

2 Choose your plan and effective date

Please indicate your plan choice below:

A B C F K L N

You are eligible to enroll if **all** of these are true:

- you are an AARP member,
- you are age 50 or older,
- you are enrolled in Medicare Parts A&B,
- you are not duplicating Medicare supplement coverage.
- If you are not yet age 65, you are eligible only if you enrolled in Medicare Part B within the last 6 months, unless you are an "Eligible Person" entitled to guaranteed acceptance as shown in the enclosed "Your Guide."

Coverage Effective Date

Your coverage will become effective on the first day of the month following receipt and approval of this application and first month's premium. You will receive a Certificate of Insurance confirming your effective date.

If you would like your coverage to begin on a later date (the 1st day of a future month), please indicate below.

Requested Effective Date

| |
M M D D Y Y Y Y

3 Answer these questions to determine if your acceptance is guaranteed

3A. Did you turn age 65 in the last 6 months?

Y N

If **YES**, skip to **Section 7**.

3B. Did you enroll in Medicare Part B within the last 6 months?

Y N

If **YES**, skip to **Section 7**.

3C. Will your plan effective date be within 6 months after turning age 65 and enrolling in Medicare Part B?

Y N

If **YES**, skip to **Section 7**.

- If you answered **YES** to **3A**, **3B**, or **3C**, your acceptance is guaranteed.
- If you answered **NO** to **3A**, **3B**, and **3C**, continue to question **3D**. ↗

3D. Have you lost other health insurance coverage and, if so, are you an "eligible person" as defined within the termination notice you received from your prior insurer?

Y N

If **YES**, skip to **Section 7**.

- If you answered **YES** to **3D**, you may be guaranteed acceptance in certain AARP Medicare Supplement Plans. **Include a copy of the termination notice with your application.**

- If you answered **NO** to all questions in this section (**3A**, **3B**, **3C** and **3D**), go to **Section 4**. ↗

If you answered **NO** to all questions in this section and:

- You are age 65 or over: Go to **Section 4**. ↗
- You are age 50 to 64: You are **NOT** eligible to apply for these plans.

4 Tell us about your tobacco usage

If you have smoked cigarettes or used any tobacco product at any time within the past twelve months, darken this circle:

Continued on next page ►

5 Answer these health questions to determine if you are eligible for this coverage

5A. Do any of these apply to you?

- have end stage renal (kidney) disease
- currently receiving dialysis
- diagnosed with kidney disease that may require dialysis
- admitted to a hospital as an inpatient within the past 90 days

Y N

5B. Within the past two years, has a medical professional recommended or discussed as a treatment option, any of the following that has **NOT** been completed:

- hospital admittance as an inpatient
- organ transplant
- back or spine surgery
- joint replacement
- surgery for cancer
- heart surgery
- vascular surgery

Y N



If you answered YES to either question in this section, you are NOT eligible for these plans at this time.

If your health status changes in the future, allowing you to answer NO to all of the questions in this section, please submit an application at that time.

For information regarding plans that may be available, contact your local state department on aging.

If you answered NO to both questions in this section, please continue to Section 6.

6 Tell us if you have any of these medical conditions to determine your rate

Complete this section only if you enrolled in Medicare Part B three or more years ago. All others go to Section 7.

Read the conditions listed below carefully. If within the past two years, you have been diagnosed, treated, or had any of the following conditions, darken the circle next to it. If you are unsure how to respond, please consult your physician.

6A. Heart or Vascular Conditions

- Aneurysm
- Arteriosclerosis or Atherosclerosis
- Artery or Vein Blockage
- Atrial Fibrillation or Atrial Flutter
- Cardiomyopathy
- Carotid Artery Disease
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Heart Attack
- Peripheral Vascular Disease or Claudication
- Stroke, Transient Ischemic Attack (TIA), or mini-stroke
- Ventricular Tachycardia

6B. Diabetes

- With any of the following complications:
Circulatory problems, Kidney problems, or Retinopathy

6C. Lung/Respiratory Conditions

- Chronic Obstructive Pulmonary Disease (COPD)
- Emphysema

6D. Cancer or Tumors

- Cancer (other than skin cancer)
- Leukemia or Lymphoma
- Melanoma

Continued on next page ►

6 Tell us if you have any of these medical conditions to determine your rate – continued

Complete this section **only if you enrolled in Medicare Part B three or more years ago**. All others go to Section 7.

Read the conditions listed below carefully. If within the past two years, you have been diagnosed, treated, or had any of the following conditions, darken the circle next to it. If you are unsure how to respond, please consult your physician.

6E. Kidney Conditions

- Chronic Renal Failure or Insufficiency
- Polycystic Kidney Disease
- Renal Artery Stenosis

6F. Liver

- Cirrhosis of the Liver

6G. Transplants

- Bone marrow or organ transplant

6H. Gastrointestinal Conditions

- Chronic Pancreatitis
- Esophageal Varices

6I. Musculoskeletal Conditions

- Amputation due to disease
- Rheumatoid Arthritis
- Spinal Stenosis

6J. Substance Abuse

- Alcohol Abuse or Alcoholism
- Drug Abuse or use of illegal drugs

6K. Brain or Spinal Cord Conditions

- Paraplegia, Quadriplegia or Hemiplegia

6L. Psychological/Mental Conditions

- Bipolar or Manic Depressive
- Schizophrenia

6M. Eye Condition

- Macular Degeneration

6N. Nervous System Conditions

- Amyotrophic Lateral Sclerosis (ALS)
- Alzheimer's Disease or Dementia
- Multiple Sclerosis (MS)
- Parkinson's Disease
- Systemic Lupus Erythematosus (SLE)

6O. Immune System Conditions

- AIDS
- HIV positive

If you darkened a circle for any of the medical conditions in this Section (6), your rate will be the level 2 rate. Please see the enclosed "Cover Page – Rates."

Continued on next page ►

7 Tell us about your past and current coverage

Please review the statements below, then answer all questions to the best of your knowledge.

- You do not need more than one Medicare Supplement insurance policy.
- You may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability, and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

For your protection, you are required to answer all the questions below (7A through 7L) and sign in the signature box on the next page.

7A. Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the Federal Medicare Program.)

Note to applicant: If you are participating in a "Spend-down Program" and have not met your "Share of Cost," please answer **NO** to this question.

Y N

If NO, skip to question **7D.**

If YES, please continue to **7B** and **7C.**

7B. Will Medicaid pay your premiums for this Medicare supplement policy?

Y N

7C. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?

Y N

Continued on next page ►

8 Authorization and Verification of Information

Please read carefully, and sign and date in the highlighted area below.

- My signature indicates I have read and understand the contents of this application form.
- I declare that the answers on this application form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that the application form becomes a part of the insurance contract. I understand that, within the first two years of the effective date of coverage, UnitedHealthcare Insurance Company may have the right to rescind my coverage, adjust my premiums, or reduce my benefits if the application form contains material misstatements.
- Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- I understand the insurance producer cannot grant approval. This application and payment of the initial premium does not guarantee coverage will be provided. I understand coverage, if provided, will not take effect until issued by UnitedHealthcare Insurance Company, and actual rates are not determined until coverage is issued.
- I understand the insurance producer may not change or waive any terms or requirements related to this application and its contents, underwriting, premium, or coverage.
- I acknowledge receipt of the **Guide to Health Insurance for People with Medicare** and the Outline of Coverage.
- I understand the person discussing plan options with me is either employed by or contracted with UnitedHealthcare Insurance Company. This person may be compensated based on my enrollment in a plan.

Authorization for the Release of Medical Information

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give UnitedHealthcare Insurance Company and its affiliates ("The Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine my eligibility for coverage and rate. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to enroll in the health plan or to receive benefits, if permitted by law. I understand the information I authorize The Company to obtain and use may be re-disclosed to a third party only as permitted under applicable law, and once re-disclosed, the information may no longer be protected by Federal privacy laws. I understand I may end this authorization if I notify The Company, in writing, prior to the issuance of coverage. After coverage is issued, this authorization is not revocable. This authorization is valid for 24 months from the date of my signature.

Please see "Your Guide" to determine if the following pre-existing condition waiting period applies to you.

I understand the plan will not pay benefits for stays beginning or medical expenses incurred during the first 3 months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within 3 months prior to the insurance effective date.

I have read all information and have answered all questions to the best of my ability.

 **Your Signature – 2 (required)**

Today's Date (required)



M	M	D	D	Y	Y	Y	Y

Note: If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

Continued on next page 

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF
MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE
UNITEDHEALTHCARE INSURANCE COMPANY**

Horsham, Pennsylvania

Save this notice! It may be important to you in the future

According to the information you furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by UnitedHealthcare Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement To Applicant By Issuer, Producer Or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement policy or leave your Medicare Advantage plan. The replacement policy is being purchased for one of the following reasons (check one):

- | | |
|---|---|
| <p>_____ Additional benefits.</p> <p>_____ No change in benefits, but lower premiums.</p> <p>_____ Fewer benefits and lower premiums</p> <p>_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.</p> | <p>_____ Disenrollment from a Medicare Advantage plan. Please explain reason for Disenrollment.</p> <p>_____ Other (Please Specify) _____</p> <p>_____</p> <p>_____</p> |
|---|---|

- | | |
|--|--|
| <p>1. Health conditions which you may presently have (Pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.</p> <p>2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to</p> | <p>the extent such time was spent (depleted) under the original policy.</p> <p>3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.</p> |
|--|--|

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer or Other Representative (Date)
(Typed Name and Address of Issuer, Producer or other representative)

(Applicant's Signature) (Date)

(Applicant's Printed Name & Address)

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|---|---|

- | | |
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(Applicant's Signature) (Date)

(Applicant's Printed Name & Address)