Application Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

AARP Membership Number (If you are already a member)

_____ – _____

First Name MI Last Name

Address Line 1

Address Line 2

City ST Zip

Note: Plans and rates described in this package are good only for residents of Washington

Instructions

1. Fill in all requested information on this form and be sure to sign where indicated.
2. Print clearly. Use CAPITAL letters.
3. Fill in the circles with black or blue ink. Not pencil.

Example: ○ Y ● N

☞ If you are not already an AARP Member, please include your AARP Membership Application and a check or money order for your annual Membership dues with this application.

✉ If reply envelope is missing, please mail to: UnitedHealthcare Insurance Company, P.O. Box 105331, Atlanta, GA 30348-5331.

1 Tell us about yourself

Birthdate

M M D D Y Y Y Y

Gender

○ M ○ F

Phone

Area Code and Phone Number

Please supply the following information, found on your Medicare card.

MEDICARE HEALTH INSURANCE

NAME
First / Middle Initial / Last

MEDICARE CLAIM #

HOSPITAL (PART A) EFFECTIVE DATE: M M 0 1 D D Y Y Y Y

MEDICAL (PART B) EFFECTIVE DATE: M M 0 1 D D Y Y Y Y

ARE BOTH MEDICARE PARTS A & B COVERAGE ACTIVE? ○ Y ○ N

E-mail address (optional)

By providing your email address, you are agreeing to receive important account information and product offers.
Be sure to write all necessary periods (.) and symbols (@) in their space.

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2 Choose your plan and effective date

Please indicate your plan choice below:

○ A ○ B ○ C ○ F ○ K ○ L ○ N

Select Plan C ○

Select Plan F ○

You are eligible to enroll if <u>all</u> of these are true:

- you are an AARP member,
- you are age 65 or older,
- you are enrolled in Medicare Parts A&B,
- you are not duplicating Medicare supplement coverage.

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

		0	1				
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 5.**

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

○ Y ○ N **If YES,** skip to **Section 5.**

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 5.**

3D. Do you intend to replace your current standardized Medicare supplement plan A through N or your more comprehensive coverage? (For example, employer-sponsored HMO, major medical, pre-standardized Medicare supplement, etc.)

○ Y ○ N **If YES,** skip to **Section 5.**

3E. 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 5.**

- If you answered **YES to 3E,** 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 Section 3, **(3A, 3B, 3C, 3D and 3E),** go to **Section 4.** ⇨

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

4A. 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

4B. 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

STOP **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 <u>both</u> questions in this section, please continue to Section 5.

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5 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 reinstituted 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 reinstituted 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 (5A through 5L) and sign in the signature box on the next page.

5A. 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 **5D.**
If YES, please continue to **5B** and **5C.**

5B. Will Medicaid pay your premiums for this Medicare supplement policy?

◯ Y ◯ N

5C. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?

◯ Y ◯ N

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5 Tell us about your past and current coverage – continued

5D. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)?

○ Y ○ N

If NO, skip to question **5H**.
If YES, fill in your start and end dates and continue to question **5E**. If you are still covered under this plan, leave the end date blank.

Start Date **End Date**

		0	1							0	1				
M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y

5E. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?

○ Y ○ N

5F. Was this your first time in this type of Medicare plan?

○ Y ○ N

5G. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

○ Y ○ N

5H. Do you have another Medicare Supplement policy in force?

○ Y ○ N

If NO, skip to question **5J**.
If YES, please continue.

5I. If YES, do you intend to replace your current Medicare Supplement policy with this policy?

○ Y ○ N

5J. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?

○ Y ○ N

If NO, please sign below, then continue to **Section 6.**
If YES, please list with what company and what type of policy in the space provided below. Then continue to question **5K**.

Company Name

Policy Type

○ HMO/PPO ○ Major Medical ○ Employer Plan
○ Union Plan ○ Other_____

5K. What are your dates of coverage under the policy you listed in **5J?** Leave the end date blank if you are still covered under the other policy.

Start Date **End Date**

M	M	D	D	Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y

5L. Are you replacing this health insurance?

○ Y ○ N

Your Signature – 1 (required)

X _____

Continued on next page ▶

6 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 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 this application form becomes a part of the insurance contract and that if the answers are incomplete, incorrect or untrue, UnitedHealthcare Insurance Company may have the right to rescind my coverage, adjust my premium, or reduce my benefits.
- It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
- I understand the 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 producer may not change or waive any terms or requirements related to this application and its contents, underwriting, premium, or coverage.
- If you are enrolling in a Medicare Select Plan: I acknowledge that I have received an Outline of Coverage, Grievance Procedure, Provider Directory and a Medicare Select Disclosure Statement covering Provider Restrictions, Right to Replace Your Medicare Supplement Plan and Quality Assurance Program. I affirm that I understand the benefits, restrictions, limitations and other provisions of the Medicare Select Plan for which I am applying.
- 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. 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.

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

Your Signature – 2 (required)

X _____

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.

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6 Authorization and Verification of Information – continued

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

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 the eligibility of and/or amount payable for my claims and for analytic studies. I understand I may end this authorization if I notify The Company, in writing, except to the extent that The Company has already acted on my authorization. If not revoked, this authorization is valid for the term of the coverage.

Your Signature – 3 **Today's Date**

X _____ 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.

Plan Rates

Please refer to the "Cover Page – Rates" for the monthly cost of the plan you have selected.

Once your application is processed, you'll be notified of your acceptance, rate and insurance start date.

Please submit your first month's payment with this application. Make your check or money order payable to: UnitedHealthcare Insurance Company. If you are currently insured under an AARP Medicare Supplement Plan, Send No Money Now. You will receive updated payment instructions later.

7 For Producer Use Only

If application is being made through a Producer, he or she must complete the following; and if appropriate, the notice of replacement coverage included with this application. All information must be completed or the application will be returned.

1. List any other medical or health insurance policies sold to the applicant:

2. List any policies that are still in force:

3. List policies sold in the past five years that are no longer in force:

Producer (Agent) Name (PLEASE PRINT) First Name MI Last Name

Producer (Agent) Phone Number

X _____ Producer (Agent) Signature (required) Producer (Agent) ID (required) M M D D Y Y Y Y

AARP membership offers so much for so little.

HEALTH / FINANCES / CONNECTING / GIVING / ENJOYING

AARP®

What Each Member Receives:		Price
Membership	- For individual member (12 months)	**$16**
Membership	- For member's spouse or partner (at any age)	**Included**
Discounts (nationwide)	- Vision: exams, frames, lenses - Pharmacy: prescriptions and over-the-counter items - Plus, look to AARPdiscounts.com for easy access to savings on trusted brands, all in one place. Enjoy one-stop deals from shopping and dining to rental cars, hotels, and cruises – and so much more!	**Included**
Trusted Information	- *AARP The Magazine*: the largest magazine circulation in the world - *AARP Bulletin Newspaper* (10 issues per year)	**Included**
Access to Health Products	- AARP-endorsed health insurance for you and your dependents - AARP-endorsed dental and long-term care insurance	**Included**
Advocacy	- Representation of your interests in Washington and your state - Confronting age discrimination by employers - Strengthening Social Security - Protecting pension and retirement benefits - Fighting predatory home loan lending	**Included**
Access to Financial Programs	- AARP-endorsed auto, homeowners, life, mobile home, motorcycle insurance - Earn rewards with a no annual fee AARP-endorsed credit card	**Included**
Local Opportunities	- Safe driving courses (also available online) - Over 2,200 local AARP chapters - Social activities, volunteer opportunities, classes & workshops	**Included**

BA25233

Yes, I'd like to join AARP today!

It's simple ... just follow these instructions.
If you're already a member, give this to someone you know or complete it to renew your membership.

Choose from 3 easy ways to join:

1.) Log on to www.AGNTU.aarpenrollment.com
2.) Call toll-free: 1-866-331-1964
3.) Send completed form in the envelope provided

_____
My Name (please print: Mr./Mrs./Ms./Dr./First, Middle Initial, Last)

_____
Address Apt.

_____
City State Zip

_____/_____/_____
Date of Birth: Month / Day / Year

I agree to pay for the term I select:

☐ **1 year/$16** ☐ **3 years/$43** ☐ **5 years/$63**

☐ Check or money order enclosed, payable to AARP. **Do not send cash.**

☐ Please keep in touch by e-mail about AARP activities, events and member benefits:

_____
Spouse's/Partner's Name (for **FREE** membership – at any age)

_____
E-mail Address V7FYUHG

Please allow up to six weeks for delivery of your Membership Kit. Dues are not deductible for income tax purposes. One membership includes spouse/partner or 2nd household member. Annual dues include $4.03 for a subscription to *AARP The Magazine* and $3.09 for the *AARP Bulletin*. We may steward your resources by converting your check into an electronic deposit. When you join or rejoin, AARP shares your membership information with the companies we have selected to provide AARP member benefits, companies that support AARP operations, and select non-profit organizations. If you do not want us to share your information with providers of AARP member benefits or non-profit organizations, please let us know by calling 1-800-516-1993 or e-mailing us at AARPmember@aarp.org. AARP member benefits are provided by third parties, not by AARP or its affiliates. Providers pay a royalty fee to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. Some provider offers are subject to change and may have restrictions. Please contact the provider directly for details.

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AARP members have access to:

Travel Discounts
Using AARP's exclusive travel savings just once could pay for your membership several times over!
- Savings on hotels, motels and resorts worldwide
- Discounted rates on airfares, cruises and auto rentals
- Special pricing on vacation packages

Health-Related Benefits
With today's high health care costs, AARP membership is more valuable than ever.
- Supplemental and custom-designed health plans for AARP members and their dependents
- Vision and prescription discounts nationwide
- Dental and long-term care insurance

Local Opportunities
AARP offers many ways to get active in your community.
- Over 2,200 local AARP chapters
- Social activities
- Volunteer opportunities
- Safe driving courses
- Classes and workshops

Protection of Your Rights
Your job. Your health. Your future. AARP will stand up for you by ...
- Representing your interests in Washington and your state
- Confronting age discrimination by employers
- Strengthening Social Security
- Protecting pension and retirement benefits
- Fighting predatory home loan lending

Dependable Financial Programs
Designed specifically for AARP members. With the high level of service you expect.
- Earn rewards with a no annual fee credit card
- Auto, homeowners, and life insurance

Valuable Information
Accurate and authoritative, direct from your reliable source – AARP.
- *AARP The Magazine*
- The *AARP Bulletin*
- FREE financial and health guides
- Our web site, www.aarp.org

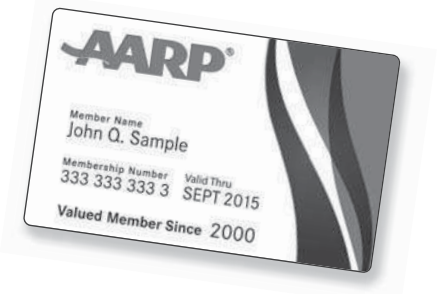
Specially Priced Products & Services
AARP helps you save in ways and places you never imagined.
- Discounts on groceries, home security, restaurants and more!
- Reduced-fee legal services*
- Roadside assistance and emergency towing

NOTE: The benefits listed are only a partial list. Your Membership Kit will supply you with a full list of approved service providers that offer exclusive services and discounts to AARP members only.

* Legal Services Network reduced-fee benefits are not available in HI, NV and OH.

Value our members appreciate.

Members often tell us their AARP membership paid for itself with the first service they use. They're surprised at how many ways and places their membership proves valuable. And it's an even better value because **your spouse/partner is included free (at any age)!**



Save $24 a year with the Electronic Funds Transfer (EFT) service

The Easiest Way to Pay

More than 2.5 million AARP® members nationwide enjoy the convenience of the EFT option. With EFT, your monthly payment will automatically be deducted from your checking or savings account. Also, you'll save $2.00 off the total monthly premium for your household.

In addition to saving up to $24 a year:

- You'll save on the cost of checks and rising postal rates.
- You don't have to take time to write a check each month.
- You don't have to worry about mailing a payment if you travel or become ill, because your payment is always deducted on or about the fifth day of each month.

Signing Up is Easy

Complete the Automatic Payment Authorization Form on the reverse side. Return it with the application and be sure to keep a copy for your records. Please be sure the information is clear, as it is required for processing your request for EFT. You do not need to include a voided check.

Your EFT Effective Date

If you are submitting this EFT form with your enrollment application, your automatic payment start date will be the same as your plan effective date. A letter will be sent to confirm this and will include the amount of your withdrawal. Please note that if your coverage is effective in the future or your account is paid in advance, EFT withdrawals will begin for the next payment due. If your account is effective in the past or is past due, a letter will be sent that explains how to make the payment that is due.

Complete Form on Reverse ▶

This side for your information only, return not required.

AUTOMATIC PAYMENT AUTHORIZATION FORM

☐ I allow UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents), hereafter named UnitedHealthcare, to take monthly withdrawals for the then-current monthly rate from the account named on this form. I also allow the named banking facility (BANK) to charge such withdrawals to this account.

Monthly withdrawal amounts will be for the total household payment due each month. This will include premiums for a spouse or other member(s) of the household on the same membership account. This authority is active until UnitedHealthcare and the BANK receive notice from me to end withdrawals in enough time to give UnitedHealthcare and the BANK a reasonable opportunity to act on it. I have the right to stop payment of a withdrawal by giving notice to the BANK in such time as to give the BANK a reasonable opportunity to act upon it. I understand such action may make the health care insurance coverage past due and subject to cancellation.

Member Name _____ AARP Member Number_____

Member Address _____
Street Addresss

Member Address _____
City State Zip Code

Bank Name _____

Bank Routing No. _____
(9 digit number)

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

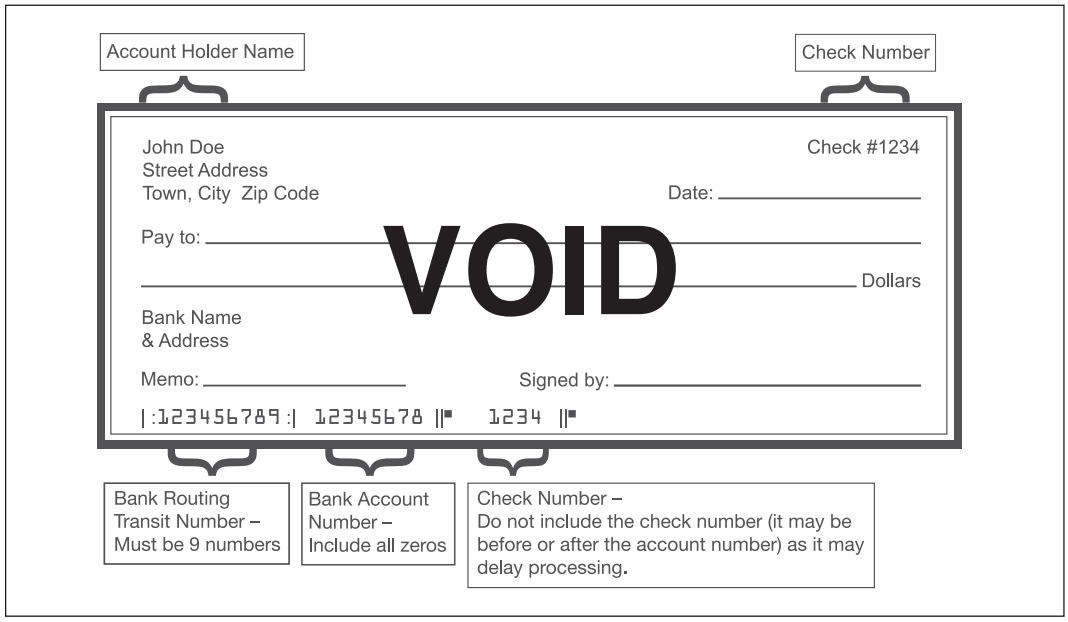
Bank Account No. _____

Bank Account Holder's Name if other than Member _____

Bank Account Holder's Signature _____

IMPORTANT

Please refer to the diagram below to obtain your bank routing information.



We look forward to continuing to serve you.

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Member Address _____
Street Addresss

Member Address _____
City State Zip Code

Bank Name _____

Bank Routing No. _____
(9 digit number)

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

Bank Account No. _____

Bank Account Holder's Name if other than Member _____

Bank Account Holder's Signature _____

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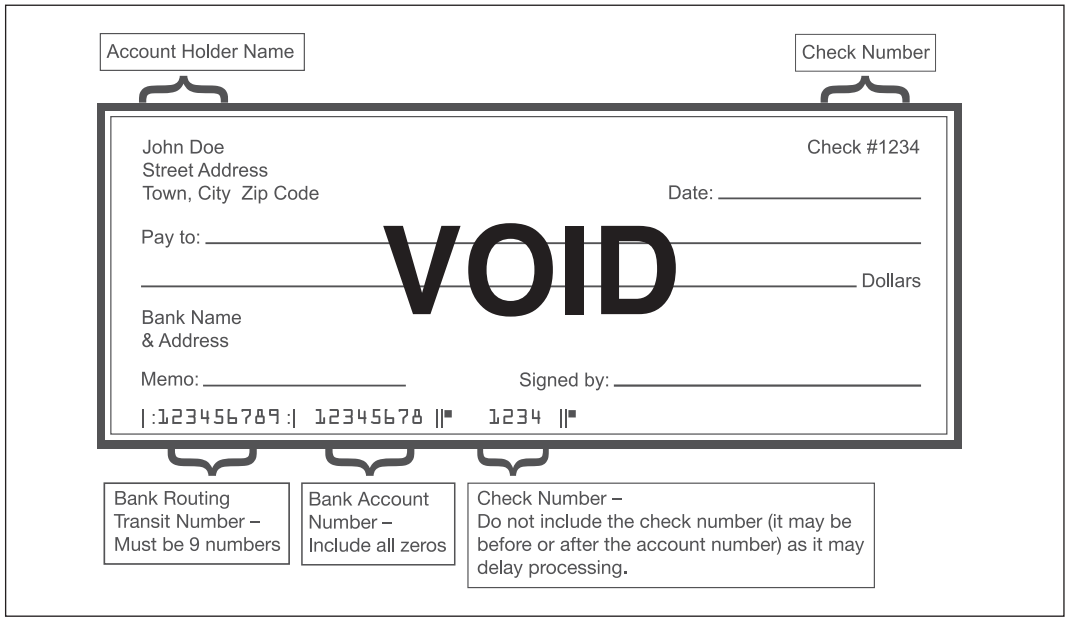

We look forward to continuing to serve you.

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):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for Disenrollment.

_____ Other (Please Specify) _____

_____

_____

1. State law provides that your replacement policy or certificate may not contain new waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
2. 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.

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)

_____

(Applicant's Signature) (Date)

_____

(Applicant's Printed Name & Address)