AARP | Medicare Advantage from UnitedHealthcare

2023 Enrollment Request Form

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

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)**

City	County	State	ZIP Code

Mailing Address **(Only if it's different from above. You can give a P.O. Box.)**

City	State	ZIP Code

Email Address (Optional)

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

How do you want to pay?

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:

Enrollee Name _____

Agent Name / ID No. _____

This page intentionally left blank.

- 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

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, 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.

This page intentionally left blank.

4. Do you or your spouse work? ☐ Yes ☐ No

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

5. Please give us the name of your primary 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 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 Part A and 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 from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract

This page intentionally left blank.

or subscriber agreement) will be covered. **Without authorization, neither Medicare nor UnitedHealthcare will pay for benefits or services**.

- ☐ **Release of Information:** By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that UnitedHealthcare will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes applicable to 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 any outside vendor used by UnitedHealthcare to call the phone number(s) I have provided.
- ☐ 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.

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 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

If you are the authorized representative, please sign above and complete the information below

*NOT A SALES AGENT

Last Name	First Name	
Address		
City	State	ZIP Code
Phone Number ( ) –	Relationship to Applicant	

Enrollee Name _____

This page intentionally left blank.

For licensed sales representative/agency use 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 (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 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

This page intentionally left blank.

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.

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: 7/31/2023

This page intentionally left blank.

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.