

plan

2025 Enrollment Request Form

□ AARP® Medicare Advantage Essentials from UHC UT-4 (HMO-POS) H4604-011-000 Select optional supplemental benefits in addition to what is included with your

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.

more information, including costs.					
☐ Platinum Dental Rider					
Information about you (Please	type or pri	nt in black or blue i	ık)		
Last name	First name		Mi	Middle initial	
Birth date	Sex □ Male □ Fen		nale	ale	
Home phone number ()	Mobile phone n		r () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		·	numbe	er(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be co	•				
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)		I			
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C			AAU	JT25HP0220752_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 your choice. You can't be denied coverage because you don't fill them out.				
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	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 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 Retiremen	t 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 u				
1. Would you prefer plan info				
	rmation in another language or Braille □ Large print □ Audi		•	
Enrollee name				
Agent name/ID number				
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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, or Chicano/a Yes, Puerto Rican				
Yes, Cuban	agnich grigin			
Yes, another Hispanic, Latino, or Sp	banish 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	Filipino Samoan			
Japanese	Japanese Other Pacific Islander			
Korean				
Vietnamese	White			
Other Asian	Other Asian I choose not to answer			
Member/Citizen of a federal or state 4. 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	how you think of yourself? Select one I use a different term:			
- ·	I doe'd different term I don't know			
Bisexual	I choose not to answer			
Discadai	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	AAUT25HP022	20752_000		

If yes, please complete the following:	
Name of health insurance company	
Member number	
7. Please give us the name of your primary care	e provider (PCP), clinic or health center.
You can find a list on the plan website or in the Pr	rovider Directory.
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
•	cations delivered electronically. We will send you e: Explanation of Benefits or the Annual Notice of ese communications through any device such as a
If you would rather have hard copies of require	d materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you have some communications are very large and may preference for delivery at any time.	nard 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 followin	g:
paying my Part B premium if I have one, unled I understand that people with Medicare are go the country, except for limited coverage near urgent care outside of the U.S. See the Summary 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. coverage begins, I must get all of my medical and care. Benefits and services authorized by dHealthcare "Evidence of Coverage" document iber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID numberY0066_ERFMA_2025_C	

 I understand that I can be enrolled in o that enrollment in this plan will automa apply for MA Private Fee-for-Service (P 	tically end my enrollme	nt in another MA plan (exceptions		
 plans). Release of information: By joining this will share my information with Medicar payments, and for other purposes allow information (see Privacy Act Statement I give UnitedHealthcare permission to sor person(s) for permissible purposes uplan. The information on this form is correct intentionally provide false information of My response to this form is voluntary. 	e, who may use it to trace wed by Federal law that t below). Share my protected hea under applicable law as to the best of my know on this form I will be dis-	ck my enrollment, to make authorize the collection of this alth information with organizations required to administer my health ledge. I understand that if I enrolled from the plan.		
plan.	,	•		
When I sign below, it means that I have re	ead and understand th	e information on this form		
show written proof (power of attorney, guar understand that I will need to submit writter behalf of the member beyond this applicati received my UnitedHealthcare UCard®, I ca UnitedHealthcare UCard to update my auth Signature of applicant/member/authorized	n proof of this right, to the on. After this application an call Customer Service norization information or ed representative	he plan, if I wish to take action on n has been approved and I have e at the number on my n file. Today's date		
If you are the authorized representation below (*Not a Sales Age		bove and complete the		
Last name	First name	First name		
Address	I			
City	State	Zip code		
Phone number () —	Relationship to	applicant		
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C		AAUT25HP0220752_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	U S)			ees eligible for	Mar 31)
Crirolices)					•	Wai OT)
☐ OEP (Newly	☐ SEP (Dual LIS			nd IEP) I SEP (Change in □ SEP (Loss of		
eligible)	change of status)		. •		EGHP coverage)	
☐ SEP (Chronic)	☐ SEP (Dual LIS				P (October 15-	□ OEPI
_ = (=: (=:::=)	maintaining)				mber 7)	
	···· ·		_		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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 for	rm 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	ge

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 Essentials from UHC UT-4 (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.

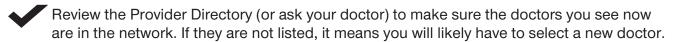
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

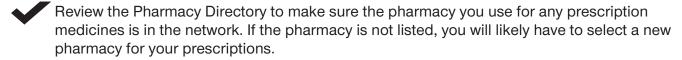
Enrollment checklist

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





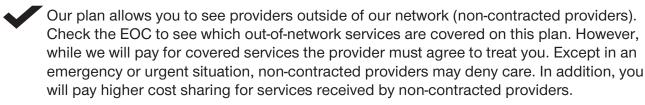




Understanding important rules







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.