AAEX24LP0134405_000



Y0066_ERFMA_2024_C

2024 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC IA-0003 (PPO) H8768-017-002 - B7M 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 print in black or blue ink) Last name First name Middle initial Birth date Sex ☐ Male ☐ Female Home phone number () Mobile phone number (Medicare number Permanent residence street address (P.O. box is not allowed) County State ZIP code City Mailing address (Only if it's different from above. You can give a P.O. box.) ZIP code State City Email address (optional) Enrollee name _ Agent name/ID number _

Member number				
Answering these questions is your choice. You can't be denied coverage because you don't them out. How do you want to pay? If you have a monthly plan premium (including any late enrollment penalty you may owe) yo pay your premium by automatic deduction from your Social Security or Railroad Retiremen 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), Soci 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	Member number			
How do you want to pay? If you have a monthly plan premium (including any late enrollment penalty you may owe) yo pay your premium by automatic deduction from your Social Security or Railroad Retiremen 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), Soci 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		Group number	RxBin	RxPCN (optional)
If you have a monthly plan premium (including any late enrollment penalty you may owe) yo 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), Soci 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	•	s your choice. You can't b	e denied covera	ge because you don't fill
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), Soci 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	How do you want to pa	ay?		
If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), Soci 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	pay your premium by autor Board (RRB) benefit check	natic deduction from your each month. You can also	Social Security	or Railroad Retirement
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	If you don't choose an option	on below, we'll send a bill	each month to y	our mailing address.
 □ 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 				
☐ 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	☐ You can pay it from	your SS check		
☐ 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	☐ Medicare can bill yo	u		
☐ I want to pay from my Railroad Retirement Board (RRB) check ☐ I want to pay directly from a bank account	☐ The Railroad Retirer	ment Board (RRB) can bill	you	
☐ I want to pay directly from a bank account	☐ I want to pay from my Sc	ocial Security check		
	☐ I want to pay from my Ra	ailroad Retirement Board (RRB) check	
Account type □ Checking □ Savings	☐ I want to pay directly from	m a bank account		
Account holder name:	• •	•		
Bank routing number///				
Bank account number//////				

Agent name/ID number _ Y0066_ERFMA_2024_C

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.m8 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.
White Black or African American
American Indian or Alaska Native
Asian Indian Chinese Filipino
Japanese Korean Vietnamese
Other Asian Native Hawaiian Samoan
Guamanian or Chamorro Other Pacific Islander
I choose not to answer Member/Citizen of a federal or state recognized Tribe (name of Tribe)
INTERTIDELY CITIZENT OF A TECHNIC OF STATE TECOGNIZED TITIDE (HAITIE OF TITIDE)
4. Do you or your spouse work?
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 health insurance company
Member number
Enrollee name
Agent name/ID number

5. Please give us the name of your primary c	are provider (PCP), clinic or health center.
You aren't limited to this list. You may go to	any doctor who accepts Medicare and the plan's payment
terms.	
You can find a list on the plan website or in t	the Provider 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 see	
Providing your email address above automat your plan communications.	cically enrolls you in paperless delivery for some of
email when new communications (For example	unications delivered electronically. We will send you an e: Explanation of Benefits or the Annual Notice of these communications through any device such as a
If you would rather have hard copies of requ	ired materials mailed to you, please check here:
	ou hard copies of required materials. Please note that ay not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the follow	ving:
keep paying my Part B premium if I have on I understand that people with Medicare are the country, except for limited coverage neargent care outside of the U.S. See the Surface I understand that when my UnitedHealthca prescription drug benefits from UnitedHealthcare unitedHealthcare and contained in my UnitedHealthcare and contained in my UnitedHealthcare will pay for benefits on I understand that I can be enrolled in only that enrollment in this plan will automatical	are coverage begins, I must get all of my medical and althcare. Benefits and services authorized by itedHealthcare "Evidence of Coverage" document scriber agreement) will be covered. Neither Medicare or services that are not covered. one Medicare Advantage (MA) plan at a time – and
Enrollee nameAgent name/ID number	

Y0066_ERFMA_2024_C

 □ Release of information: By joining this Medical will share my information with Medicare, who me payments, and for other purposes allowed by Finformation (see Privacy Act Statement below). □ I give UnitedHealthcare permission to share my organizations or person(s) for permissible purposed administer my health plan. □ I give consent for all entities under UnitedHealth used by UnitedHealthcare to call the phone numerically provided false information on this formation on this formation. 	nay use it to track my enrogenay use it to track my enrogenation for the desired health informations and its affiliates and its	Ilment, to make the collection of this tion with as required to I any outside vendor sing an autodialer derstand that if I om the plan.
My response to this form is voluntary. However plan.	, laliure to respond may al	rect emoliment in the
When I sign below, it means that I have read and	understand the informat	ion on this form
If I sign as an authorized representative, it means I is show written proof (power of attorney, guardianship understand that I will need to submit written proof of behalf of the member beyond this application. After received my UnitedHealthcare UCard®, I can call Cu UnitedHealthcare UCard to update my authorization	o, etc.) of this right if Medic of this right, to the plan, if I this application has been ustomer Service at the nur	care asks for it. I wish to take action on approved and I have
Signature of applicant/member/authorized repre	esentative Today's date	
If you are the authorized representative, information below	please sign above an	d complete the
*Not a Sales Agent		
Last name	First name	
Address		
City	State	ZIP code
Phone number () –	Relationship to applicant	
Enrollee name		
Agent name/ID number Y0066_ERFMA_2024_C		AAEX24LP0134405_000

For Licensed Sales	Representative/age	ncy use only	7	
Licensed Sales Representative/writing ID			Initial receipt date	
Licensed Sales Represe	entative/agent name		Proposed	d 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 (Dual LIS change of status)	☐ SEP (Change in residence)		☐ SEP (Loss of EGHP coverage)
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)	☐ AEP (October 15- December 7)		□ OEPI
☐ SEP (SEP reason)				
Licensed Sales Repre	sentative signature (opt	ional)	Da	te

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-0003 (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.

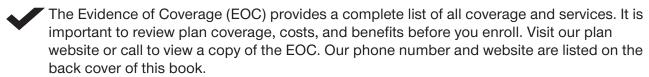
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

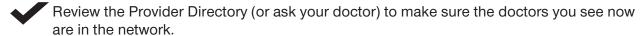
OMB No. 0938-1378 Expires: 7/31/2024 Y0066 ERFMA 2024 C

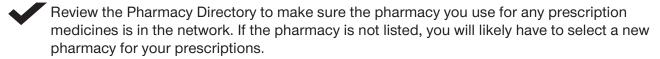
Enrollment checklist

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







Review the Formulary to make sure your drugs are covered.

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.