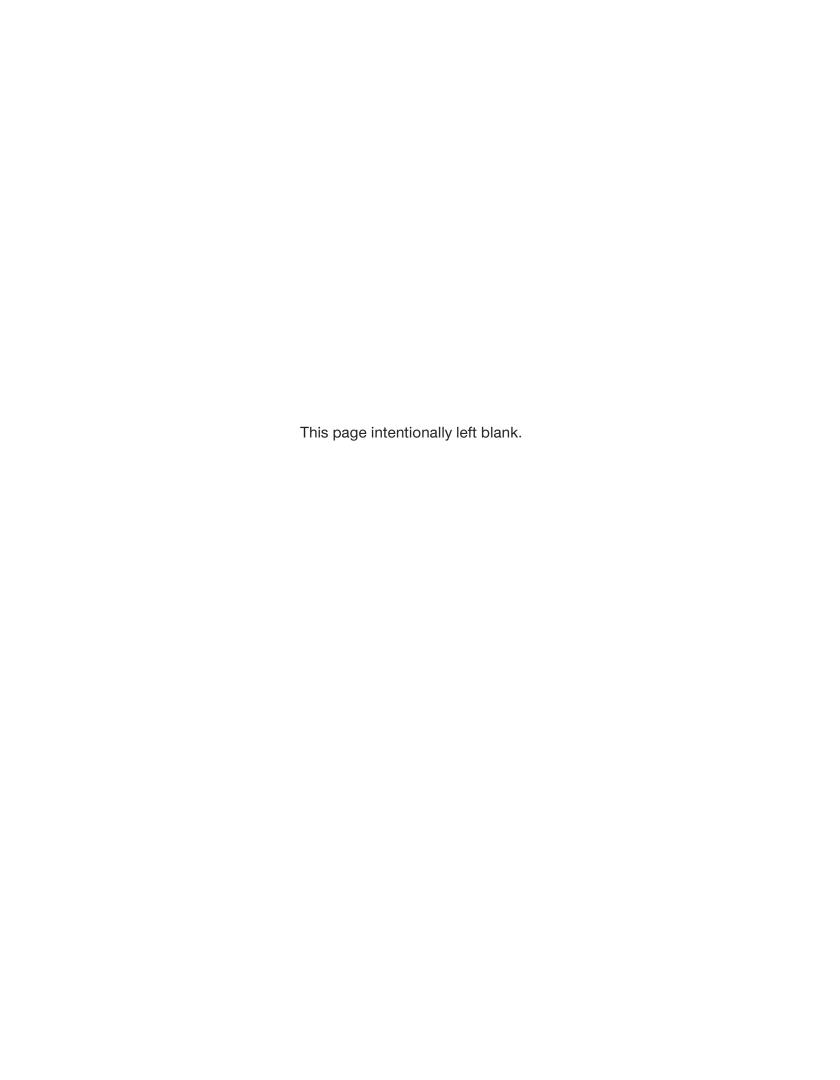




2023 Enrollment Request Form

☐ AARP® Medicare Advantage Patriot (HMO-POS) H0755-037-000 - APC

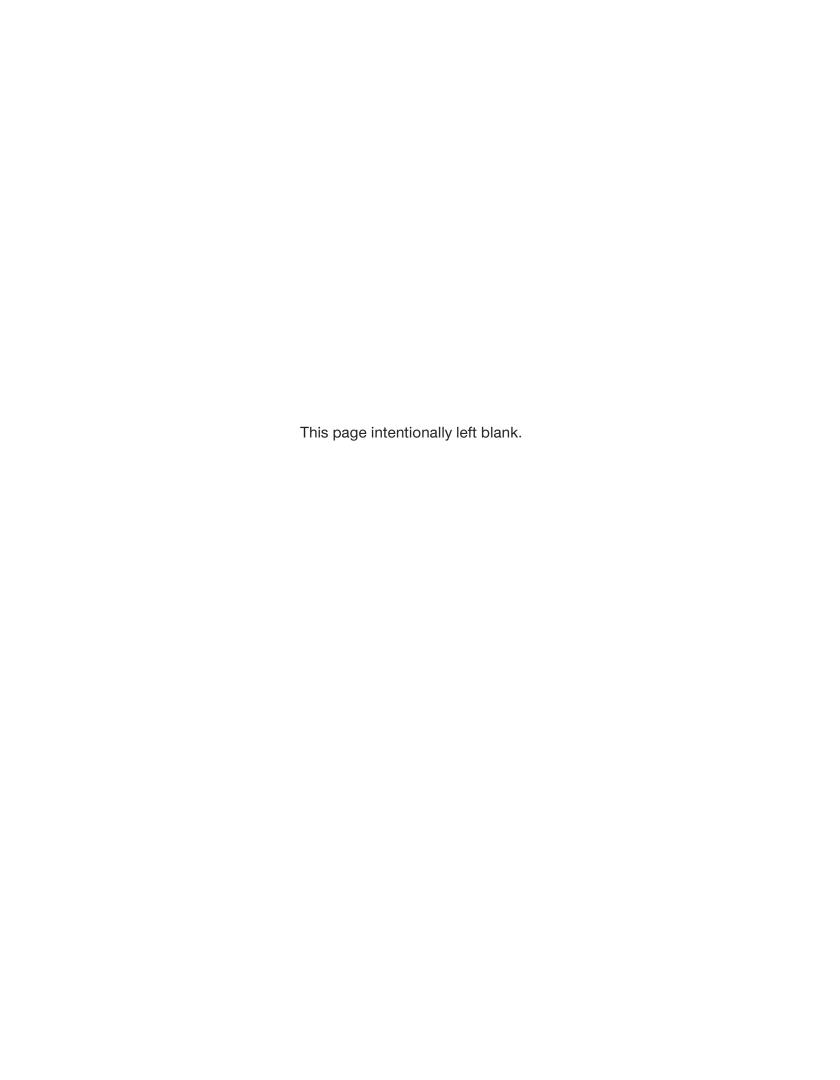
Look Nove	you (Please	e type or print in	black or blue i	nk)			
Last Name		First Name		Mid	dle Initial		
Birth Date			Sex □ Male	 □ Male □ Female			
Home Phone Number () -		-	Mobile Phone Number () -				
Medicare Number							
Permanent Residence	Street Addre	ess (P.O. Box is	not allowed)				
City	y County			State	ZIP Code		
Mailing Address (Only	if it's differe	ent from above.	You can give	a P.O. Box.)			
City				State	ZIP Code		
Email Address (Optiona	al)						
	ons is vour c	hoice You can't	the denied co	verage beca			
answering these question	· · · · · · · · · · · · · · · · · · ·	noice. Tou carri	be defiled co		use you don t till		
nem out.	·	noice. Fou carri	be defiled oo		use you don t till		
nem out. How do you want t	to pay?			·	·		
hem out.	to pay? plan premiur automatic de heck each m	m (including any eduction from yo	late enrollmer our Social Secu	nt penalty you	u may owe) you ca ad Retirement		
hem out. How do you want to If you have a monthly pour premium by a Board (RRB) benefit cl	to pay? plan premiur automatic de heck each m sfer (EFT).	m (including any eduction from yo nonth. You can a	late enrollmer our Social Secu Ilso pay from a	nt penalty you rity or Railro bank accou	u may owe) you ca ad Retirement nt through		
hem out. How do you want to lif you have a monthly pour premium by a Board (RRB) benefit cle Electronic Funds Trans	to pay? plan premiur automatic de heck each m sfer (EFT). option below D-Income Re	m (including any eduction from you nonth. You can a w, we'll send a belated Monthly A	late enrollmer our Social Secu Ilso pay from a oill each month	nt penalty you nrity or Railro bank accou to your mail ount (Part D	u may owe) you ca ad Retirement nt through ing address.		
If you have a monthly pay your premium by a Board (RRB) benefit of Electronic Funds Trans If you don't choose an If you must pay a Part	to pay? plan premiur automatic de heck each m sfer (EFT). option below D-Income Re you a letter	m (including any eduction from you nonth. You can a w, we'll send a belated Monthly A and ask you how	late enrollmer our Social Secu ilso pay from a oill each month adjustment Am wyou want to p	nt penalty you nrity or Railro bank accou to your mail ount (Part Doay it:	u may owe) you ca ad Retirement nt through ing address.		



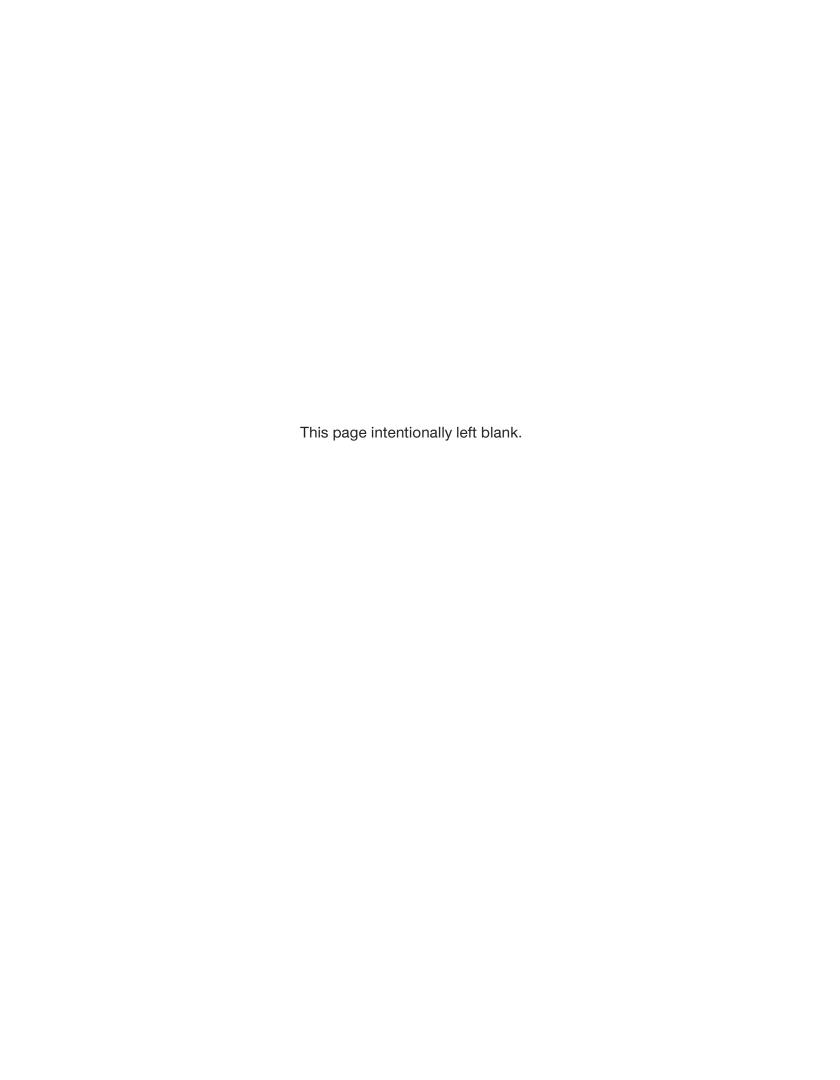
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☐ You can pay it from your SS check					
☐ Medicare can bill you					
☐ The Railroad Retirement Board (RRB) can bill you					
☐ I want to pay from my Social Security					
I want to pay from my Railroad Retirement Board (RRB) check					
I want to pay 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					
. Would you prefer plan information in another language or an accessible format? \square Yes \square 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. 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, Chicano/a Yes, Puerto Rican Yes, Cuban Yes, another Hispanic, Latino, or Spanish origin I choose not to answer.					
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.					
Guamanian or Chamorro Other Pacific Islander					

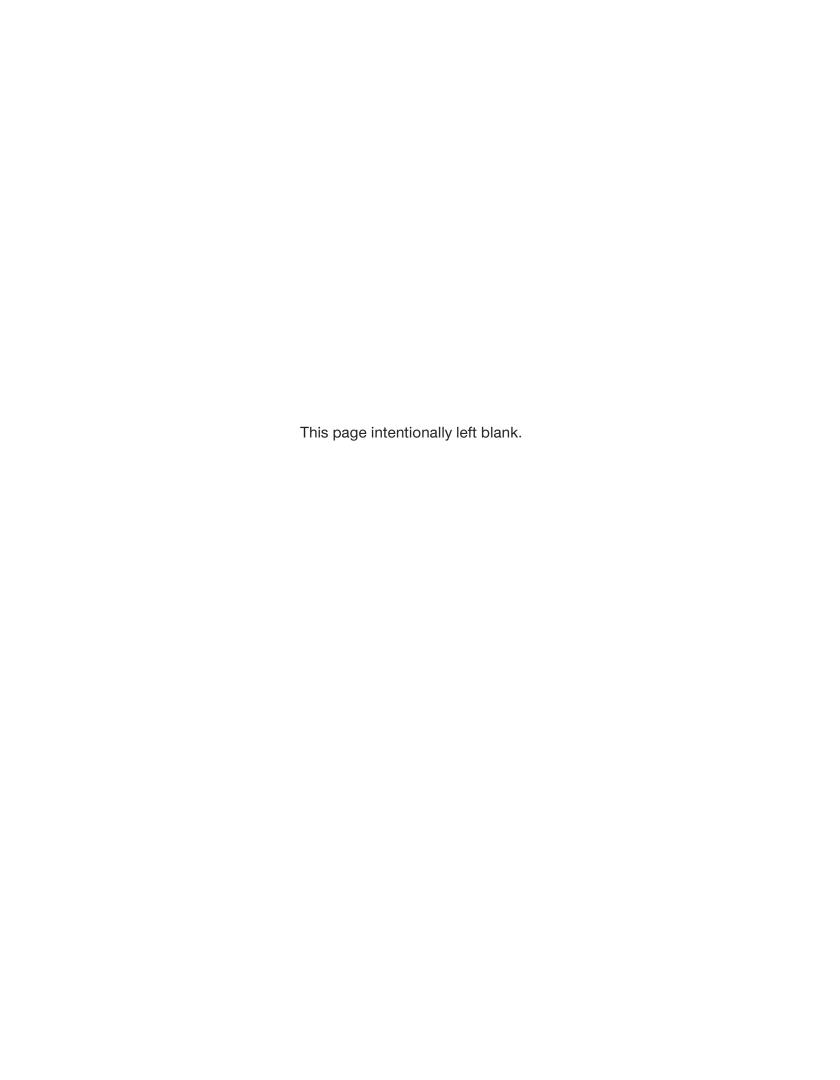
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4. Do you or your spouse work?	☐ Yes ☐ No
	insurance that will cover medical services? ge, LTD coverage, Workers' Compensation, ☐ Yes ☐ No
Name of Health Insurance Company	
Member Number	
5. Please give us the name of your prima	ry care provider (PCP), clinic or health center.
You can find a list on the plan website or	in 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	
your plan communications. You will get many of your required plan coremail when new communications (For exanchanges) are available online. You can accomputer, tablet, or mobile phone.	nmunications delivered electronically. We will send you an apple: Explanation of Benefits or the Annual Notice of ess these communications through any device such as a
if you would rather have hard copies of re	equired materials mailed to you, please check here:
	il you hard copies of required materials. Please note that d may not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the fo	llowing:
premium if I have one, unless Medicaid I understand that people with Medicare the country, except for limited coverag urgent care outside of the U.S. See the I understand that when my UnitedHealt from UnitedHealthcare. Benefits and see	stay in UnitedHealthcare. I must keep paying my Part B d or someone else pays for it. e are generally not covered under Medicare while out of e near the U.S. border. This plan covers emergency and Summary of Benefits for more information. Therefore coverage begins, I must get all of my medical ervices authorized by UnitedHealthcare and contained coverage" document (also known as a member contract



or subscriber agreement) will be covered. With UnitedHealthcare will pay for benefits or ser		er Medicare nor	
□ Release of Information: By joining this Medic Drug Plan, I acknowledge that the plan will release is necessary for treatment, payment, and he UnitedHealthcare will release my information, Medicare, who may release it for research and authorize the collection of this information (see I give UnitedHealthcare permission to share morganizations or person(s) for permissible purpadminister my health plan. □ I give consent for all entities under UnitedHeal UnitedHealthcare to call the phone number(s) □ The information on this form is correct to the bintentionally provide false information on this form is voluntary. However plan.	care Advantage Plan or Me ease my information to Me ealth care operations. I also including my prescription of other purposes applicable Privacy Act Statement be my protected health informations under applicable law thcare and any outside very law provided. Dest of my knowledge. I unform I will be disenrolled from I	edicare and other plans of acknowledge that drug event data, to see to federal law that elow). Attion with a required to a required by derstand that if I com the plan.	
When I sign below, it means that I have read and	d understand the informat	tion on this form	
If I sign as an authorized representative, it means I show written proof (Power of attorney, guardianshi understand that I will need to submit written proof behalf of the member beyond this application. After received my UnitedHealthcare® UCard, I can call C UnitedHealthcare UCard to update my authorization Signature of Applicant/Member/Authorized Rep	ip, etc.) of this right if Medi of this right, to the plan, if ler er this application has been Customer Service at the nu on information on file.	care asks for it. I I wish to take action on a approved and I have mber on my	
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 Applican	t	

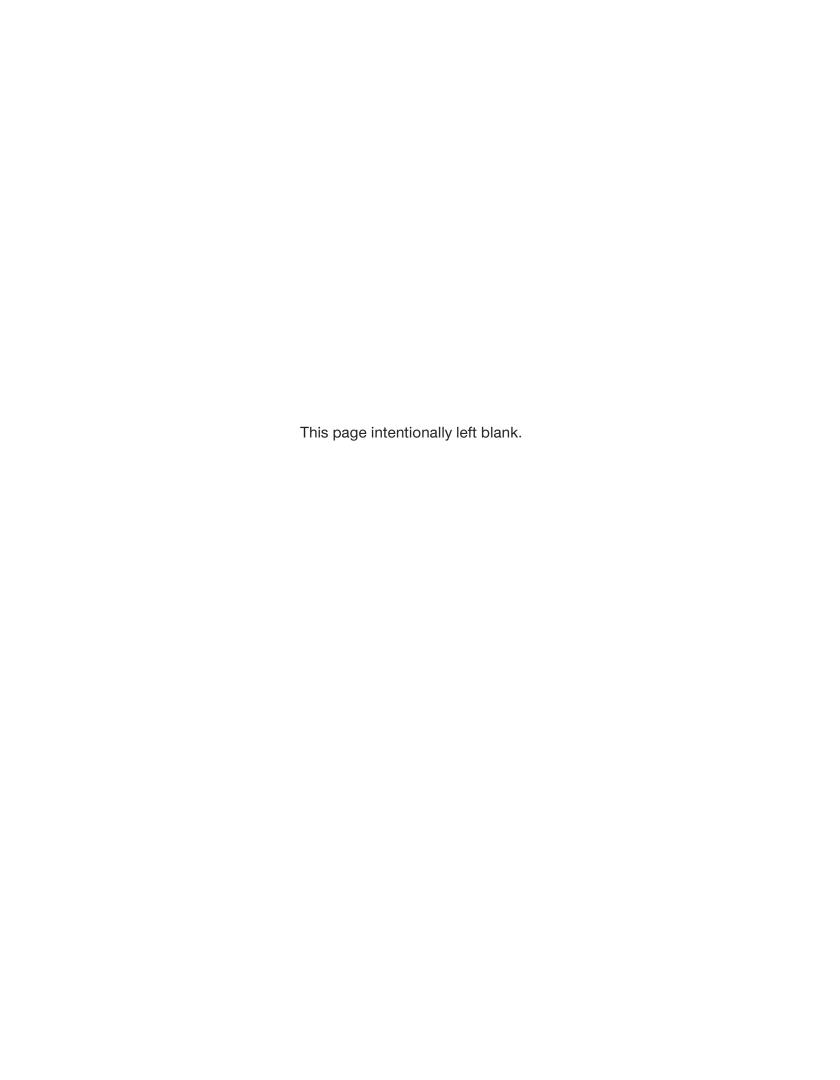


For licensed sales	representative/agen	cy u	se only			
Employer Group Name						
Employer Group ID			Branch ID			
Licensed Sales Representative/Writing ID				Initial Receipt Date		
Licensed Sales Representative/Agent Name				Proposed Effective Date		
Agent must complete						
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PD enrollees eligible for 2nd IEP)			☐ OEP (Jan 1 - Mar 31)	
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	☐ SEP (Change in residence) ☐ AEP (October 15-December 7)			☐ SEP (Loss of EGHP coverage) ☐ OEPI	
☐ SEP (SEP Reason) _						
Licensed Sales Repre	esentative Signature (Op	tiona	1)	D	ate:	

Please mail or fax this completed form to:

UnitedHealthcare P.O. Box 30770 Salt Lake City, UT 84130-0770

Fax: 1-888-950-1170



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.

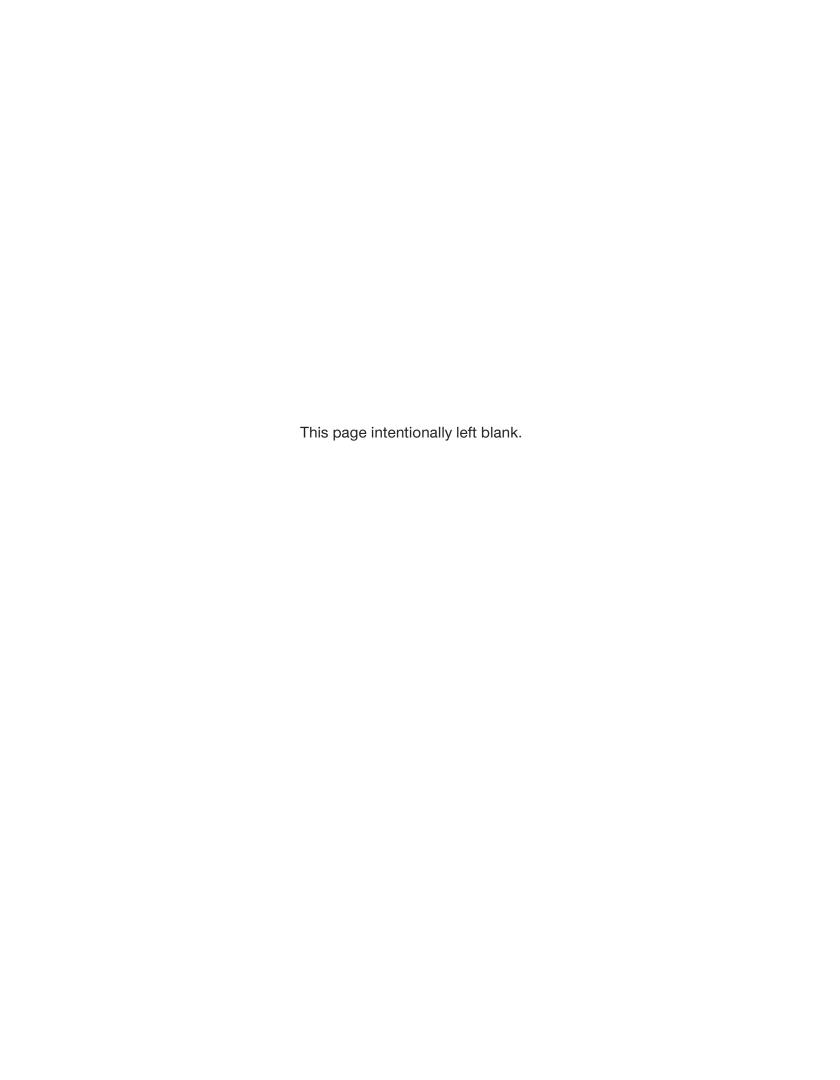
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This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

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: 7/31/2023

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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 at the number listed on the back cover of this book.

Understanding the Benefits



The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit our plan website or call to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.



Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.



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 a higher copay for services received by non-contracted providers.