

2026 Enrollment Request Form

☐ AARP® Medicare Advantage Access from UHC NC-23 (PPO) H2001-084-000

Information about you (Please type or print in black or blue ink)					
Last name	First name			Middle initial	
Birth date		Sex □ Male I	☐ Femal	e	
Home phone number ()	_	Mobile phone number () —			
You can stay on top of your plan and health with timely, helpful calls. □ Check here to consent to receive calls using auto dialer/artificial or prerecorded voice technology. You can change your preference at any time.					
Medicare number					
Permanent residence street address experiencing homelessness, a P.O. address)					
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				1	
You will receive some plan information Changes, electronically (quicker than review online. □ Check here if you prefer to receive preference at any time.	n mail). We'll	email you when	new doci	uments are ready to	
Enrollee name Agent name/ID number					
V0066 EEMA 2026 C				AANC261 P0320573 000	

Do you have other insurance (Examples: Other private insura programs.) If yes, what is it?		•	☐ Yes ☐ No benefits or state
Name of other insurance			
			1
Member number	Group number	RxBin	RxPCN (optional)
Answering these questions is fill them out.	your choice. You can't be de	enied coverage b	ecause you don't
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 ch month. You can also pay fro	Security or Railroa	d Retirement
If you don't choose an option b	pelow, we'll send a bill each mo	onth to your mailir	ng address.
If you must pay a Part D-Incom	e Related Monthly Adjustment	Amount (Part D-I	RMAA),
Social Security (SS) will send y	ou a letter and ask you how yo	u want to pay it:	
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) ch	ieck	
\square I want to pay directly from a	bank account		
Account type ☐ Checking I	□ Savings		
Account holder name:			
Bank routing number/			
Bank account number/_	/_/_/_/_		
*Members enrolled in the EFT Insurance Company the new concurrent retroactive charges plu tell both UHC and my bank. I u	harges from my bank Account s monthly premium amount. If	which may include I choose to stop I	de up to \$200.00 of paying by EFT, I will
A few questions to help u	is manage your plan		
1. Which language or accessi		uture plan inforr	nation?
Enrollee name			
Agent name/ID number			
Y0066_EFMA_2026_C		AAN	C26LP0320573_000

☐ English ☐ Spanish				
☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD				
If you don't see the language or format you wan 1-844-723-6473, TTY 711, 8 a.m8 p.m. local to AARPMedicarePlans.com for online help. If no information in English.	me, 7 days a week. Or visit			
2. Do you or your spouse work?	☐ Yes ☐ No			
Do you or your spouse have other health insurance				
(Examples: Other employer group coverage, LTD auto liability, or Veterans benefits) If yes, please complete the following:				
Name of health insurance company				
Member number				
3. Please give us the name of your primary care	provider (PCP), clinic or health center.			
You aren't limited to this list. You may go to any do payment terms. You can find a list on the plan website or in the Pro-	·			
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?			
Please read and sign				
By completing this form, I agree to the following	:			
paying my Part B premium if I have one, unless I understand that people with Medicare are get the country, except for limited coverage near urgent care outside of the U.S. See the Summ I understand that when my UnitedHealthcare or prescription drug benefits from UnitedHealthcare and contained in my United	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and hary of Benefits for more information. coverage begins, I must get all of my medical and hare. Benefits and services authorized by Healthcare "Evidence of Coverage" document her agreement) will be covered. Neither Medicare			
Enrollee name				
Agent name/ID number	AANC26LP0320573_000			

 I understand that I can be enrolled in only or that enrollment in this plan will automatically apply for MA Private Fee-for-Service (PFFS), 	end my enrollment in and	ther MA plan (exceptions			
plans). Release of information: By joining this Med will share my information with Medicare, who payments, and for other purposes allowed by information (see Privacy Act Statement below	o may use it to track my er by Federal law that authoriz	rollment, to make			
☐ I give UnitedHealthcare permission to share	onformation (see Privacy Act Statement below). 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 organizations.				
 The information on this form is correct to the intentionally provide false information on this My response to this form is voluntary. However plan. 	s form I will be disenrolled	from the plan.			
When I sign below, it means that I have read a	nd understand the inform	nation on this form			
show written proof (power of attorney, guardians understand that I will need to submit written produced behalf of the member beyond this application. As received my UnitedHealthcare UCard®, I can call UnitedHealthcare UCard to update my authorizate Signature of applicant/member/authorized reports of the submitted produced in the	of of this right, to the plan, fter this application has be I Customer Service at the rition information on file. presentative Today	if I wish to take action on en approved and I have number on my y's date			
information below (*Not a Sales Agent)	, prodoc orgin doore an				
Last name	First name				
Address					
City	State	Zip code			
Phone number () —	Relationship to applicat	nt			
For individuals helping enrollee with co	mpleting this form on	ly			
Enrollee name					
Agent name/ID numberY0066_EFMA_2026_C		 AANC26LP0320573_000			

•	n if you're an individual (aird parties) helping an e				ounselors, family
Name		Relationship to enrollee			
Signature		National Producer Number (Agents/Brokers only)			
For Licensed Sal	es Representative/a	agenc	y u	se only	
Licensed Sales representative/Writing ID		Initial receipt date		e	
Licensed Sales representative/agent name			Proposed effect		ve date
Employer group nam	ne				
Employer group ID		В	Branch ID		
Agent must compler ☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees) ☐ en		nrol	P (MA-PD lees eligible for	□ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS ☐ change of status) re ☐ SEP (Dual LIS ☐				☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason)	•				
Licensed Sales repr	resentative signature (o	ptiona	al)	Da	te
		dHealtl Box 30 ity, UT 888-95	ncai 077(841 0-11	re 0 30-0770 170	
	er				AANC26LP0320573_000

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 Access from UHC NC-23 (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.

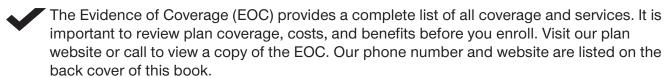
UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers. You do not need to be an AARP member to enroll. AARP encourages you to consider your needs when selecting products and does not make specific product recommendations for individuals.

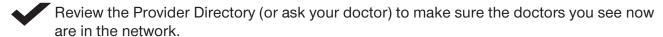
OMB No. 0938-1378 Expires: 12/31/2026 Y0066 EFMA 2026 C

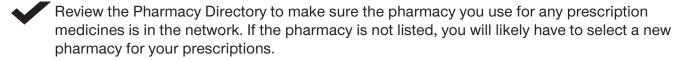
Enrollment checklist

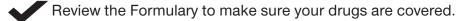
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

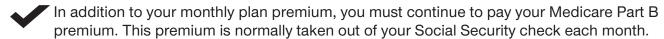


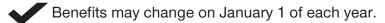


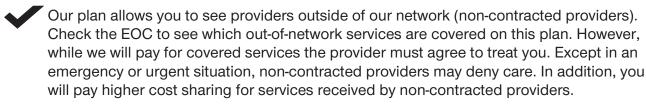




Understanding important rules







Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care 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.