DID YOU REMEMBER TO:

✓ Complete the information on the form?

✓ Sign and date?

Thank you!

RA25027C

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 23810 MINNEAPOLIS MN

POSTAGE WILL BE PAID BY ADDRESSEE

UNITEDHEALTH GROUP
PO BOX 535235
PITTSBURGH PA 15253-9900

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

▲ DETACH HERE, PLACE IN THE ATTACHED RETURN ENVELOPE AND SEAL ▲

AARP® | Medicare Supplement from UnitedHealthcare®

UnitedHealthcare

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EZ Claim Pay is a convenient option to have funds withdrawn toward your Medicare Part B deductible on a per-claim basis at the time an applicable claim payment occurs.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

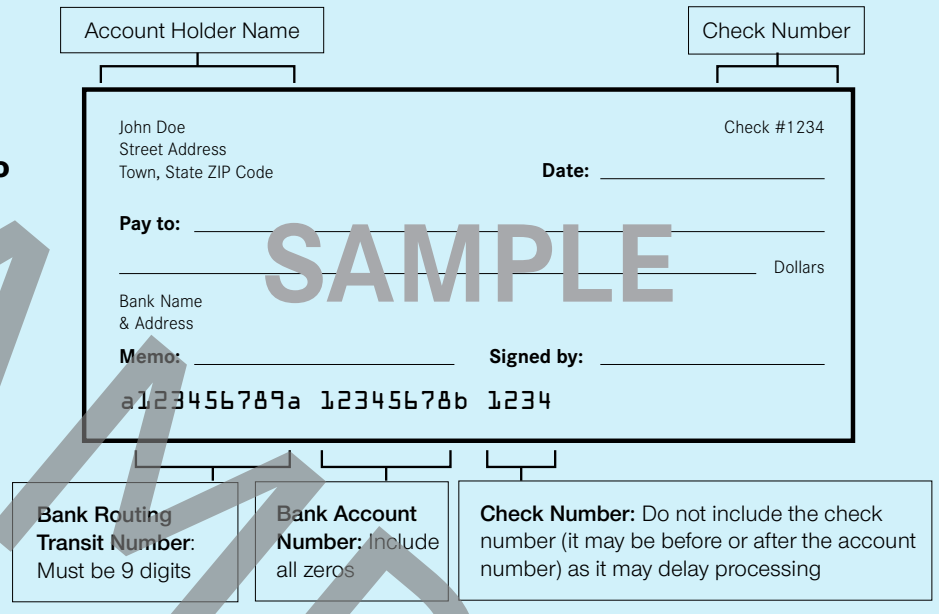
Bank Account Holder's Name (if different from insured): _____

Bank Account Holder's Signature: _____ Date: _____

MI10101B

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

Please do <u>not</u> include a check when sending back your enrollment form.



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.

Remoistenable

Glue Area

Glue Area

Glue Area

Glue Area