AARP® | Medicare Rx from UnitedHealthcare®

2025 Enrollment Request Form

☐ **AARP® Medicare Rx Preferred from UHC (PDP)**

Information about you (Please type or print in black or blue ink)

Last name	First name	Middle initial

Birth date	Sex ☐ Male ☐ Female
Home phone number ( ) —	Mobile phone number ( ) —

☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology.

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	State	Zip code

Mailing address **(Only if it's different from above. You can give a P.O. box.)**

City	State	Zip code

Email address (optional)

Do you have other insurance that will cover your prescription drugs? ☐ Yes ☐ No
(Examples: Other private insurance, TRICARE, federal employee coverage, VA benefits or state programs.)
If **yes**, what is it?

Name of other insurance

Member number	Group number	RxBin	RxPCN (optional)

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Enrollee name _____

How do you want to pay?

If you have a monthly plan premium (including any late enrollment penalty you may owe), you can pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT).

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 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 us manage your plan

1. Would you prefer plan information in another language or an accessible format?

If you would prefer plan information in another language or accessible format, please check what you'd like: ☐ Spanish ☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

If you don't see the language or format you want, please call UnitedHealthcare toll-free at **1-800-753-8004**, 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 origin? Select all that apply.

____ No, not of Hispanic, Latino/a, or Spanish origin
____ Yes, Mexican, Mexican American, or Chicano/a
____ Yes, Puerto Rican
____ Yes, Cuban
____ Yes, another Hispanic, Latino, or Spanish 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:
____ Asian Indian
____ Chinese
____ Filipino
____ Japanese
____ Korean
____ Vietnamese
____ Other Asian

Native Hawaiian or Pacific Islander:
____ Guamanian or Chamorro
____ Native Hawaiian
____ Samoan
____ Other Pacific Islander

____ White
____ **I choose not to answer**

____ Member/Citizen of a federal or state recognized Tribe (name of Tribe)_____

4. What is your gender? Select one.

_____ Woman
_____ Man
_____ Non-binary
_____ I use a different term: _____
_____ **I choose not to answer**

5. Which of the following best represents how you think of yourself? Select one.

_____ Lesbian or gay
_____ Straight, that is, not gay or lesbian
_____ Bisexual
_____ I use a different term: _____
_____ I don't know
_____ **I choose not to answer**

6. Do you or your spouse work? ☐ Yes ☐ No

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone.

If you would rather have hard copies of required materials mailed to you, please check here:

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Please read and sign

By completing this form, I agree to the following:

Enrollee name _____

- ☐ I must keep Hospital (Part A) or Medical Part B (or both) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- ☐ I understand that I am joining the plan for the entire calendar year. If I want to change plans, I'll need to do so between October 15 and December 7. This is the Annual Enrollment Period for Medicare Advantage **and** Medicare prescription drug coverage. I understand that there may be special situations at other times during the year in which I can leave the plan.
- ☐ I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information.
- ☐ I understand that when my UnitedHealthcare coverage begins, I must get all of my prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.
- ☐ I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- ☐ **Release of information:** By joining this Medicare Prescription Drug Plan, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- ☐ I give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health plan.
- ☐ I give consent for all entities under UnitedHealthcare and its affiliates and any outside vendor used by UnitedHealthcare to call the phone number(s) I have provided using an autodialer and/or prerecorded voice.
- ☐ The information on this form is correct, to the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan.
- ☐ My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

When I sign below, it means that I have read and understand the information on this form

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare member ID card, I can call Customer Service at the number on my UnitedHealthcare member ID card to update my authorization information on file.

Signature of Applicant/Member/Authorized Representative **Today's date**

If you are the authorized representative, please sign above and complete the

Enrollee name _____

information below (*Not a Sales Agent)

Last name	First name	
Address		
City	State	Zip code
Phone number ( ) —	Relationship to applicant	

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name	Relationship to enrollee
Signature	National Producer Number (Agents/Brokers only)

For sales representative/agency use only

Sales representative/Writing ID	Initial receipt date
Sales representative/agent name	Proposed effective date
Employer group name	
Employer group ID	Branch ID

Agent must complete

☐ IEP	☐ IEP 2	☐ SEP (Institutional)
☐ SEP (GEP Part B)	☐ SEP (Change in residence)	☐ SEP (Loss of EGHP coverage)
☐ SEP (PDP/OEP)	☐ SEP (CMS/State Assignment)	☐ SEP (Dual LIS change of status)
☐ SEP (Dual LIS maintaining)	☐ AEP (October 15 – December 7)	

☐ SEP (SEP reason) _____

Sales representative signature (optional) **Date**

Enrollee name _____

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 Rx Preferred from UHC (PDP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. 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 or pharmacy 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: 06/30/2026

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 Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ✔ Review the Formulary to make sure your drugs are covered.

Understanding important rules

- ✔ Benefits, premiums and/or copays/coinsurance may change on January 1 of each year.
- ✔ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medicaid or another third party. This premium is normally taken out of your Social Security check each month.
- ✔ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare 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.