

2025 Enrollment Request Form

☐ AARP® Medicare Advantage Extras from UHC WA-14 (HMO-POS) H3805-044-000

Information about you (Place	typo or pri	nt in black or b	luo ink)	
Last name	type or print in black or blue ink		Middle initial	
Birth date		Sex □ Male □	l Femal	е
Home phone number ()	_	Mobile phone number () —		
☐ 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		State	Zip code
Mailing address (Only if it's differen	t from above	e. You can give a	P.O. bo	x.)
City		5	State	Zip code
Email address (optional)		'		'
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C				AAWA25HP0220786 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 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☐ I want to pay from my Social	, ,			
. ,	•	nock		
☐ 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	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				

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 state4. 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	e, LTD coverage, Workers' Compensation,	ı
auto liability, or Veterans benefits)		☐ Yes ☐ No
Enrollee name		
Agent name/ID number		
Y0066_ERFMA_2025_C	AAWA25HP0	220786_000

If yes, please complete the following:	
Name of health insurance company	
Member number	
7. Please give us the name of your primary care	
You can find a list on the plan website or in the Pr	ovider Directory.
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	s provider? ☐ Yes ☐ No
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.	•
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 Sumn I understand that when my UnitedHealthcare prescription drug benefits from UnitedHealthc	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and nary of Benefits for more information. coverage begins, I must get all of my medical and care. Benefits and services authorized by dealthcare "Evidence of Coverage" document ber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	

 I understand that I can be enrolled in that enrollment in this plan will autom apply for MA Private Fee-for-Service (I 	atically end my enrollme	nt in another MA plan (exceptions
 plans). Release of information: By joining the will share my information with Medical payments, and for other purposes allowinformation (see Privacy Act Statement I give UnitedHealthcare permission to or person(s) for permissible purposes plan. The information on this form is correct intentionally provide false information. My response to this form is voluntary. 	are, who may use it to trace owed by Federal law that nt below). In share my protected hears under applicable law as not to the best of my know on this form I will be discontinuous.	ck my enrollment, to make authorize the collection of this lth information with organizations required to administer my health edge. I understand that if I enrolled from the plan.
plan.		
When I sign below, it means that I have	read and understand th	e information on this form
show written proof (power of attorney, gua understand that I will need to submit writte behalf of the member beyond this applica received my UnitedHealthcare UCard®, I of UnitedHealthcare UCard to update my aut Signature of applicant/member/authoria	en proof of this right, to the thin application. After this application can call Customer Service thorization information or zed representative	ne plan, if I wish to take action on has been approved and I have at the number on my n file. Today's date
If you are the authorized representation below (*Not a Sales Ag		pove and complete the
Last name	First name	
Address		
City	State	Zip code
Phone number () —	Relationship to	applicant
Enrollee name		
Enrollee nameAgent name/ID numberY0066_ERFMA_2025_C		

For individuals hel	ping enrollee with	or cor	mple	eting this form o	only
Complete this section	if you're an individual	(i.e. a	agen	ts, brokers, SHIP c	ounselors, family
members, or other thir	•	•	_		, ,
Name	<u>a. pa</u>			ship to enrollee	
Name		1101	atioi	iship to chiolicc	
Cianatura		Not	iono	I Dradua ar Nurah ar	(Agarta/Drakara anhi)
Signature		ivai	lona	i Producer Number	(Agents/Brokers only)
				_	
For Licensed Sales	s Representative/	age	ncy	use only	
Licensed Sales repres	entative/Writing ID			Initial receipt dat	te
Licensed Coles were				Duamas and affects	
Licensed Sales repres	entative/agent name			Proposed effecti	ve date
Employer group name					
. ,					
Employer group ID				Branch ID	
Employer group ID				Dianchid	
Agent must complete)				
☐ IEP (MA-PD	☐ ICEP (MA enrolle	es)	ПΙ	EP (MA-PD	□ OEP (Jan 1 -
enrollees)	L 1021 (W// Official)	00)		ollees eligible for	Mar 31)
emonees)				l IEP)	iviai 01)
C OED (Novely				,	
☐ OEP (Newly	☐ SEP (Dual LIS			SEP (Change in	☐ SEP (Loss of
eligible)	change of status)			dence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS			AEP (October 15-	☐ OEPI
	maintaining)		Dec	cember 7)	
Enrollee name					
Agent name/ID number					
Y0066_ERFMA_2025_C					AAWA25HP0220786_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 Extras from UHC WA-14 (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.

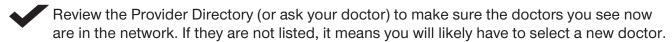
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

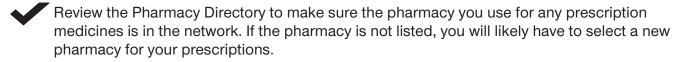
Enrollment checklist

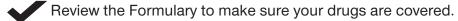
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





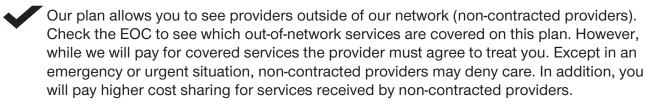




Understanding important rules







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.