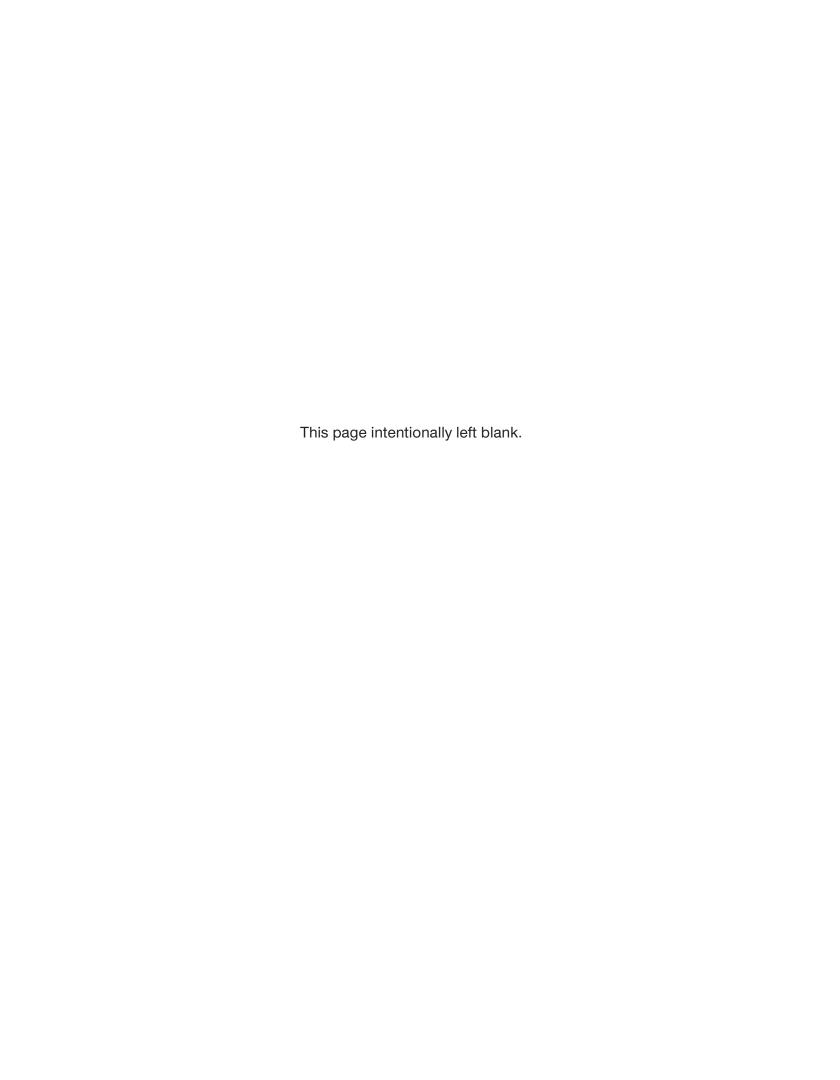
AARP Medicare Rx UnitedHealthcare

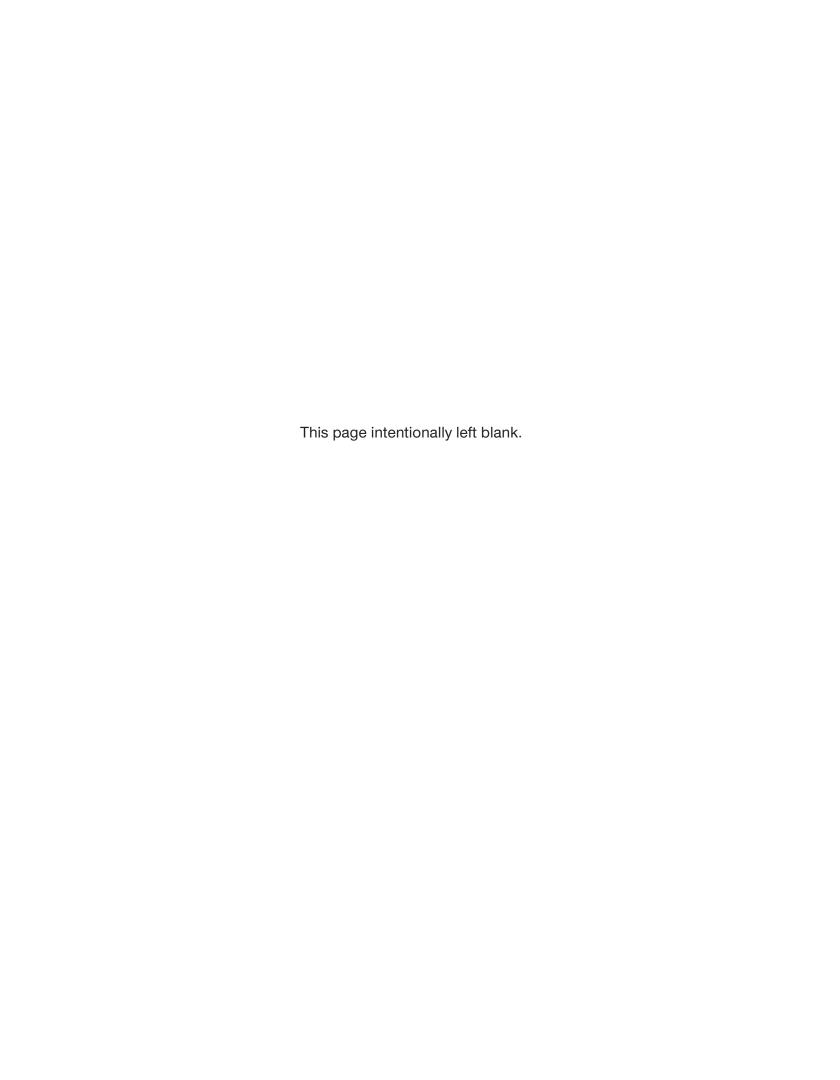
2020 Enrollment Request Form

2020 Enrollment Request Form	1		
Please contact the plan if you need this inform (Braille).	nation in another	language or an acces	ssible format
Please check the plan you want:			
☐ AARP® MedicareRx Preferred (PDP) A			
Please Read This Important Information			
This is a Part D plan. It's designed to help pay Medicare Advantage plan:	the cost of pres	cription drugs. Note:	If you have a
 ☐ You may already have drug coverage ☐ You will lose that plan automatically who would lose your medical coverage. This as well as your prescription drug cover Advantage plan sends you and if you have an MA-only PFFS plan your MA-only PFFS plan. If you currently have health coverage from your employer or union health benefits. You join this plan. Read the communication you questions, visit their website, or contact the information on whom to contact, your beneficial your coverage can help. 	s will affect both age. Read the in ave questions, on you may still end an employer or ou could lose you e office listed in	your doctor and hosp formation that your M contact your Medicare nroll in a PDP plan and union, joining this plan ur employer or union of union sends you. If you their communications	pital coverage ledicare Advantage d will not lose n could affect coverage if you u have s. If there isn't
Information about you			
Please type or print in black or blue ink.			
□ Mr. Last Name □ Mrs. □ Ms.	First Name		Middle Initial
Birth Date MM - DD - YYYYY	Sex □ I	Male □ Female	
Daytime Phone Number () —		Phone Number: () –
Enrollee Name Agent Name / ID No Y0066_190611_023700_M			PD4502830_00



Permanent Residence Street Address (P.O.	. Box is not allowed)		
City	County		ZIP Code
Mailing Address (only if it's different from	above. You can give	a P.O. Box.)
City	у	State	ZIP Code
E-mail Address			1
Fo select paperless delivery complete and address.	sign the application	and provide	your email
You will get many of your required plan comman email when new communications (For exachanges) are available online. You can access computer, tablet, or mobile phone.	ample: Explanation of	Benefits or	he Annual Notice
f you would rather have hard copies of req	quired materials mai	led to you, p	lease check here
Instead of paperless delivery, we will mail y some communications are very large and preference for delivery at any time.	•	-	
Information about your Medicare			
Please take out your red, white and blue Me	edicare card to comp	lete this sect	ion.
 Fill out this information as it appears on your Medicare card. -OR- 	Name (as it appears	on your Me	dicare card):
☐ Attach a copy of your Medicare card or	Medicare Number:		
your letter from Social Security or the	Sex:		
Railroad Retirement Board.	Is Entitled to	Е	ffective Date
	Hospital (Part A)		IM - DD - YYYY
	Medical (Part B)		
	You must have Medicare Part A or Part B (to join a Medicare prescription drug plan.		IM - DD - YYYY
			or Part B (or both)

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How do you want to pay?

you signed up for e-delivery.

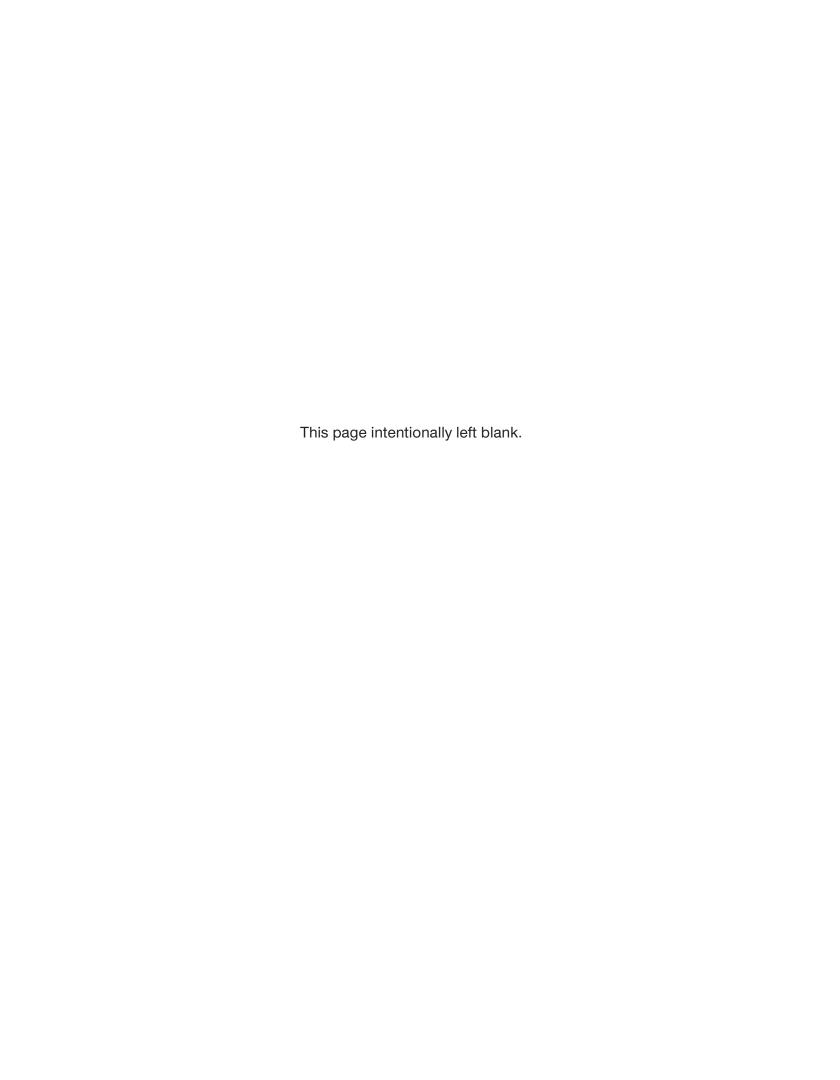
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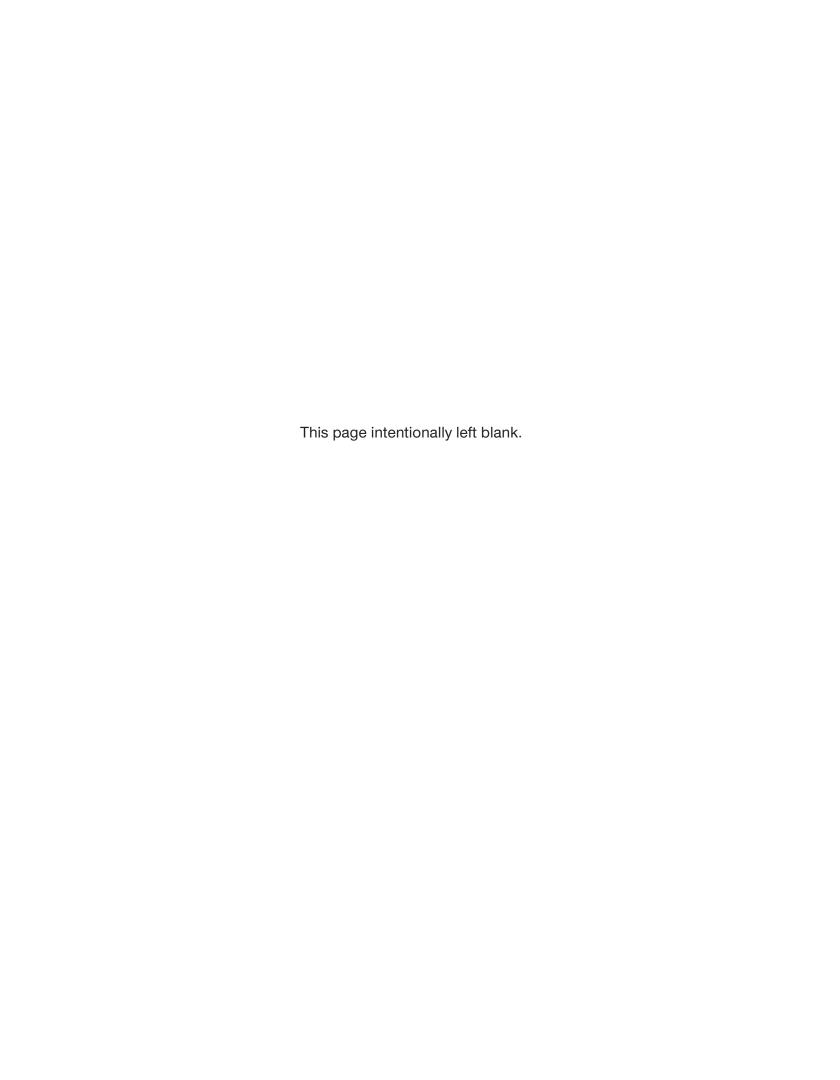
Enrollee Name _

If you have a monthly plan premium (including any late enrollment penalty you may owe), you can choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT), online or by mail.

This plan has a premium (monthly payment). Please choose how you want to pay it. Note: If you have a late enrollment penalty (LEP), we'll add it to your premium.

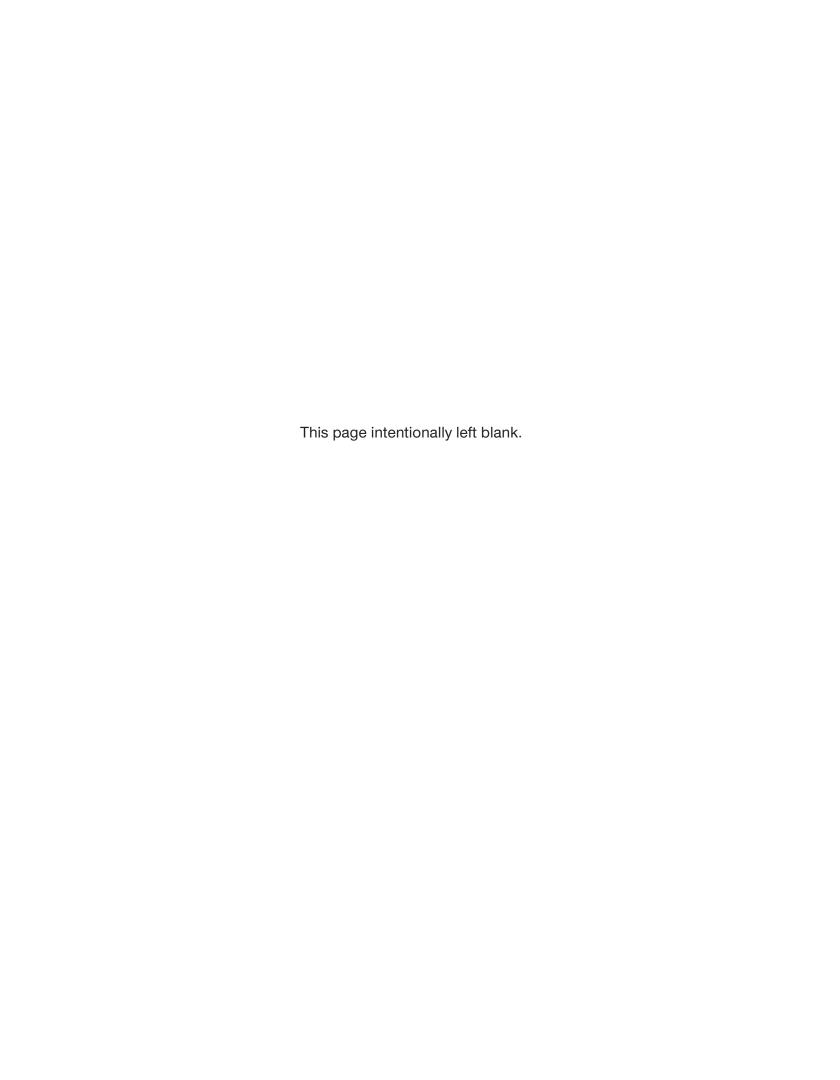
If you don't choose an option, we'll send a bill each month to your mailing address. ☐ I want to pay from my Social Security or Railroad Retirement Board (RRB) check. I get monthly benefits from: ☐ Social Security ☐ RRB We'll set it up. It may take a few months before payment starts, so the first payment may include more than one premium. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction or there is a delay in setup, we will send you a paper bill for your monthly premiums. ☐ I want to pay directly from a bank account. ☐ Please attach a blank check from the account you'd like to use. Write "VOID" across the front. Please DO NOT send a deposit slip or money order. □ Please read the statement below. The bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). The bank will pay the funds from a checking or savings account on or about the fifth of each month. The charges may include up to \$200 of current retroactive charges plus the monthly premium amount. If I choose to stop paying directly from an account, I will tell both UHIC and the bank. I will give them a reasonable amount of time to change the method of payment. Account Type □ Checking □ Savings Account Holder Name Bank Routing Number Bank Account Number Signature ____ Date MM - DD - YYYY \square I want to pay by mail. We'll send a bill to your mailing address each month or you will receive an email notification if



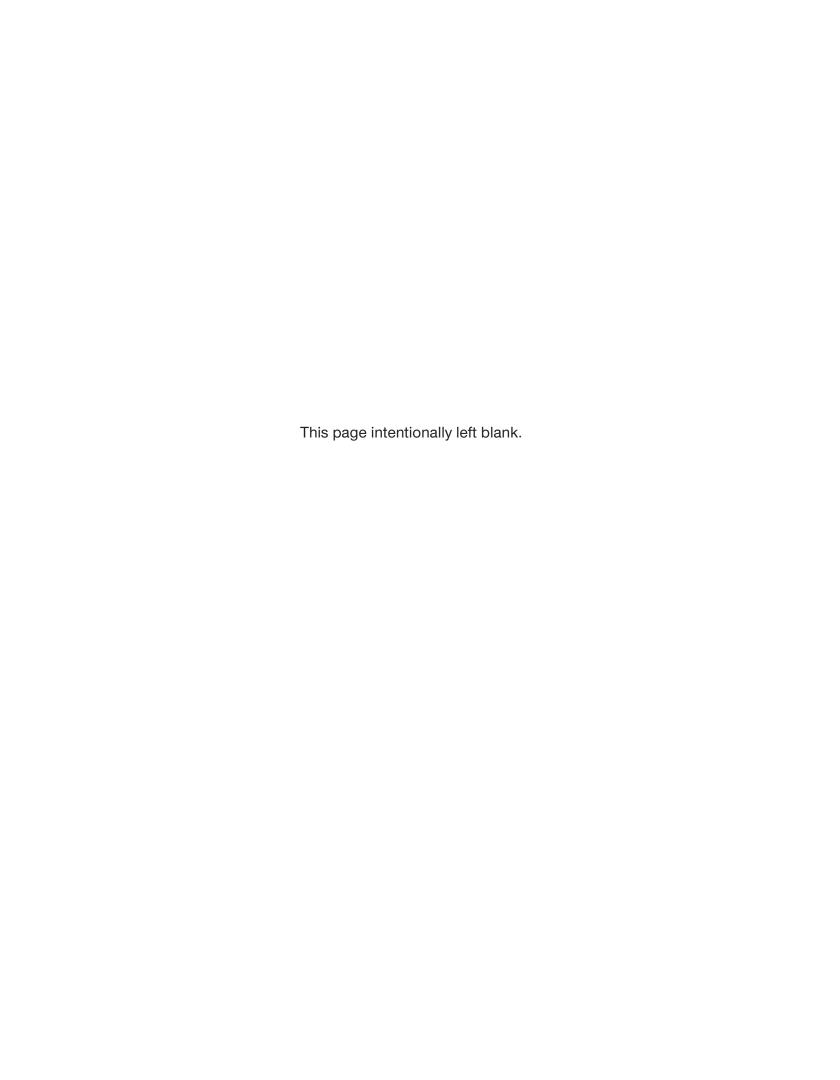


2. Do you live in a nursing home of	•	-			☐ Yes ☐ No
Name		<u> </u>			
Address		City		State	ZIP Code
Phone Number ()	_	Date you moved	d there	MM - D	D - YYYY
3. Do you have other insurance the (Examples: Other private insurance programs.) If yes, what is it? Name of Other Insurance	-		•	ge, VA t	☐ Yes ☐ No penefits, or state
Member Number	Group Number			an Started M - DD - YYYY	
Please read and sign					
By completing this form, I agree t	to the following	•			
 □ This is a Medicare Prescription Prescription Drug coverage is in Supplement plan. □ I need to keep my Medicare Paunless Medicaid or someone elemants of I can only be in one Medicare Forescription Drug plan, my enrowed lift I have prescription drug coverblan. □ I understand that I am joining the need to do so between Octobe Medicare Advantage and Medispecial situations at other times □ This plan covers a specific area plan in the new area. Medicare some limited coverage near the or get other Medicare prescription drug covered as Medicare prescription drug co	rts A or B. I must lse pays for it. Prescription Drugollment in this plantage now or if I go ne plan for the er 15 and December and December of the planto mover in th	ginal Medicare. The street paying my graph at time-if I an will end that eget it from somewher 7. This is the nodrug coverage. In which I can leave out of the area are when I'm out of the area area are when I'm out of the area area.	This is n y Part B am curr enrollme where el ar. If I w Annual I under eave the i, I will ca of the co prescrip	ot a Med premium ently in a nt. se later, ant to ch Enrollm stand the plan. all my plan ountry. He this plan tion dru	m if I have one, a Medicare I will tell the hange plans, I'll tent Period for at there may be an to switch to a However, I have and don't have g coverage (as

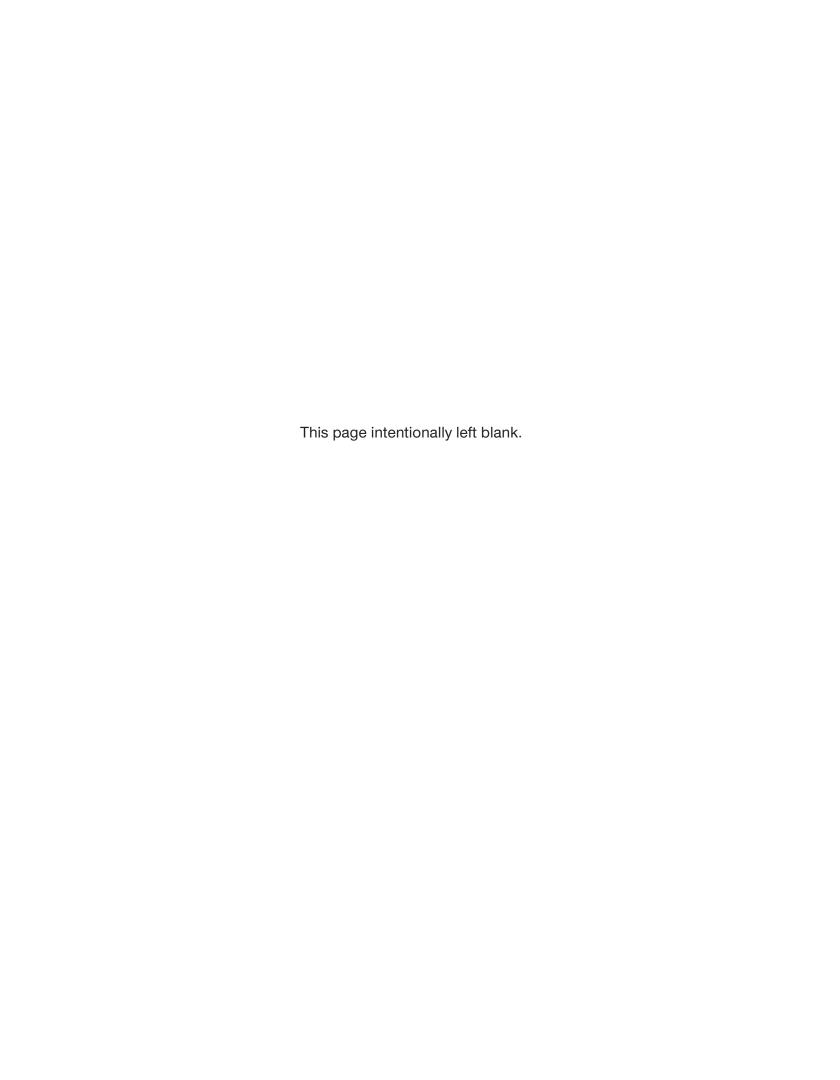
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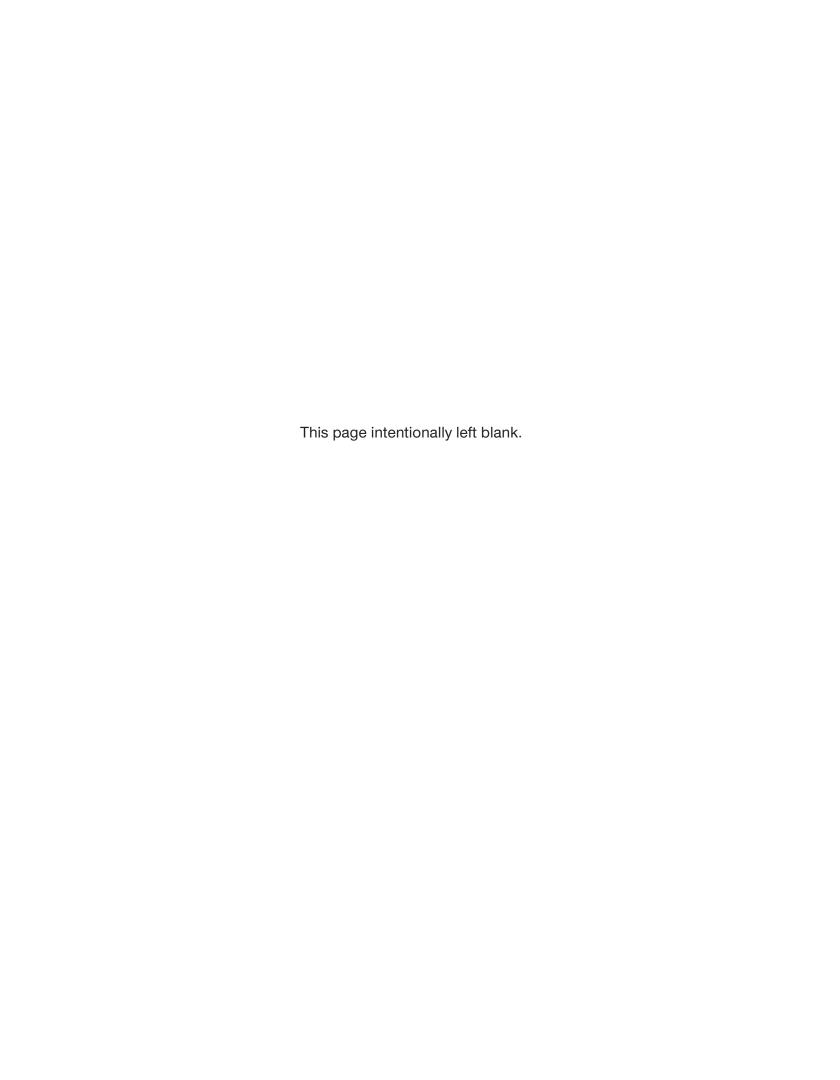
□ I will receive information on how to get an Evidence of Coverage member contract or subscriber agreement.) The EOC will list set the plan's terms and conditions. The plan will cover services it a listed in the EOC. If a service isn't listed in the EOC or approved plan won't pay for it. If I disagree with how the plan covers my cappeal. □ I understand I must use network pharmacies except in an emergappeal if I disagree with how the plan covers or pays for service. □ My plan will give my information, including my prescription drug other plans when needed for treatment, payment and health car information to understand how my care was handled or billed. On information when they help pay for my care. Medicare may also and other purposes. All federal laws and rules protecting my pri □ I understand that my state may offer help and advice with Medic other Medicare Advantage or Prescription Drug plan options, my state Medicaid program, and the Medicare Savings Program. □ If I get help from a sales agent, broker or someone who has a company pay that person for this help. □ The information on this form is correct, to the best of my knowled.	ervices the plan covers, as well as approves, as well as services by the plan, Medicare and the are, I have the right to make an gency. I have the right to make an services. I have the right to make an service and reoperations. Medicare and reoperations. Medicare uses the other plans may need my or give my information for research vacy will be followed. Care supplement insurance or redical assistance through the contract with the plan, the plan redge. I understand that if I put
When Leign below it means that I have read and understand the	
When I sign below, it means that I have read and understand the If I sign as an authorized representative, it means I have the legal reshow written proof (Power of attorney, guardianship, etc.) of this rigunderstand that I will need to submit written proof of this right, to to on behalf of the member beyond this application. After this application have received your UnitedHealthcare member ID card, please number on the back of your UnitedHealthcare member ID card to information on file.	right under state law to sign. I can ight if Medicare asks for it. I the plan, if I wish to take action ation has been approved and call Customer Service at the
Signature of Applicant/Member/Authorized Representative	Today's Date



information below. *NOT A SALES AGENT	piease sign above an	a complete the
Last Name	First Name	
Address		
City	State	ZIP Code
Phone Number () -	Relationship to Applican	t



For sales representative/agency use only.				
□ New Member Employer	Group Name			
□ Plan Change				
Employer Group ID		Branch II		
Sales Representative/Writing @AGENTID@	ID		Initial Receipt Date	YY
Sales Representative/Agent Name @AGENTFULLNAME@ Proposed Effective Date MM - DD - YYYY				
Sales Representative Phone	Number @AGENTPHONE	Ξ@		
Where did this application or	ginate?			
 □ National Retail/Mall Program □ Local Event Outreach □ Appointment □ Other □ Member Meeting □ Community Meeting □ Walmart Program 				□ Other
How was this application sub	mitted? Mail	Fax 🗆	Online	
Agent must complete				
□IEP	□ IEP 2		SEP (Institutional)	
☐ SEP (GEP Part B)	☐ SEP (Change in ☐		SEP (Loss of EGHP	
	residence) co		coverage)	
☐ SEP (PDP/OEP)	,		☐ SEP (Dual LIS change	
	Assignment)	01	status)	
☐ SEP (Dual LIS maintaining)	☐ AEP (October 15 – December 7)			
G,	December 1)			
☐ SEP (SEP Reason) ☐ SEP Eligibility Date MM -	DD - VVVV			
Sales Representative Signa	iture (required)		Date: MM - DD - Y	



Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. 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 or pharmacy recommendations for individuals.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711). 注意:如果您說中文,您可以免費獲得語言援助服務。請致電 1-855-814-6894 (聽力語言殘障服務專線 TTY: 711).

