

<b>2024 Enrollment R€</b> □ AARP® Medicare Advantage	-		2 032 00	10 B	7N
Select optional suppleme		` '			
You can add the following beneare enrolling, or within 3 month information, including costs.  □ Platinum Dental Rider			•		•
Information about you (Ple	ease type or print in	black or blue	ink)		
Last name	First name			Mido	dle initial
Birth date	·	Sex □ Male	e □ Fer	nale	
Home phone number ( )	-	Mobile phon	e numbe	er (	) -
Medicare number					
Permanent residence street add	dress (P.O. box is n	ot allowed)			
City	County		State		ZIP code
Mailing address (Only if it's diff	ferent from above.	You can give	a P.O. b	ox.)	
City			State		ZIP code
Email address (optional)			<u> </u>		
Enrollee name					
Agent name/ID number Y0066_ERFMA_2024_C					

(Examples: Other private insurar programs.)	ice, TRICARE, federal employ	ee coverage, VA	benefits or state
If yes, what is it?  Name of other insurance			
Member number	Group number	RxBin	RxPCN (optional)
Answering these questions is yo them out.	ur choice. You can't be denie	d coverage beca	use you don't fill
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	c deduction from your Social s	Security or Railro	oad Retirement
If you don't choose an option b	elow, we'll send a bill each m	onth to your mai	ling address.
If you must pay a Part D-Incom Security (SS) will send you a le	• •	•	)-IRMAA), Social
☐ 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) c	heck	
$\square$ I want to pay directly from a	bank account		
Account type  Checking	<u> </u>		
Bank routing number/_			<del></del>
Bank account number/_			
Enrollee name			

# A few questions to help us manage your plan

1. Would you prefer plan information	n in another language or an a	accessible format?□ Yes □ No
Please check what you'd like: ☐ Sp	anish □ Braille □ Other	
If you don't see the language or form 1-844-723-6473, TTY 711, 8 a.m8 AARPMedicarePlans.com for online	3 p.m. local time, 7 days a wee	
2. Are you Hispanic, Latino/a, or Spa  No, not of Hispanic, Latino/a  Yes, Mexican, Mexican Ame  Yes, Puerto Rican  Yes, Cuban  Yes, another Hispanic, Latino I choose not to answer	a, or Spanish origin rican, or Chicano/a	pply.
American Indian or Alaska N Asian Indian Japanese	Black or African American ative Chinese Korean	Filipino Vietnamese
Guamanian or Chamorro I choose not to answer	Native Hawaiian Other Pacific Islander or state recognized Tribe (nar	Samoan me of Tribe)
4. Do you or your spouse work?		☐ Yes ☐ No
Do you or your spouse have other he (Examples: Other employer group cauto liability, or Veterans benefits)  If yes, please complete the following	overage, LTD coverage, Work	
Name of health insurance company	1	
Member number		
Enrollee name		
Agent name/ID number Y0066_ERFMA_2024_C		AAEX24LP0134419_000

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	5. Please give us the name of your primary ca	re provider (PCP), clinic or health center.
Provider or PCP full name  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 seen this provider?   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:   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 and 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. Neither Medicare nor U	You aren't limited to this list. You may go to a	ny doctor who accepts Medicare and the plan's payment
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 seen this provider?   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:  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 and prescription drug benefits from UnitedHealthcare 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 Adva		D : 1 D: 1
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<ul> <li>□ Release of information: By joining this Medical will share my information with Medicare, who repayments, and for other purposes allowed by Finformation (see Privacy Act Statement below).</li> <li>□ I give UnitedHealthcare permission to share my organizations or person(s) for permissible purposed administer my health plan.</li> <li>□ I give consent for all entities under UnitedHealth used by UnitedHealthcare to call the phone nuted and/or prerecorded voice.</li> <li>□ The information on this form is correct to the beintentionally provide false information on this form.</li> </ul>	nay use it to track my enrogenay use it to track my enrogenation for the desired law that authorize the provided use the prov	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.	r, failure to respond may at	fect enrollment 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 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 UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file.			
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 numberY0066_ERFMA_2024_C		AAEX24LP0134419_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 (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS	☐ SEP (Chang residence) ☐ AEP (Octob		☐ SEP (Loss of EGHP coverage) ☐ OEPI
,	maintaining)	December 7)	Jei 13-	
☐ 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

Enroll	ee name	
	name/ID number	
•	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-0004 (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.

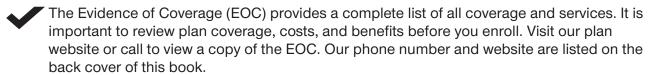
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

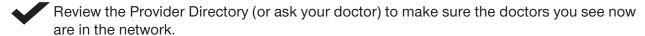
OMB No. 0938-1378 Expires: 7/31/2024 Y0066 ERFMA 2024 C

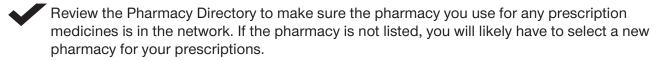
## **Enrollment checklist**

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.