

2024 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC IA-0002 (HMO-POS) H5253-108-002 - B7L

Information about y	ou (Pleas	e type or print in	black or bl	ue ink)		
Last name		First name			Mid	dle initial
Birth date	Birth date		Sex ☐ Male ☐ Female			
Home phone number ()	-	Mobile phone number () -			
Medicare number						
Permanent residence str	reet addre	ss (P.O. box is r	not allowed)		
City	Co	ounty		State		ZIP code
Mailing address (Only if	it's differ	ent from above.	You can gi	ve a P.O. b	oox.)	
City				State		ZIP code
Email address (optional)						
Do you have other insura	ance that	will cover your	prescriptio	n drugs?		☐ Yes ☐ No
(Examples: Other private programs.)	insurance	, TRICARE, fede	ral employe	e coverage	e, VA	benefits or state
If yes, what is it? Name of other insurance)					
Member number	Gı	roup number		RxBin		RxPCN (optional)
Answering these question them out.	ns is your o	choice. You can'	t be denied	coverage I	oecai	use you don't fill
How do you want to	pay?					
Enrollee name						
Agent name/ID number _						
Y0066_ERFMA_2024_C						AAEX24HP0134287_0

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? ☐ Yes ☐ No Please check what you'd like: ☐ Spanish ☐ Braille ☐ Other____ 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 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 Enrollee name ___

Agent name/ID number ___ Y0066_ERFMA_2024_C

3. What's your race? Select all that apply.		
	ck or African American	
American Indian or Alaska Native		
Asian Indian Chir		Filipino
Japanese Kore		Vietnamese
	ive Hawaiian	Samoan
Guamanian or Chamorro Other	er Pacific Islander	
Member/Citizen of a federal or state	recognized Tribe (nam	e of Tribe)
Moniboly diazon of a loadial of diaco	, 1000gm200 11150 (nam	0 01 11100/
4. Do you or your spouse work?		☐ Yes ☐ No
Do you or your spouse have other health ins	surance that will cover n	nedical services?
(Examples: Other employer group coverage	, LTD coverage, Worker	rs' Compensation,
auto liability, or Veterans benefits)		☐ Yes ☐ No
If yes, please complete the following:		
Name of health insurance company		_
Member number		
You can find a list on the plan website or in Provider or PCP full name	the Provider Directory.	
Provider/PCP number:	•	umber exactly as it appears
		n the Provider Directory. It will
Are you now seeing or have you recently see		Don't include dashes.) ∕es □ No
Providing your email address above automa your plan communications.	atically enrolls you in p	aperless delivery for some of
You will get many of your required plan commemail when new communications (For example Changes) are available online. You can access computer, tablet, or mobile phone.	le: Explanation of Benef	its or the Annual Notice of
If you would rather have hard copies of requ	uired materials mailed	to you, please check here:
☐ Instead of paperless delivery, we will mail you		
some communications are very large and meregerence for delivery at any time.	·	
Enrollee name		
Agent name/ID number		
Y0066_ERFMA_2024_C		AAEX24HP0134287_000

Please read and sign

By completing this form, I agree to the following:

, demploting the form, ragice to the following.
□ I must keep both Hospital (Part A) and Medical (Part B) 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 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 medical an 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 Medicare Advantage (MA) plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private-Fee-For-Service (PFFS), MA Medicare Medical Savings
Account (MSA) plans).
 □ Release of information: By joining this Medicare Advantage 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.
hen I sign below, it means that I have read and understand the information on this form
sign as an authorized representative, it means I have the legal right under state law to sign. I car

WI

If I 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 UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file.

Enrollee name	
Agent name/ID number	
,	

Signature of applicant/member/authorized representative Today's date

ative, please sign abo	ove and complete t
First name	
State	ZIP code
Relationship to ap	oplicant
	First name State

For Licensed Sales	Representative/age	ency use only	7			
Licensed Sales Representative/writing ID			Initial receipt date			
Licensed Sales Representative/agent name				Proposed effective date		
Employer group name						
Employer group ID		Branch II				
Agent must complete						
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PD enrollees eligi 2nd IEP)		☐ OEP (Jan 1 - Mar 31)		
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS	☐ SEP (Chang residence) ☐ AEP (Octob		☐ SEP (Loss of EGHP coverage) ☐ OEPI		
☐ SEP (SEP reason)	maintaining)	December 7)				
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

Enrollee name	
Agent name/ID number	
Y0066_ERFMA_2024_C	

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 IA-0002 (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.

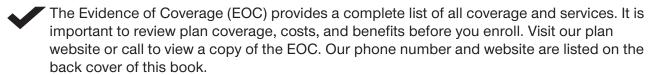
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

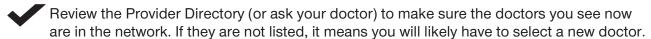
OMB No. 0938-1378 Expires: 7/31/2024 Y0066 ERFMA 2024 C

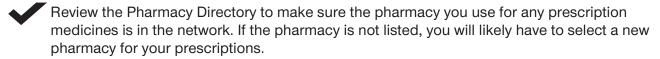
Enrollment checklist

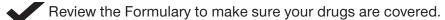
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits









Understanding important rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits may change on January 1 of each year.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay higher cost sharing for services received by non-contracted providers.
- 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.