

2025 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC WI-0009 (PPO) H0294-026-000

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 blue	ink)		
Last name	First name			Middle initial	
Birth date		Sex □ Male □ Fe	emal	Э	
Home phone number ()	_	Mobile phone numb	oer () —	
☐ I give consent for UnitedHealthcare using an autodialer and/or prerecord			e nur	nber(s) I have provided	
Medicare number					
Permanent residence street address homelessness, a PO Box may be co	•				
City	County	Stat	е	Zip code	
Mailing address (Only if it's different from above. You can give a P.O. box.)					
City		Stat	е	Zip code	
Email address (optional)					
Enrollee name					
Agent name/ID number Y0066_ERFMA_2025_C				AAWI25LP0221383_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 y	ou a letter and ask you how yo	u want to pay it:	
☐ You can pay it from you	r 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 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 Large print Audi		•
Enrollee name			
Agent name/ID number			
Y0066_ERFMA_2025_C		AAV	VI25LP0221383_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 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	
5. Which of the following best represents	how you think of yourself? Select one.	
Lesbian or gay	I use a different term:	
Straight, that is, not gay or lesbian	I don't know	
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 ca	re provider (PCP), clinic or health center.
You aren't limited to this list. You may go to any payment terms. You can find a list on the plan website or in the F	
Provider or PCP full name	Toward Billocioly.
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 th	nis provider?
an email when new communications (For examp	nications delivered electronically. We will send you ble: Explanation of Benefits or the Annual Notice of hese communications through any device such as a
If you would rather have hard copies of requir	ed materials mailed to you, please check here:
	hard copies of required materials. Please note that y not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the followi	ng:
paying my Part B premium if I have one, un I understand that people with Medicare are the country, except for limited coverage nea urgent care outside of the U.S. See the Sun I understand that when my UnitedHealthcar prescription drug benefits from UnitedHealt UnitedHealthcare and contained in my Unite	generally not covered under Medicare while out of ar the U.S. border. This plan covers emergency and nmary of Benefits for more information. The coverage begins, I must get all of my medical and theare. Benefits and services authorized by edHealthcare "Evidence of Coverage" document criber agreement) will be covered. Neither Medicare
Enrollee name	
Agent name/ID number Y0066_ERFMA_2025_C	AAWI25LP0221383_000

 I understand that I can be enrolled in or that enrollment in this plan will automat apply for MA Private Fee-for-Service (PF 	ically end my enrollmer	nt in another MA plan (exceptions
 plans). Release of information: By joining this will share my information with Medicare 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. He plan. 	e, who may use it to trace wed by Federal law that below). The below protected heal ander applicable law as to the best of my knowled this form I will be discontinuous.	ck my enrollment, to make authorize the collection of this th information with organizations required to administer my health edge. I understand that if I enrolled from the plan.
When I sign below, it means that I have re	ad and understand the	o information on this form
show written proof (power of attorney, guard understand that I will need to submit written behalf of the member beyond this application received my UnitedHealthcare UCard®, I can UnitedHealthcare UCard to update my authorized Signature of applicant/member/authorized If you are the authorized representation.	proof of this right, to the proof of this right, to the proof of this application in call Customer Service orization information or ed representative	ne plan, if I wish to take action on has been approved and I have at the number on my file. Today's date
information below (*Not a Sales Age Last name	First name	
Address		
City	State	Zip code
Phone number () —	Relationship to	applicant
Enrollee name		
Agent name/ID number Y0066_ERFMA_2025_C		 AAWI25LP0221383_000
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For individuals help	ping enrollee with	com	plet	ing this form on	ly
Complete this section i	_		_	_	_
members, or other third	•		_		
Name				hip to enrollee	
Signature		Natio	onal F	Producer Number (A	Agents/Brokers only)
For Licensed Sales	Representative/a	agen	cv u	se only	
Licensed Sales representative/Writing ID				Initial receipt date	
Licensed Sales representative/agent name				Proposed effective	e date
Employer group name					
Employer group ID			В	ranch ID	
Agent must complete ☐ IEP (MA-PD enrollees) ☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ ICEP (MA enrolled ☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	, , , , , , , , , , , , , , , , , , ,	enrol 2nd I □ SE resid □ AE	P (MA-PD lees eligible for EP) EP (Change in ence) EP (October 15- mber 7)	☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI
Enrollee name					

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□ SEP (SEP reason)			
Licensed Sales representative signature (optional)	Date		
Please mail or fax this completed form	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			

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-0009 (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.

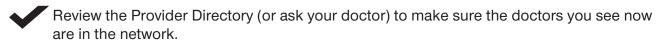
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

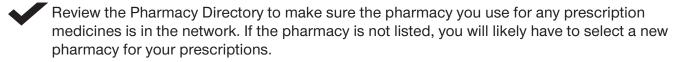
Enrollment checklist

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



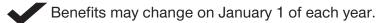


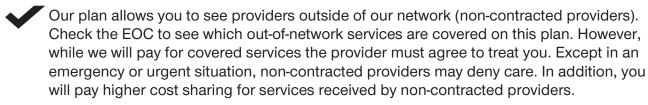


Review the Formulary to make sure your drugs are covered.

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.