



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. 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.

2. 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.

3. Do not protect each individual attachment.

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

4. 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 4PC)**

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AARP Medicare Supplement Insured Information Change (Form 2)

Do NOT use for Pending Enrollment Applications

Use this form to update insured member's contact information, current plan's effective date, change in their AARP Membership Number due to joining or separating an account, household and gender information. Please complete ALL required fields marked with an asterisk (*) and mark the () for information that needs to be updated. **Changes that require insured member or authorized representative signatures will take effect on the first day of the month following the date the completed request is received. All other changes will be effective once processed.**

*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

☐ Temporary Address - Add

A temporary address cannot be submitted more than 30 days before the intended start date and may remain valid for a maximum of 180 days.

Start Date* _____

End Date* _____

Temporary address

Street _____

City _____ State _____ Zip _____

☐ 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 Change:

Current Phone Number on File: _____

Home: _____

Mobile: _____

Work: _____

Additional: _____

Please indicate the preferred phone number: _____

☐ ADDRESS CHANGE for ☐ permanent OR ☐ mailing address

An address change cannot be submitted until the move has occurred or the mailing address has been established, as the change will be effective once processed.

Old Address:

Street _____

City _____ State _____ Zip _____

New Address:

Street _____

City _____ State _____ Zip _____

☐ Gender Change: ☐ Male ☐ Female

Requires Insured Member Signature below

☐ Email Address Change

Email: _____

Over please →

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.

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