

# How to Use Cisco Secure Email for Agent Change Request Forms

for AARP® Medicare Supplement Insurance Plans from UnitedHealthcare®



**Follow these helpful tips to ensure you are sending Agent Change Request forms to UnitedHealthcare properly through Cisco secure email:**

**1. Make sure you have access to Cisco Secure Email.**

If you need access, please send a request to the Producer Help Desk (PHD) at [PHD@uhc.com](mailto:PHD@uhc.com). The PHD will send a secure email in reply, which will enable you to access and register to use UnitedHealthcare's secure email service. Please do not send any email attachments as part of your request.

**NOTE:** If you have received and opened a secure email from the PHD in the past and previously registered to use UnitedHealthcare's secure email service via <https://res.cisco.com>, you do not need to send an additional request for access.

**2. Only Cisco Secure Email can be used to send Agent Change Request forms to UnitedHealthcare.**

Refer to the forms for the specific email address to send the applicable form and attachments. Emails from a different secure email product cannot be processed.

**3. Do not submit AARP Medicare Supplement Plan applications to UnitedHealthcare via Cisco Secure email.**

Only Agent Change Request forms and their supporting documentation can be sent.

**4. Do not protect each individual attachment.**

Simply attach items to Cisco secure email. UnitedHealthcare cannot process protected attachments.

**5. All attachments must be in a .JPG, .PDF or .TIF format.**

No other formats will be accepted.

***Thank you for your help in keeping member's personal information safe!***

**Remember, the Cisco secure email capability is only available for the following forms, found on [Jarvis](#) under Enrollments > Application Status: AARP Med Supp General Information Change - Form 1, AARP Med Supp Insured Information Change - Form 2, AARP Med Supp Back Termination and Refund Request - Form 3, AARP Med Supp Pending Apps - Form 4, AARP Med Supp Plan Changes - Form 4 for Plan Changers.**

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## AARP Medicare Supplement Insured Information Change (Form 2)

### Do NOT use for Pending Enrollment Applications

Use this form to submit changes to the insured member's telephone number, address, current plan's effective date or a change in their AARP Membership Number due to joining or separating an account. Please complete ALL required fields marked with an asterisk (\*) and mark the ( ) for information that needs to be updated. An insured member or authorized representative signature on this form is not needed unless otherwise noted as required.

**\*Required field**

**\*Insured Member Name:**

**\*First:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **\*Last:** \_\_\_\_\_

**\*AARP Membership Number:** \_\_\_\_\_

**\*Date of Birth** \_\_\_\_\_

**\*Agent Name:** \_\_\_\_\_

**\*Agent ID:** \_\_\_\_\_

**\*Agent Phone Number:** \_\_\_\_\_

**\*Agent e-mail:** \_\_\_\_\_

**\*Name of Agent/Agency Representative** \_\_\_\_\_

#### AARP Membership Number Update

Validate the Membership Number by calling the PHD or AARP.

##### JOIN 2 SEPARATE ACCOUNTS

**Account 1:**

**Account 2:**

Primary account to be retained should be listed as Account 1. If the account is set up for EFT, enter the last 4 digits of the bank account from which both plans will withdraw payment.

##### SEPARATE 2 ACCOUNTS

Account 1

Name \_\_\_\_\_

AARP Number \_\_\_\_\_

if EFT on account, last 4 digits of bank account \_\_\_\_\_

Account 2

Name \_\_\_\_\_

AARP Number \_\_\_\_\_

if EFT on account, last 4 digits of bank account \_\_\_\_\_

If EFT has not previously been accepted, you must submit a New EFT Form.

**Requires an Insured Member Signature below**

**Plan Effective Date Change** (no plan change):

**Current Plan Effective Date (mm/dd/yyyy):** \_\_\_\_\_

**Requested Plan Effective Date (mm/dd/yyyy):** \_\_\_\_\_

**Note:** The requested plan effective date must be **after** the signature date on the application, after the application receipt date and **no more** than 12 weeks from the signature date.

**Requires Insured Member Signature below**

**Household Discount not indicated on the application (UHICA Plans)**

I live in a household with at least one resident (no more than 3) that is currently an AARP member or will be on the plan effective date?

**AARP member name:** \_\_\_\_\_

**AARP member date of birth: (Month/Day/Year)** \_\_\_\_\_

**Requires Insured Member Signature below**

**Phone Number:**

**Additional Contact Number:** \_\_\_\_\_

**Change Primary Phone Number on File**

**Old Number** \_\_\_\_\_

**New Number** \_\_\_\_\_

**ADDRESS CHANGE** for permanent OR mailing address

**Future Start Date** \_\_\_\_\_

**Old Address:**

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**New Address:**

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Gender Change:** Male Female

**Requires Insured Member Signature below**

**Please make the changes indicated above on my account. I understand that all required fields related to my request must be completed on the form or my request will not be processed. Also, requested changes will be effective the first of the month following the date my completed request is received.**

\_\_\_\_\_  
**Insured Member or Authorized Representative Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Agent Or Agent/Agency's Representative Signature**

\_\_\_\_\_  
**Date**

\*\*\*\*\*

**THIS FORM IS FOR AGENT USE ONLY FOR AARP MEDICARE SUPPLEMENT INSURANCE PLANS**

**Do not add fields or handwritten comments to this document.**

**This form cannot be used for MA or PDP or any other UnitedHealthcare Plans**