

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC VA-0005 (PPO) H2001-097-000

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 bl	ue ink)		
Last name	First name			Middle initial	
Birth date		Sex □ Male □	Femal	e	
Home phone number ()	_	Mobile phone nu	ımber () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		•	one nur	mber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be co	•				
City	County	S	State	Zip code	
Mailing address (Only if it's different from above. You can give a P.O. box.)					
City		S	State	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C				AAVA25LP0221039_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 below, we'll send a bill each month to your mailing address.				
If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA),				
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 Retirement 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		AAV	'A25LP0221039_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		ı
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 prin	mary care provider (PCP), clinic or health center.
You aren't limited to this list. You may go payment terms. You can find a list on the plan website or	to any doctor who accepts Medicare and the plan's
	THE Provider Bilectory.
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 this provider?
an email when new communications (Fo	communications delivered electronically. We will send you or example: Explanation of Benefits or the Annual Notice of access these communications through any device such as a
	f required materials mailed to you, please check here:
	mail you hard copies of required materials. Please note that and may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the	following:
paying my Part B premium if I have I understand that people with Medic the country, except for limited cover urgent care outside of the U.S. See I understand that when my UnitedHe prescription drug benefits from Unit UnitedHealthcare and contained in (also known as a member contract of	and Medical (Part B) to stay in UnitedHealthcare. I must keep one, unless Medicaid or someone else pays for it. Care are generally not covered under Medicare while out of rage near the U.S. border. This plan covers emergency and the Summary of Benefits for more information. Ealthcare coverage begins, I must get all of my medical and edHealthcare. Benefits and services authorized by my UnitedHealthcare "Evidence of Coverage" document or subscriber agreement) will be covered. Neither Medicare enefits or services that are not covered.
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	AAVA25LP0221039_000

that enrollment in this plan will automatically	end my enrollment in ano	
apply for MA Private Fee-for-Service (PFFS), plans).	MA Medicare Medical Sav	vings Account (MSA)
 □ Release of information: By joining this Medwill share my information with Medicare, wh payments, and for other purposes allowed be information (see Privacy Act Statement below I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan. 	o may use it to track my er y Federal law that authoriz w). my protected health inforr	rollment, to make the collection of this mation with organizations
 The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. Howe plan. 	s form I will be disenrolled	from the plan.
When I sign below, it means that I have read a	nd understand the inform	nation on this form
understand that I will need to submit written produced behalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can cal	fter this application has be	en approved and I have
UnitedHealthcare UCard to update my authoriza Signature of applicant/member/authorized re	tion information on file. presentative Today	y's date
•	tion information on file. presentative Today	y's date
Signature of applicant/member/authorized re If you are the authorized representative	tion information on file. presentative Today	y's date
Signature of applicant/member/authorized re If you are the authorized representative information below (*Not a Sales Agent)	tion information on file. presentative Today , please sign above a	y's date
Signature of applicant/member/authorized relative information below (*Not a Sales Agent) Last name	tion information on file. presentative Today , please sign above a	y's date
If you are the authorized representative information below (*Not a Sales Agent) Last name Address	presentative Today please sign above an First name	y's date nd complete the Zip code
Signature of applicant/member/authorized relative information below (*Not a Sales Agent) Last name Address City	presentative Today please sign above and First name State Relationship to applicant	y's date nd complete the Zip code

For individuals hel	ping enrollee with	cor	npl	eting this form o	only
Complete this section	if you're an individual	(i.e. a	agen	its, brokers, SHIP co	ounselors, family
members, or other thir	•	•	_		, ,
Name	<u>- - </u>			ship to enrollee	
Name		1 1010	atioi	iship to chiolicc	
Cianatura		National Producer Number (Agents/Brokers only)			
Signature		Ival	iona	i Producer Number	(Agents/ brokers only)
				_	
For Licensed Sales	s Representative/	ageı	ncy	use only	
Licensed Sales repres	entative/Writing ID			Initial receipt dat	e
Licensed Color repres	antativa/agant nama			Duan and offer the state	
Licensed Sales repres	entative/agent name			Proposed effecti	ve date
Employer group name					
Employer group ID				Branch ID	
Employer group ib				Dianomid	
Agent must complete)				
☐ IEP (MA-PD	☐ ICEP (MA enrollee	es)		EP (MA-PD	□ OEP (Jan 1 -
enrollees)	,	,		ollees eligible for	Mar 31)
· · · · · · · · · · · · · · · · · · ·				l IEP)	
☐ OEP (Newly	☐ SEP (Dual LIS			SEP (Change in	☐ SEP (Loss of
eligible)	change of status)			idence)	EGHP coverage)
• ,	,			,	0 ,
☐ SEP (Chronic)	☐ SEP (Dual LIS			AEP (October 15-	□ OEPI
	maintaining)		Dec	cember 7)	
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C					
10000_ENFIVIA_2025_C					AAVA25LP0221039_000

☐ SEP (SEP reason)		
Licensed Sales representative signature (optional)	Date	
Please mail or fax this completed form	o:	
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 from UHC VA-0005 (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.

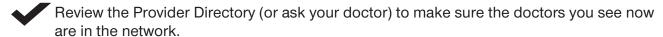
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

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





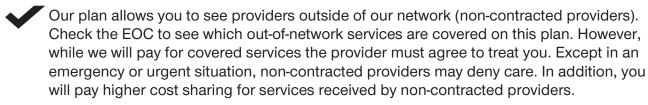


Review the Formulary to make sure your drugs are covered.

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.