

2025 Enrollment Request Form

 \square AARP® Medicare Advantage from UHC WA-0005 (HMO-POS) H3805-015-000

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 prii	nt in black or blu	ie ink)		
Last name	First name			Middle initial	
Birth date	Sex □ Male □ Fem		Female	ale	
Home phone number ()	_	Mobile phone nur	mber () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord		· ·	ne 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		ate	Zip code	
Mailing address (Only if it's different from above. You can give a P.O. box.)					
City		St	tate	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number					
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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 automation 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-Incom	e Related Monthly Adjustment	Amount (Part D-I	RMAA),	
Social Security (SS) will send y	ou a letter and ask you how yo	ou 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 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	s manage your plan			
1. Would you prefer plan info	rmation in another language	or an accessible	format?	
	rmation in another language of Braille			
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 Spa		
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.	recognized Tribe (name of Tribe)	
Woman	I use a different term:	
Man Non-binary	I choose not to answer	
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		
auto liability, or Veterans benefits)	s, 1.2 develage, tremele dempendation,	☐ 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 primary care	e provider (PCP), clinic or health center.
You can find a list on the plan website or in the P	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 thi	s provider? ☐ Yes ☐ No
Providing your email address above automatic your plan communications.	ally enrolls you in paperless delivery for some of
an email when new communications (For example	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 I 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 following	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 neadurgent care outside of the U.S. See the Sum 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 licare. Benefits and services authorized by dHealthcare "Evidence of Coverage" document liber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID numberY0066_ERFMA_2025_C	

 I understand that I can be enrolled in only of that enrollment in this plan will automaticall 	y end my enrollment in	another MA plan (exceptions	
apply for MA Private Fee-for-Service (PFFS) plans).	, MA Medicare Medica	al Savings Account (MSA)	
 Release of information: By joining this Me will share my information with Medicare, wh payments, and for other purposes allowed information (see Privacy Act Statement below I give UnitedHealthcare permission to share or person(s) for permissible purposes under plan. 	no may use it to track n by Federal law that aut ow). e my protected health i er applicable law as req	ny enrollment, to make horize the collection of this nformation with organizations quired to administer my health	
 The information on this form is correct to the intentionally provide false information on the My response to this form is voluntary. Howen plan. 	is form I will be disenro	olled from the plan.	
When I sign below, it means that I have read a	and understand the in	formation on this form	
understand that I will need to submit written probehalf of the member beyond this application. A received my UnitedHealthcare UCard®, I can caunitedHealthcare UCard to update my authorization. Signature of applicant/member/authorized received my authorized my authorized received my authorized my	After this application had all Customer Service at ation information on file epresentative	as been approved and I have the number on my e. Today's date	
If you are the authorized representative information below (*Not a Sales Agent)	e, please sign abov	e and complete the	
Last name	First name		
Address			
City	State	Zip code	
Phone number () —	Relationship to applicant		
Enrollee name			
Agent name/ID number		ΔΔWΔ25HP0220708 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 representative/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)					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				□ OEPI	
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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 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 from UHC WA-0005 (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.

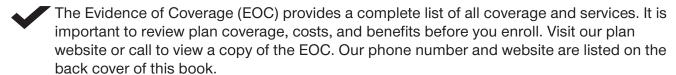
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

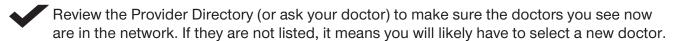
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

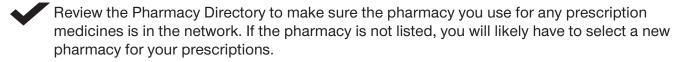
Enrollment checklist

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





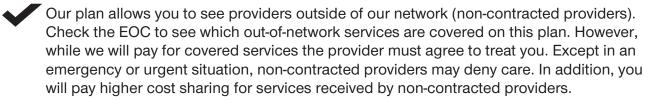




Understanding important rules







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.