Application Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

About You

AARP Membership Number (If you are already a member)

Prefix First MI Last Suffix

Address Line 1

Address Line 2

City ST Zip

Date of Birth Gender

Phone Number (Primary) Phone Number (Secondary)

E-mail Address

Medicare ID (Claim) Number

Hospital (Part A) Effective Date Medical (Part B) Effective Date

Are both Medicare Parts A & B active? (Yes or No)

2422968392

Note: You must be an AARP Member in order to enroll in an AARP Medicare Supplement Insurance Plan.
The information you provide, including your e-mail address and phone number, may be used to contact you.

Plan Selection and Start Date

The following plans are available: A B C F K L N

Your choice is: ________________

You are eligible to enroll if all 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.

Requested Starting Date:
Your coverage will start on the 1st of a month. Once your application has been approved, you will receive a "Certificate of Coverage" confirming your plan start date.

I request my coverage to start on the following date:

____

Guaranteed Issue Questions

The questions in this section are used to determine if you qualify for guaranteed issue for an AARP Medicare Supplement Insurance Plan.

1. Did you turn 65 in the last 6 months?

____
Yes or No

If YES, skip to the Past and Current Insurance Coverage section.

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

____
Yes or No

If YES, skip to the Past and Current Insurance Coverage section.

3. Will your requested plan start date be within 6 months after you turn age 65 and are enrolled in Medicare Part B?

____
Yes or No

If YES, skip to the Past and Current Insurance Coverage section.

4. Have you lost an employer-sponsored health plan within the last 6 months?

____
Yes or No

If YES, skip to the Past and Current Insurance Coverage section.

5. Have you lost Medi-Cal within the last 6 months due to an increase in your income or assets?

____
Yes or No

If YES, skip to the Past and Current Insurance Coverage section.

6. Are you a military retiree, or spouse of a retiree, and within the last 6 months were your health care services cancelled due to a base closure, because the base no longer offers services, or because you relocated?

____
Yes or No

If YES, skip to the Past and Current Insurance Coverage section.

7. Was your Medicare supplement coverage cancelled within the last 6 months because your residence changed to a location not serviced by your plan?

____
Yes or No

If YES, skip to the Past and Current Insurance Coverage section.

8. Are you enrolling during your 30-day birthday Open Enrollment period that begins on your birthday?

____
Yes or No

If **YES** and you are replacing a Medicare supplement plan, you may be entitled to guaranteed issue in certain AARP Medicare Supplement Plans. **Skip to the Past and Current Insurance Coverage section.**

If **YES** and you are **NOT** replacing a Medicare supplement plan, continue to question **9**.

9. Have you lost other health insurance coverage and are you considered an eligible person as defined within the termination notice you received from your previous insurer?

____
Yes or No

If the answer is **YES**, you may be guaranteed issue in certain AARP Medicare Supplement Plans. **Please include a copy of the termination notice with your application.**

Please Read

If you answered **YES** to question **9** above, you may be guaranteed issue of certain AARP Medicare Supplement Plans, and you are not required to answer any health questions. You can move directly to the **Past and Current Insurance Coverage** section.

If you answered **NO** to all the questions in this section, please continue to the **Eligibility Health Questions** section.

Tobacco Usage – Do not answer this question if you are in your Open Enrollment or entitled to guaranteed issue.

Have you smoked cigarettes or used any tobacco product at any time within the past twelve months? ____________
Yes or No

Eligibility Health Questions

(You do not have to answer these questions if you answered **YES** to any of the questions in the previous section.)

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

1. During the past two years, were you diagnosed or treated for end-stage renal (kidney) disease?

   ____
   Yes or No or Not Sure

2. During the past two years, did a medical professional tell you that you may require dialysis?

   ____
   Yes or No or Not Sure

3. Are you currently receiving dialysis?

   ____
   Yes or No or Not Sure

4. Were you admitted to a hospital as an inpatient within the past 90 days?

   ____
   Yes or No or Not Sure

5. Within the past two years, has a medical professional told you that you may need to be hospitalized as an inpatient **and you have not yet had that hospitalization?**

   ____
   Yes or No or Not Sure

6. Within the past two years, has a medical professional told you that you may need to have any of the following surgeries **and you have not yet had that surgery?**

   - Organ transplant

     ____
     Yes or No or Not Sure

   - Back or spine surgery

     ____
     Yes or No or Not Sure

   - Joint replacement

     ____
     Yes or No or Not Sure

   - Surgery for cancer

     ____
     Yes or No or Not Sure

   - Heart surgery

     ____
     Yes or No or Not Sure

   - Vascular surgery

     ____
     Yes or No or Not Sure

Please Read

If you answered **NO** or **NOT SURE** to all of the questions in this section, please **continue to the Past and Current Insurance Coverage** section.
If you answered **YES** to any 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 these questions, please submit a new application at that time.
For information on plans that may be available, please contact your local state department on aging.

Past and Current Insurance 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 additional information concerning policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free telephone number, 1-800-434-0222, for a free referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

For your protection, you are required to answer the following questions. Please click "I have read and agree to the above" at the end of this section.

1. Are you covered for medical assistance through California's Medi-Cal program?

Note to applicant: If you have a share of cost under the Medi-Cal program, please answer **NO** to this question.

____
Yes or No

PLEASE READ
If you answered **YES** to question **1**, please answer questions **2** and **3**.

If you answered **NO** to question **1**, please skip to question **4**.

2. If **YES**, will Medi-Cal pay your premiums for this Medicare supplement policy?

____
Yes or No

3. Do you receive any benefits from Medi-Cal **OTHER THAN** payments toward your Medicare Part B premium?

____
Yes or No

Past and Current Insurance Coverage - *continued*

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

______
Yes or No

PLEASE READ
If you answered **YES** to question **4**, please enter your coverage start and end dates below and continue to questions **5**, **6** and **7**. (Note: If you are still covered under this plan, leave the End Date blank.)

If you answered **NO** to question **4**, please skip to question **8**.

______ **Start Date** ______ **End Date**

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

______
Yes or No

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

______
Yes or No

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

______
Yes or No

8. Do you have another Medicare Supplement policy in force?

______
Yes or No

PLEASE READ
If you answered **YES** to question **8**, please continue to question **9**.

If you answered **NO** to question **8**, please skip to question **10**.

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

______
Yes or No

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

______
Yes or No

PLEASE READ
If you answered **YES** to question **10**, please list with what insurance company and what type of policy in the space provided below and continue to questions **11** and **12**.

If you have answered **NO** to question **10**, please click "I have read and agree to the above" at the end of this section and move to the **Review and Submit** portion of the application.

______
Company Name

______
Policy Type
(HMO/PPO, Major Medical, Employer Plan, Union Plan or Other)

11. What are your dates of coverage under the policy you listed in **10**? Leave the end date blank if you are still covered under the other policy.

______ **Start Date** ______ **End Date**

12. Are you replacing this health insurance?

______
Yes or No

☐ I have read and agree to the above.

______
Today's Date

IMPORTANT INFORMATION

PLEASE READ CAREFULLY AND CLICK "I have read and agree to the above" AT THE END OF THIS SECTION.

- My electronic signature indicates I have read and understand the contents of this application form.
- I affirm that the answers on this application are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that the enrollment 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 or adjust my premium.
- 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 when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.
- I acknowledge that I have reviewed the ***Guide to Health Insurance for People with Medicare*** and the Outline of Coverage.
- I understand the coverage under the plan I am applying for will not take effect until issued by UnitedHealthcare Insurance Company.

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

☐ I have read and agree to the above.

____

Today's Date

IMPORTANT INFORMATION - *continued*

Authorization for the Release of Medical Information
Not required if you answer "yes" to any question in the Guaranteed Issue Questions section. I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, or insurance company 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 only as permitted under applicable federal or state law. 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 valid for 24 months from the date of my signature. I understand that I or my authorized representative may obtain a copy of this form.

Please see "Your Guide" to determine if the following pre-existing condition waiting period applies to you. The pre-existing condition exclusion does not apply to you if you are in your Open Enrollment or entitled to guaranteed issue.

I understand the plan will not pay benefits for 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.

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

Not required if you answered "YES" to any of the questions in the Guaranteed Issue Questions section.

☐ I have read and agree to the above.

____
Today's Date

PLEASE READ CAREFULLY AND CLICK "I have read and agree to the above" AT THE END OF THIS SECTION.

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, or insurance company 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.

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

☐ I have read and agree to the above.

____
Today's Date