



2027 Enrollment Request Form

☐ **AARP® Medicare Rx Saver 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 () —

Stay on top of your plan and health with timely, helpful texts and calls. You can change your preferences at any time.

Check here to consent to receive texts from UnitedHealthcare at the mobile phone number you provided about:

- ☐ Important benefit information to help you manage your plan
- ☐ Reminders about preventive care or health screenings

You also agree to the texting terms and conditions at **uhc.com/txt-tcs**. Message frequency varies. Message and data rates may apply. Text STOP to opt out of a texting program.

- ☐ Check here to consent to receive calls from UnitedHealthcare and its affiliates at the phone number(s) you provided. This includes calls made using an autodialer or an artificial prerecorded voice.

Medicare number

Permanent residence street address (**Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address**)

City	County	State	Zip code
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Mailing address (**Only if it's different from above. You can give a P.O. Box.**)

City	State	Zip code
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Email address

You will receive some plan information, such as your Explanation of Benefits and Annual Notice of Changes, electronically (quicker than mail). We'll email you when new documents are ready to review

Enrollee name _____

online.

☐ Check here if you prefer to receive paper copies by mail. You can change your delivery preference at any time.

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

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 ____/____/____/____/____/____/____/____/____/____

*Members enrolled in the EFT program agree to these terms: My bank may pay UnitedHealthcare Insurance Company the new charges from my bank Account which may include up to \$200.00 of current retroactive charges plus monthly premium amount. If I choose to stop paying by EFT, I will tell both UHC and my bank. I understand it could take 1-2 months to process the change.

Enrollee name _____

A few questions to help us manage your plan

1. Which language or accessible format do you prefer for future plan information?

- ☐ English ☐ 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 **1-855-284-7089**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **AARPMedicarePlans.com** for online help. **If no selection is made, you will receive plan information in English.**

2. Have you served in the U.S. military?

☐ Yes ☐ No

3. If yes, have you received care or services from a VA hospital or clinic?

☐ Yes ☐ No

4. Do you or your spouse work?

☐ Yes ☐ No

Do you or your spouse have other health insurance that will cover medical services? (Examples: Other employer group coverage, LTD coverage, Workers' Compensation, Auto Liability, or Veterans benefits)

☐ Yes ☐ No

If yes, please complete the following:

Name of other health insurance company

Member number for other health insurance

Payer ID for other health insurance

Do you give us permission to request and share your health information with the other health insurance company you listed above?

☐ Yes ☐ No

If yes, we'll request your records and share them with your other plan to keep your medical records complete and help support your care. You can opt out at any time on your member site or by calling Customer Service.

5. Do you give us permission to request your health information from your previous health insurance company?

☐ Yes ☐ No

If yes, we'll request your records from your previous plan to keep your medical records complete and help support your care. You can opt out at any time on your member site or by calling Customer Service.

If yes, please complete the following:

Name of previous health insurance company

Member number for previous health insurance company

Payer ID for previous health insurance company

Enrollee name _____

6. Do you give us permission to share your health information with your network providers?

☐ Yes ☐ No

If yes, we'll share your health information with your network providers so they can work together on your care. If no, your provider may still access some information as allowed by law to make sure you get the right care. You can change your preference at any time on your member site or by calling Customer Service. If you don't make a selection now, we'll automatically share your information with your network providers.

Please read and sign

By completing this form, I agree to the following:

- 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

Enrollee name _____

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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 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, please select a qualifying election period for this enrollment

Enrollee name _____

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- | | | |
|--|---|--|
| ☐ 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 (Integrated Care) | ☐ AEP (Oct 15 – Dec 7) | |
- ☐ SEP (SEP reason) _____

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 Rx Saver 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.

OMB No. 0938-1378

Expires: 02/28/2029

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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.

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 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.