

RA25027C

DID YOU REMEMBER TO:

- ✓ Complete the information on the form?
- ✓ Sign and date?

Thank you!



UNITEDHEALTH GROUP
PO BOX 535235
PITTSBURGH PA 15253-9900

BUSINESS REPLY MAIL

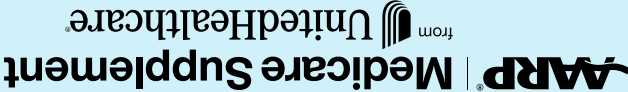
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UnitedHealthcare
PO BOX 30607 • Salt Lake City, UT 84130-0607



EZ CLAIM PAY ENROLLMENT FORM

Please read both sides of this form before signing below and keep a copy for your records.

EZ Claim Pay is a convenient option to have funds withdrawn toward your Medicare Part B deductible on a per-claim basis at the time an applicable claim payment occurs.

Please see other side for authorization details.

▼ FOLD HERE ▼

Insured Name: _____

AARP Medicare Supplement Plan Health Insurance ID Number (11 digits, including zeros): _____

ZIP Code: _____ State: _____ Phone Number: _____

Bank Name: _____

Bank Routing Number (9 digits): _____

Bank Account Number: _____

(Please see diagram on back for location of bank information.)

Account Type (select one): ☐ Checking ☐ Savings (statement savings only)

Email Address (optional): _____

Bank Account Holder's Name (if different from insured): _____

Bank Account Holder's Signature: _____ Date: _____

MI10101B

This diagram is only to show where to obtain your bank information.

Please do not include a check when sending back your enrollment form.

Account Holder Name

Check Number

John Doe
Street Address
Town, State ZIP Code

Check #1234

Date: _____

Pay to: _____

_____ Dollars

Bank Name
& Address

Memo: _____ Signed by: _____

a123456789a 12345678b 1234

Bank Routing
Transit Number:
Must be 9 digits

Bank Account
Number: Include
all zeros

Check Number: Do not include the check
number (it may be before or after the account
number) as it may delay processing

EZ CLAIM PAY AUTHORIZATION - SERVICE DETAILS

When you choose automated payments through the Electronic Funds Transfer (EFT) service, your Medicare Part B deductible will be automatically deducted from either your checking or savings account as described below.

I authorize United HealthCare Services, Inc. and its affiliates hereafter named UnitedHealthcare to take recurring withdrawals from the account named as of the date I sign the EZ Claim Pay Enrollment Form for my Medicare Part B deductible responsibility for any claim(s) to which Medicare applies all or part of my deductible. (Medicare applies the deductible only on claims that are for covered services.) Withdrawals will be taken periodically as claims subject to the Medicare Part B deductible arise.

I understand I will receive a notice alerting me to an upcoming withdrawal, prior to the EFT deduction being withdrawn from the account named on this form.

This authority is active until UnitedHealthcare receives notice from me to end withdrawals, in enough time to give UnitedHealthcare a reasonable opportunity to act on it. Notice can be made by calling **1-877-223-1628**. I understand by revoking the above-mentioned authority I will be responsible for paying and managing my Medicare Part B deductible costs.

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