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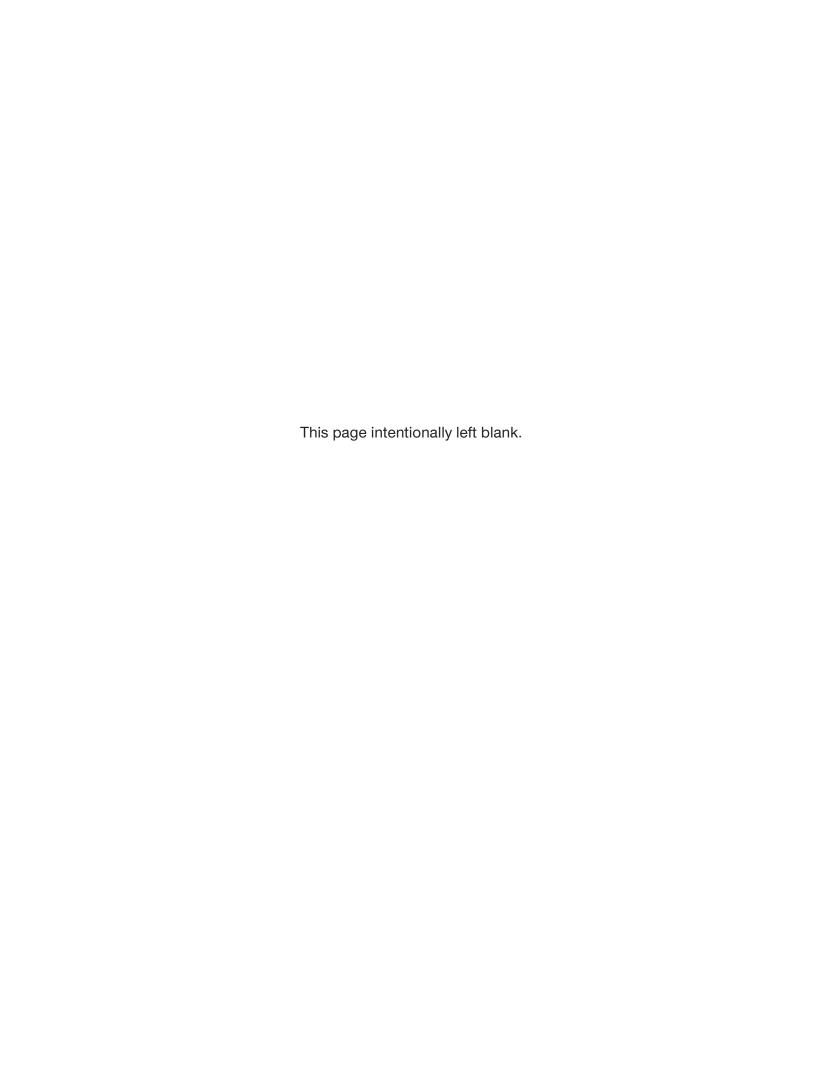


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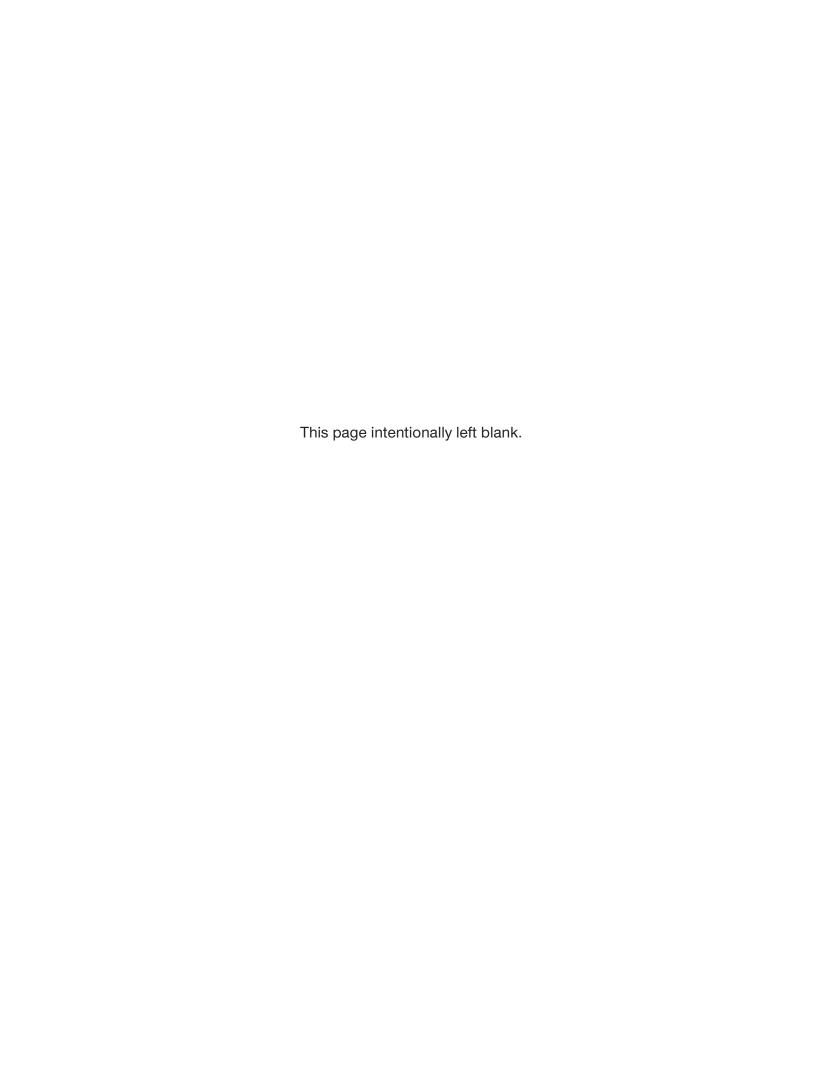


2023 Enrollment Request Form

☐ AARP® Medicare Advantage Choice (PPO) H8768-022-000 - AO1 Select optional supplemental benefits in addition to what is included with your plan You can add the following benefit rider(s) 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 City State Email Address (Optional) Enrollee Name _ Agent Name / ID No.

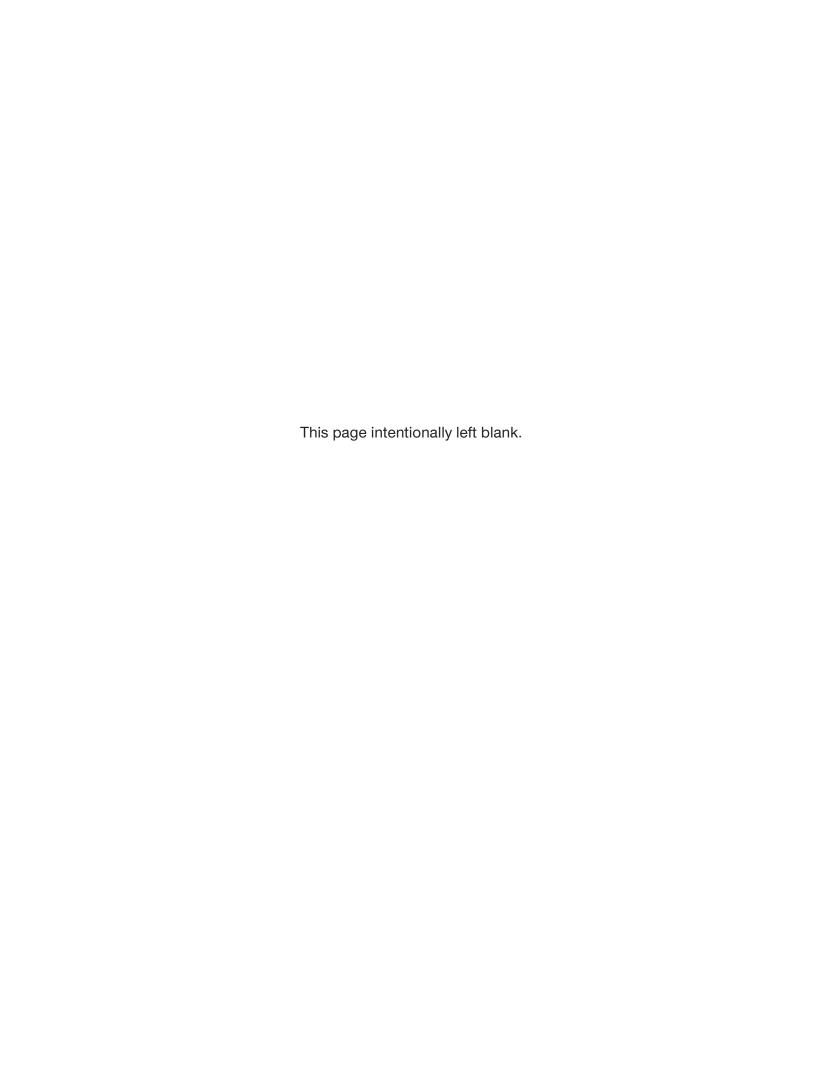


If yes, what is it? Name of Other Insurance Member Number						
Member Number						
	er Number Group Number RxBin					
Answering these questions is y them out.	our choice. You can't be denie	d coverage beca	ause you don't fill			
How do you want to pay	?					
pay your premium by automa	emium (including any late enrolatic deduction from your Social ach month. You can also pay from T).	Security or Railro	oad Retirement			
If you don't choose an option	below, we'll send a bill each m	onth to your ma	iling address.			
• • •	ne Related Monthly Adjustmen etter and ask you how you wan	•	D-IRMAA) Social			
☐ You can pay it from yo	ur SS check					
☐ Medicare can bill you						
☐ The Railroad Retirement Board (RRB) can bill you						
☐ I want to pay from my Socia	al Security					
☐ I want to pay from my Railr	oad Retirement Board (RRB) c	heck				
☐ I want to pay directly from a	a bank account					
Account Type □ Checking Account Holder Name:	□ Savings					
Bank Routing Number/						
Bank Account Number/	_/_/_/_/_/_/_					

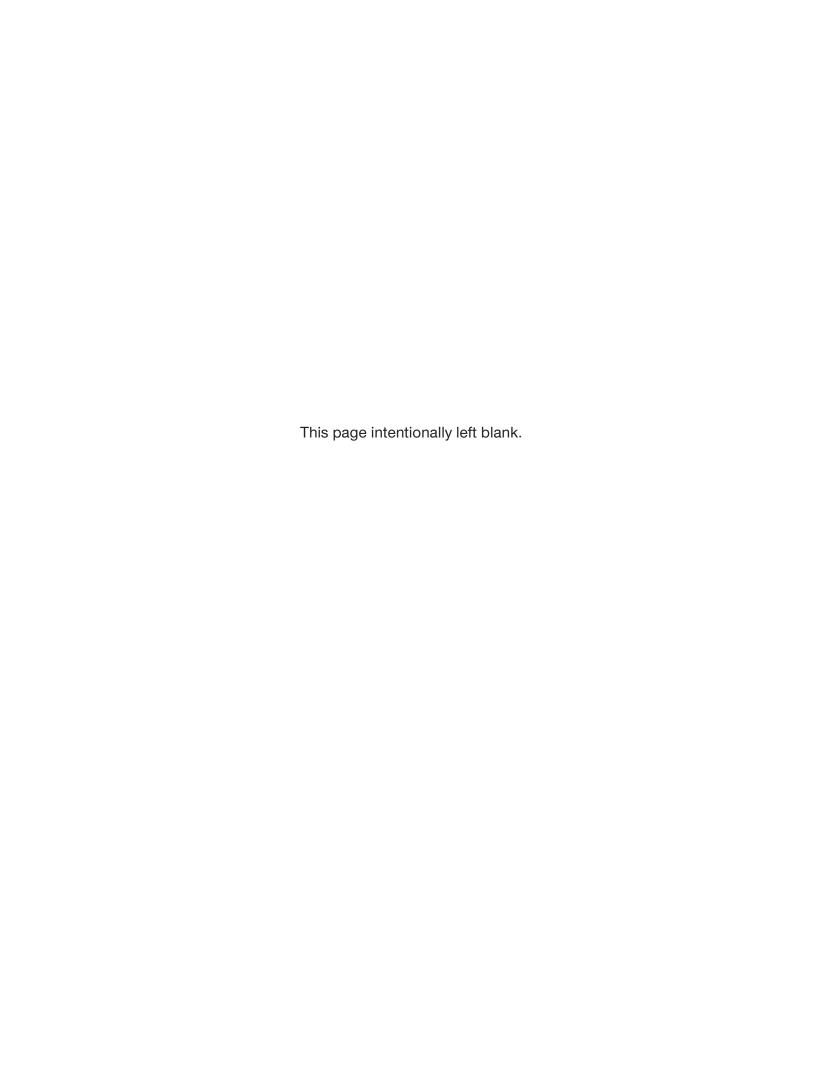


A few questions to help us manage your plan

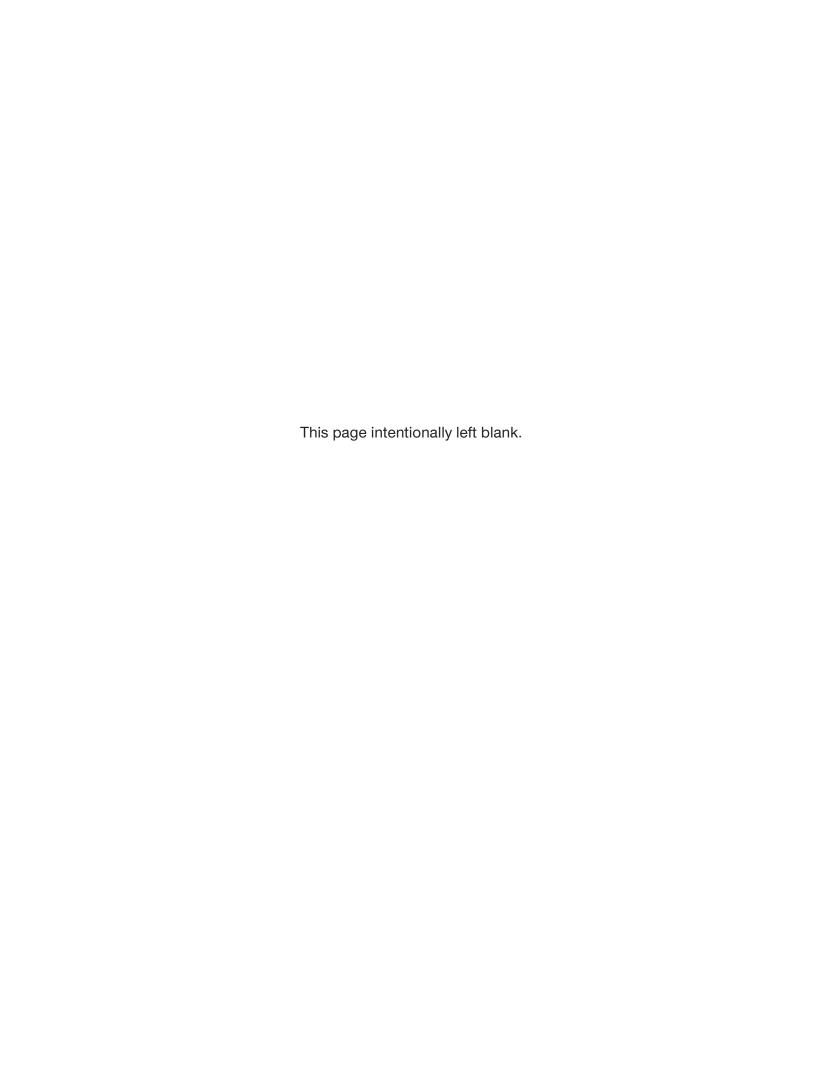
1. Would you prefer plan information in another language or an accessible format?□ Yes □ No					
Please check what you'd like: ☐ Spanish ☐ Braille ☐ Other					
If you don't see the language or format you want, please call UnitedHealthcare toll-free at 1-844-723-6473, TTY 711 8 a.m8 p.m. local time, 7 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, 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.					
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 can You aren't limited to this list. You may go to an terms.	re provider (PCP), clinic or health center. ny doctor who accepts Medicare and the plan's payment
You can find a list on the plan website or in th	e 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 automatic your plan communications.	cally enrolls you in paperless delivery for some of
email when new communications (For example:	Explanation of Benefits or the Annual Notice of nese communications through any device such as a
If you would rather have hard copies of requir	ed materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you some communications are very large and may preference for delivery at any time.	hard copies of required materials. Please note that not fit in all mailboxes. You can change your
Please read and sign	
By completing this form, I agree to the followi	ng:
premium if I have one, unless Medicaid or s I understand that people with Medicare are the country, except for limited coverage nea urgent care outside of the U.S. See the Sum I understand that when my UnitedHealthcar prescription drug benefits from UnitedHeal UnitedHealthcare and contained in my Unite (also known as a member contract or subsc authorization, neither Medicare nor United	generally not covered under Medicare while out of ar the U.S. border. This plan covers emergency and amary of Benefits for more information. The coverage begins, I must get all of my medical and the theore. Benefits and services authorized by the ded Healthcare "Evidence of Coverage" document the riber agreement) will be covered. Without the description of the theorem in the covered of the theorem is a service of the covered of the cover
Drug Plan, I acknowledge that the plan will ras is necessary for treatment, payment, and UnitedHealthcare will release my information	dicare Advantage Plan or Medicare Prescription release my information to Medicare and other plans health care operations. I also acknowledge that n, including my prescription drug event data, to nd other purposes applicable to federal law that see Privacy Act Statement below).



 I give UnitedHealthcare permission to share my organizations or person(s) for permissible purpadminister my health plan. I give consent for all entities under UnitedHealt UnitedHealthcare to call the phone number(s) The information on this form is correct to the bintentionally provide false information on this form My response to this form is voluntary. However plan. 	hoses under applicable law hcare and any outside ver have provided. est of my knowledge. I und orm I will be disenrolled fro	v as required to ndor used by derstand that if I om the plan.				
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 or 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, 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					

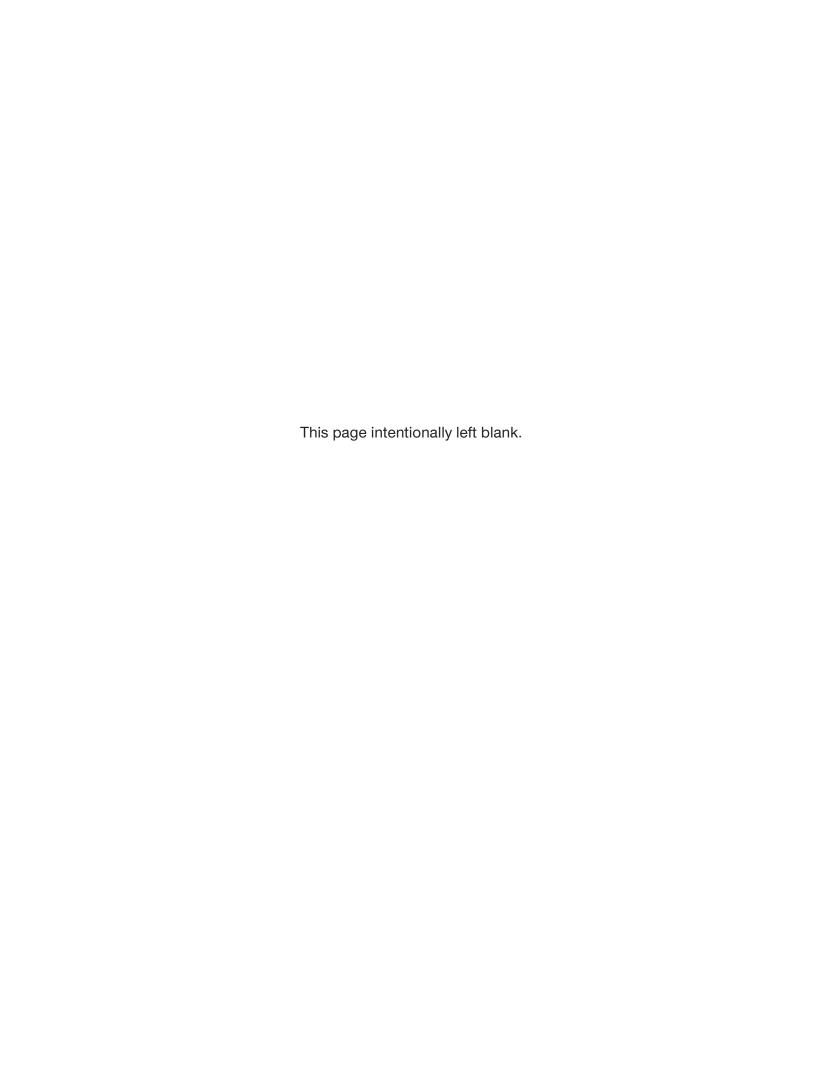


For licensed sales representative/agency use only						
Employer Group Name						
Employer Group ID			Branch ID			
Licensed Sales Representative/Writing ID		Initial Receipt Date				
Licensed Sales Representative/Agent Name		Proposed Effective Date				
Agent must complete						
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PD enrollees eligible for 2nd IEP)			☐ OEP (Jan 1 – Mar 31)	
☐ OEP (Newly eligible) ☐ SEP (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 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



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.

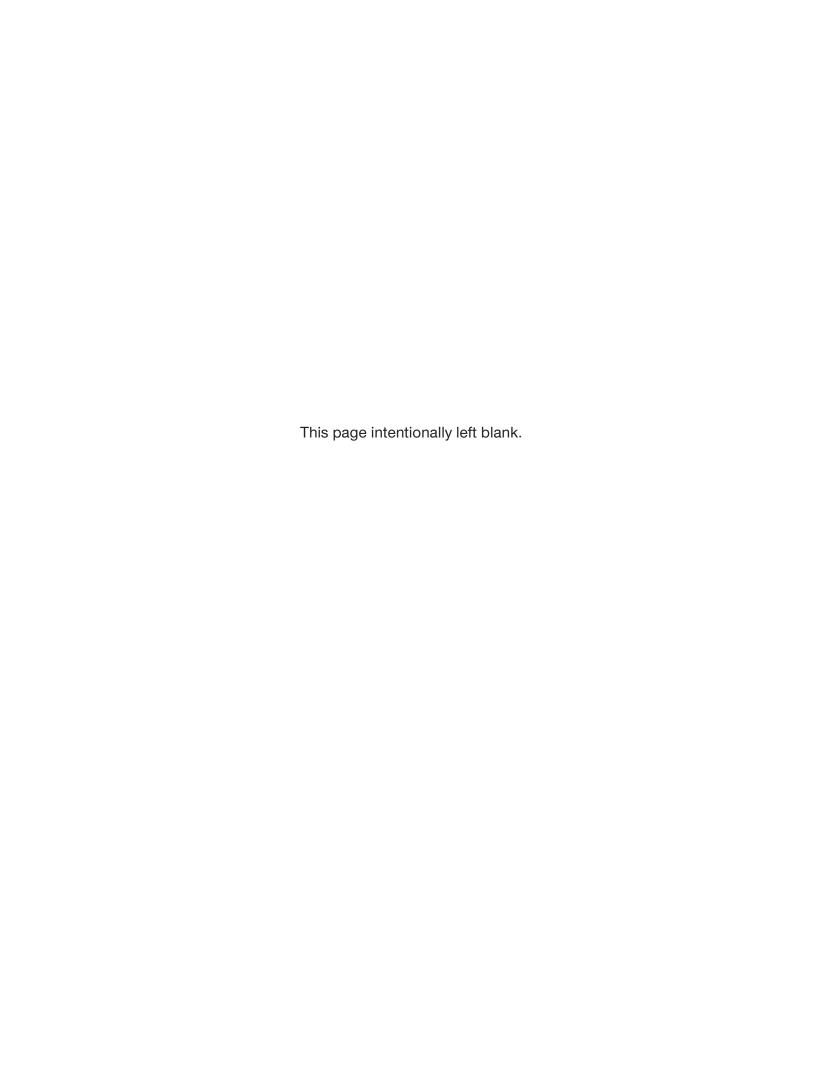
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This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

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.



Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.



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.