



Employer Group Name: Cement Masons and Plasterers 528	
Group Number/GPS ID: 24726	
GPS Branch Number: 001	Effective Date:

## 2025 Enrollment Request Form

AARP® Medicare Rx Preferred from UHC (PDP)

### Information about you (Please type or print in black or blue ink)

Last name	First name	Middle initial
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Birth date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Home phone number (       )       –	Mobile phone number (       )       –
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I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology.

Medicare number \_\_\_\_\_

Permanent residence street address (**Don't enter a P.O. box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address**)

City	County	State	Zip code
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Mailing address (**Only if it's different from above. You can give a P.O. box.**)

City	State	Zip code
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Email address (optional) \_\_\_\_\_

**Do you have other insurance that will cover your prescription drugs?**  Yes  No  
(Examples: Other private insurance, TRICARE, federal employee coverage, VA benefits or state programs.)

If **yes**, what is it?

Name of other insurance \_\_\_\_\_

Member number	Group number	RxBin	RxPCN (optional)
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**Answering these questions is your choice. You can't be denied coverage because you don't fill**

Enrollee name \_\_\_\_\_

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:

- 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 check

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?

If you would prefer plan information in another language or accessible format, please check what you'd like:  Spanish  Braille  Large Print  Audio CD  Data CD

If you don't see the language or format you want, please call UnitedHealthcare toll-free at **1-800-753-8004**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit

**AARP Medicare Plans.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, or 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.

Enrollee name \_\_\_\_\_

\_\_\_ American Indian or Alaska Native

\_\_\_ Black or African American

Asian:

\_\_\_ Asian Indian

\_\_\_ Chinese

\_\_\_ Filipino

\_\_\_ Japanese

\_\_\_ Korean

\_\_\_ Vietnamese

\_\_\_ Other Asian

Native Hawaiian or Pacific Islander:

\_\_\_ Guamanian or Chamorro

\_\_\_ Native Hawaiian

\_\_\_ Samoan

\_\_\_ Other Pacific Islander

\_\_\_ White

\_\_\_ **I choose not to answer**

\_\_\_ Member/Citizen of a federal or state recognized Tribe (name of Tribe)\_\_\_\_\_

**4. What is your gender? Select one.**

\_\_\_ Woman

\_\_\_ Man

\_\_\_ Non-binary

\_\_\_ I use a different term: \_\_\_\_\_

\_\_\_ **I choose not to answer**

**5. Which of the following best represents how you think of yourself? Select one.**

\_\_\_ Lesbian or gay

\_\_\_ Straight, that is, not gay or lesbian

\_\_\_ Bisexual

\_\_\_ I use a different term: \_\_\_\_\_

\_\_\_ I don't know

\_\_\_ **I choose not to answer**

**6. Do you or your spouse work?**

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:**

Enrollee name \_\_\_\_\_

- I must keep Hospital (Part A) or Medical Part B (or both) 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 I am joining the plan for the entire calendar year. If I want to change plans, I'll need to do so between October 15 and December 7. This is the Annual Enrollment Period for Medicare Advantage **and** Medicare prescription drug coverage. I understand that there may be special situations at other times during the year in which I can leave the plan.
- 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 prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.
- I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- **Release of information:** By joining this Medicare Prescription Drug Plan, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by 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 its affiliates and any outside vendor used by UnitedHealthcare to call the phone number(s) I have provided using an autodialer and/or prerecorded voice.
- 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 member ID card, I can call Customer Service at the number on my UnitedHealthcare member ID card to update my authorization information on file.

**Signature of Applicant/Member/Authorized Representative**

**Today's date**

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

Enrollee name \_\_\_\_\_  
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**information below** (\* Not a Sales Agent)

Last name

First name

Address

City

State

Zip code

Phone number (       )       –

Relationship to applicant

**For individuals helping enrollee with completing this form only**

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name

Relationship to enrollee

Signature

National Producer Number (Agents/Brokers only)

**For sales representative/agency use only**

Sales representative/Writing ID

Initial receipt date

Sales representative/agent name

Proposed effective date

Employer group name

Employer group ID

Branch ID

**Agent must complete** IEP IEP 2 SEP (Institutional) SEP (GEP Part B) SEP (Change in residence) SEP (Loss of EGHP coverage) SEP (PDP/OEP) SEP (CMS/State Assignment) SEP (Dual LIS change of status) SEP (Dual LIS maintaining) AEP (October 15 - December 7) SEP (SEP reason) \_\_\_\_\_**Sales representative signature (optional)****Date**

Enrollee name \_\_\_\_\_

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**Please mail or fax this completed form to:**

UnitedHealthcare  
P.O. Box 30770  
Salt Lake City, UT 84130-0770  
Fax: 1-888-950-1170  
Fax the front and back of each page

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**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 Rx Preferred from UHC (PDP) is 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.

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: 06/30/2026

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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

- ✓ 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

- ✓ Benefits, premiums and/or copays/coinsurance may change on January 1 of each year.
- ✓ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medicaid or another third party. This premium is normally taken out of your Social Security check each month.
- ✓ 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.