |   |                     |                                 |  |
| Y0066_ERFMA_2025_C  |   | AAT                 | X25LP0221177_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                    |            |
| 4. What is your gender? Select one Woman    | recognized Tribe (name of Tribe)          |            |
| Man<br>Non-binary                           | I choose not to answer                    |            |
| 5. Which of the following best represents   |   |            |
| Lesbian or gay                              | I use a different term:                   |            |
| Straight, that is, not gay or lesbian       |   |            |
| Bisexual                                    | I choose not to answer                    |            |
| 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                          |   | 221177_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<br>the website or in the Provider Directory. It will be<br>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<br>Changes) are available online. You can accomputer, tablet or mobile phone.   | mmunications delivered electronically. We will send you example: Explanation of Benefits or the Annual Notice of cess these communications through any device such as a |
| If you would rather have hard copies of r   | 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  | ollowing:   |
| paying my Part B premium if I have on I understand that people with Medicar the country, except for limited coverage 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 so nor UnitedHealthcare will pay for benefits |   |
| Enrollee name   |   |
| Agent name/ID number<br>Y0066_ERFMA_2025_C  |   |

| <ul> <li>I understand that I can be enrolled in only or<br/>that enrollment in this plan will automatically<br/>apply for MA Private Fee-for-Service (PFFS),</li> </ul>  | end my enrollment in ano   | ther MA plan (exceptions   |  |
|--|--|--|--|
| <ul> <li>Release of information: By joining this Med will share my information with Medicare, who payments, and for other purposes allowed be information (see Privacy Act Statement belowed I give UnitedHealthcare permission to share or person(s) for permissible purposes under 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. However plan.</li> </ul> | o may use it to track my ency Federal law that authorized).  my protected health information applicable law as required best of my knowledge. It is form I will be disenrolled | rollment, to make e the collection of this mation with organizations d to administer my health understand that if I 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 proof behalf of the member beyond this application. At received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizate Signature of applicant/member/authorized representative information below (*Not a Sales Agent)   | of of this right, to the plan, ifter this application has be Customer Service at the rition information on file.  Presentative Today   | if I wish to take action on<br>en approved and I have<br>number on my<br>'s date   |  |
| Last name  | First name   |  |  |
| Address  |  |  |  |
| City   | State  | Zip code   |  |
| Phone number ( ) —   | Relationship to applicant  |  |  |
| Enrollee nameAgent name/ID number  |  |  |  |
| Y0066_ERFMA_2025_C   |  | AATX25LP0221177_000  |  |

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| For individuals helping enrollee with completing this form only |                         |                 |       |      |   |                      |
|---|-------------------------|-----------------|-------|------|---|----------------------|
| Complete this section   | if you're an individual | (i.e.           | ager  | nts  | , brokers, SHIP cou                     | unselors, family     |
| members, or other thir  | d parties) helping an e | enrol           | lee f | ill  | out this form.                          |                      |
| Name  |                         | Rel             | atio  | nsł  | nip to enrollee                         |                      |
| Signature   |                         | Nat             | tiona | ıl F | Producer Number (A                      | Agents/Brokers only) |
| For Licensed Sales  | s Representative/       | age             | ncv   | u    | se only                                 |                      |
| Licensed Sales represe  |                         |                 | •     |      | Initial receipt date                    |                      |
| Licensed Sales represe  | entative/agent name     |                 |       |      | Proposed effective                      | e date               |
| Employer group name   |                         |                 |       |      |   |                      |
| Employer group ID   |                         |                 |       | Ві   | ranch ID                                |                      |
| Agent must complete ☐ IEP (MA-PD                                |                         | 00)             |       |      | P (MA-PD                                | ☐ OEP (Jan 1 –       |
| enrollees)  | ☐ ICEP (MA enrolled     | <del>U</del> S) |       |      | ees eligible for                        | Mar 31)              |
| Crirolices)   |                         |                 |       |      | EP)                                     | Wai OT)              |
| ☐ OEP (Newly  | ☐ SEP (Dual LIS         |                 |       |      | P (Change in                            | ☐ SEP (Loss of       |
| eligible)   | change of status)       |                 |       |      | ` •                                     | EGHP coverage)       |
| ☐ SEP (Chronic)   | ☐ SEP (Dual LIS         |                 |       |      | P (October 15-                          | □ OEPI               |
| _ = (=: (=:::=)   | maintaining)            |                 |       |      | mber 7)                                 |                      |
|   | ···· <b>·</b>           |                 | _     |      | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                      |
|   |                         |                 |       |      |   |                      |
|   |                         |                 |       |      |   |                      |
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|   |                         |                 |       |      |   |                      |
|   |                         |                 |       |      |   |                      |
|   |                         |                 |       |      |   |                      |
|   |                         |                 |       |      |   |                      |
|   |                         |                 |       |      |   |                      |
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|   |                         |                 |       |      |   |                      |
|   |                         |                 |       |      |   |                      |
|   |                         |                 |       |      |   |                      |
|   |                         |                 |       |      |   |                      |
|   |                         |                 |       |      |   |                      |
| Enrollee name   |                         |                 |       |      |   |                      |
| Agent name/ID number  | •                       |                 |       |      |   |                      |

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| ☐ 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 from UHC TX-0007 (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.

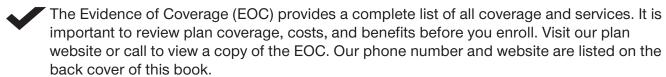
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

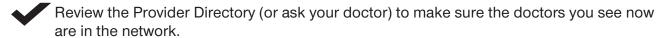
OMB No. 0938-1378 Expires: 6/30/2026 Y0066\_ERFMA\_2025\_C

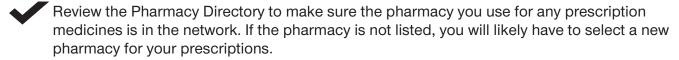
## **Enrollment checklist**

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

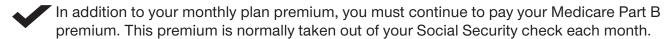




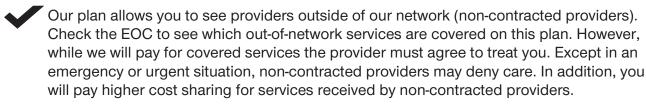


Review the Formulary to make sure your drugs are covered.

#### **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.