

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC WI-0010 (HMO-POS) H5253-004-000

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Information about you (Please	type or pri	nt in black or t	olue ink)
Last name	First name			Middle initial
		I		
Birth date		Sex ☐ Male [☐ Femal	е
Home phone number ()	_	Mobile phone r	number (() –
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			hone nur	mber(s) I have provided
Medicare number				
Permanent residence street address	(Don't enter	a P.O. box. Not	e: For in	dividuals experiencing
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	a P.O. bo	ox.)
City			State	Zip code
Email address (optional)		I		
Enrollee name				
Enrollee nameAgent name/ID number				
Y0066_ERFMA_2025_C				AAWI25HP0220727_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				
		l	T	
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	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 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 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	• • •	or on opposible	format?	
1. Would you prefer plan info				
	rmation in another language or Braille		•	
Enrollee name				
Agent name/ID number				
Y0066_ERFMA_2025_C		AAW	/I25HP0220727_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 Spanish		
Yes, Mexican, Mexican American, o Yes, Puerto Rican	of Chicano/a	
Yes, Cuban	aniah aviain	
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	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		,
auto liability, or Veterans benefits)		☐ Yes ☐ No
Enrollee name		
Enrollee nameAgent 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 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?
Providing your email address above automatications.	ally enrolls you in paperless delivery for some of
You will get many of your required plan communications an email when new 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 Sumr 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 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 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 only of that enrollment in this plan will automatical 		• , , ,	
apply for MA Private Fee-for-Service (PFFS plans).), MA Medicare Me	edical Savings Account (MSA)	
 □ Release of information: By joining this Me will share my information with Medicare, w payments, and for other purposes allowed information (see Privacy Act Statement bel □ I give UnitedHealthcare permission to share 	ho may use it to tra by Federal law tha ow). e my protected hea	ack my enrollment, to make at authorize the collection of this alth information with organizations	
or person(s) for permissible purposes under plan.	er applicable law as	is required to administer my health	
The information on this form is correct to the intentionally provide false information on the intentional of the information on the intentional of the information on the intentional of the information on the information of the information	nis form I will be dis	senrolled from the plan.	
 My response to this form is voluntary. How plan. 	ever, railure to resp	pond may affect enrollment in the	
When I sign below, it means that I have read	and understand th	he information on this form	
behalf of the member beyond this application. received my UnitedHealthcare UCard®, I can cau UnitedHealthcare UCard to update my authorized Signature of applicant/member/authorized received my authorized my author	all Customer Service ation information of	ce at the number on my	
If you are the authorized representative information below (* Not a Sales Agent)	e, please sign a	above and complete the	
Last name	First name		
Address			
City	State	Zip code	
Phone number () —	Relationship to applicant		
	,		
Enrollee nameAgent name/ID number			

For individuals he	lping enrollee with	com	nple ¹	ting this form o	nly
Complete this section			-		-
•	rd parties) helping an e	•	_		•
Name	, , ,			hip to enrollee	
Signature		Natio	onal	Producer Number	(Agents/Brokers only)
For Licensed Sale	s Renresentative/	agen	CV I	ise only	
For Licensed Sales Representative/a Licensed Sales representative/Writing ID		agon	oy c	Initial receipt date	е
Licensed Sales repres	sentative/agent name			Proposed effective date	
Employer group name)				
Employer group ID			Е	ranch ID	
Agent must complete	9		•		
☐ IEP (MA-PD	☐ ICEP (MA enrolle	es) l	□ IE	P (MA-PD	□ OEP (Jan 1 -
enrollees)		(enro	llees eligible for	Mar 31)
			2nd	,	
☐ OEP (Newly	☐ SEP (Dual LIS			EP (Change in	☐ SEP (Loss of
eligible)	change of status)			ence)	EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS			EP (October 15-	□ OEPI
	maintaining)		Dece	ember 7)	
Enrollee name					
Agent name/ID numbe					<u>-</u>
Y0066_ERFMA_2025_C					AAWI25HP0220727_000

☐ SEP (SEP reason)	-
Licensed Sales representative signature (optional)	Date
Please mail or fax this completed fo	rm to:
UnitedHealthcare	
P.O. Box 30770	
Salt Lake City, UT 84130-0770	
Fax: 1-888-950-1170	
Fay the front and back of each na	α _Φ

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 WI-0010 (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.

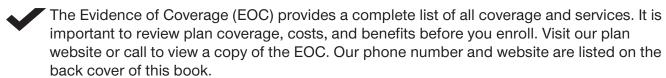
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

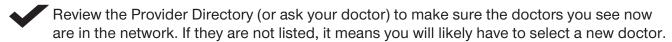
OMB No. 0938-1378 Expires: 6/30/2026 Y0066 ERFMA 2025 C

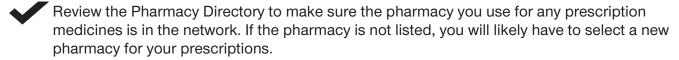
Enrollment checklist

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

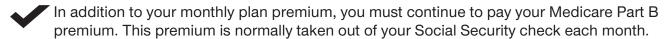


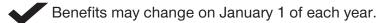


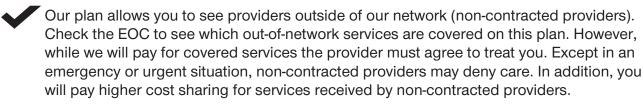


Review the Formulary to make sure your drugs are covered.

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.