

2024 Enrollment Request Form

☐ AARP® Medicare Advantage from UHC MI-0008 (PPO) H0294-028-000 - BB0

Information about y	/ou (Please	e type or print in	black or blu	ue ink)			
Last name		First name			Middl	liddle initial	
Birth date			Sex ☐ Male ☐ Female				
Home phone number () -			Mobile phone number () -				
Medicare number							
Permanent residence st	reet addres	ss (P.O. box is n	ot allowed)				
City	County			State		ZIP code	
Mailing address (Only if	it's differe	ent from above.	You can giv	ve a P.O. I	oox.)		
City			State			ZIP code	
Email address (optional)						
Do you have other insur	ance that	will cover your _l	orescription	drugs?		☐ Yes ☐ No	
(Examples: Other private programs.) If yes, what is it?	insurance,	TRICARE, fede	ral employee	e coverage	e, VA b	enefits or state	
Name of other insurance	9						
Member number	Gr	Group number		RxBin		xPCN (optional)	
Answering these questio them out.	ns is your c	choice. You can'	t be denied	coverage	oecaus	e you don't fill	
How do you want to	pay?						
Enrollee name							
Agent name/ID number _ Y0066 ERFMA 2024 C						.AMI24LP0133648 00	

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

ack or African American
ninese Filipino
orean Vietnamese
ative Hawaiian Samoan
ther Pacific Islander
As we are surfaced Tables (or one of Tables)
te recognized Tribe (name of Tribe)
□ Yes □ No
nsurance that will cover medical services?
ge, LTD coverage, Workers' Compensation,
☐ Yes ☐ No
in the Provider Directory.
in the Provider Directory.
(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.) seen this provider?
(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.)
(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.) seen this provider? ☐ Yes ☐ No
(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.) seen this provider? ☐ Yes ☐ No natically enrolls you in paperless delivery for some of munications delivered electronically. We will send you are ple: Explanation of Benefits or the Annual Notice of
(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.) seen this provider? Yes No natically enrolls you in paperless delivery for some of amunications delivered electronically. We will send you are aple: Explanation of Benefits or the Annual Notice of ess these communications through any device such as a quired materials mailed to you, please check here:
(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.) seen this provider? ☐ Yes ☐ No natically enrolls you in paperless delivery for some of munications delivered electronically. We will send you are ple: Explanation of Benefits or the Annual Notice of ess these communications through any device such as a
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☐ 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. □ 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.
$\hfill \square$ 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
Enrollee name
Agent name/ID number

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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 representative Today's date

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If you are the authorized representation below	ive, please sign ab	ove and complete the
*Not a Sales Agent		
Last name	First name	
Address		
City	State	ZIP code
Phone number () -	Relationship to a	pplicant
nrollee name		
Agent name/ID number		

For Licensed Sales	Representative/age	ncy 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 (Dual LIS change of status)	☐ SEP (Chang		☐ SEP (Loss of EGHP coverage)		
☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)	☐ AEP (Octob December 7)	er 15-	□ 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 _
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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 MI-0008 (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.

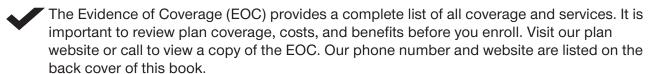
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

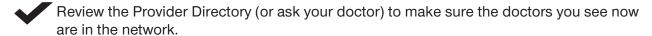
OMB No. 0938-1378 Expires: 7/31/2024 Y0066 ERFMA 2024 C

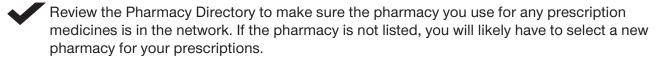
Enrollment checklist

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.