

SERFF Tracking Number: UHLC-125858994 State: Arkansas
Filing Company: United HealthCare Insurance Company State Tracking Number: 40540
Company Tracking Number: B65189USWBAR01 01A
TOI: MS05G Group Medicare Supplement - Standard Sub-TOI: MS05G.001 Plan A
Plans
Product Name: Medicare Supplement
Project Name/Number: On Line Agent Enrollment Applications/B65189USWBAR01 01A

Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: Medicare Supplement SERFF Tr Num: UHLC-125858994 State: ArkansasLH

TOI: MS05G Group Medicare Supplement - SERFF Status: Closed State Tr Num: 40540

Standard Plans

Sub-TOI: MS05G.001 Plan A Co Tr Num: B65189USWBAR01 State Status: Filed-Closed
01A

Filing Type: Advertisement Co Status: Reviewer(s): Stephanie Fowler

Authors: Michelle Ambach, Tammy Frederick, Bobbie Walton Disposition Date: 11/14/2008

Date Submitted: 10/15/2008 Disposition Status: Filed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: On Line Agent Enrollment Applications

Project Number: B65189USWBAR01 01A

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 11/14/2008

State Status Changed: 11/14/2008

Corresponding Filing Tracking Number:

Filing Description:

We enclose for your information and review, proof copies of an enrollment application which will be used on URL: www.aarphealth.com for use in connection with the AARP Medicare Supplement Insurance Plans. This advertisement is new and is very similar in content to the paper version of the Agent's application that was approved by the Department on 9/28/07 under file no: B50405NMDUAR01 01A.

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Association

Deemer Date:

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“The definitions, disclosures, eligibility requirements, exclusions, limitations, Group Policy Form No. GRP 79171 GPS-1, as well as the statement “.....not connected with, or endorsed by, the U.S. Government or the federal Medicare program” can be found on BA8982 DIS AR WEB (02/06) which was approved by the Department on 10/2/08 under file no: BA8982 DIS AR WEB (02/06).

Company and Contact

Filing Contact Information

Susan Cipollo, Director Susan_J_Cipollo@uhc.com
 601 Office Center Dr. (267) 470-1519 [Phone]
 Fort Washington, PA 19034 (267) 470-1906[FAX]

Filing Company Information

United HealthCare Insurance Company CoCode: 79413 State of Domicile: Connecticut
 450 Columbus Boulevard Group Code: 707 Company Type: Health
 PO Box 150450
 Hartford, CT 06115-0450 Group Name: State ID Number:
 (215) 653-8046 ext. [Phone] FEIN Number: 36-2739571

Filing Fees

Fee Required? Yes
 Fee Amount: \$25.00
 Retaliatory? No
 Fee Explanation: STATE REQUIRED FILING FEE
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	\$25.00	10/15/2008	23195087

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Stephanie Fowler	11/14/2008	11/14/2008

SERFF Tracking Number: UHLC-125858994 *State:* Arkansas
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Disposition

Disposition Date: 11/14/2008

Implementation Date:

Status: Filed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Form	ENROLLMENT FORM	Filed	Yes

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Form Schedule

Lead Form Number: B65189USWBAR01 01A

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Filed	B65189USWBAR01 01A	Application/ENROLLMENT	Enrollment FORM	Initial		50	AR_final.pdf

STEPS

1 2 3 4 5 6 7 8 9 10

INSTRUCTIONS

? Help

Required input fields are marked with an asterisk (*)

Welcome to the online enrollment program for the AARP Medicare Supplement Insurance Plan, insured by United HealthCare Insurance Company, Fort Washington, PA 19034. Please read all information on this page before beginning your application.

BEFORE GETTING STARTED

Before getting started, you will need to have the following information available during the enrollment process:

- **Medical history**, if applicable
- **Prior insurance coverage information**, if applicable

The estimated time required to complete the application process is approximately 35 minutes.

If you do not complete the process and leave your computer idle for 30 minutes, you will be logged out of your application.

As you click the "Continue" and "Previous" buttons while you complete your application, your information will be saved. You can retrieve your saved application at any time by visiting the "Your Account" section of the AARP Health website.

You will not be required to pay for your insurance coverage at the time of the online enrollment; you will be billed later for your first month's premium.

If you are currently insured, you will be receiving updated information reflecting your new monthly rate.

Your coverage will become effective on the first day of the month following receipt and approval of your completed application, provided your first month's payment is received within 30 days from the effective date shown on your Certificate of Insurance.

Once your enrollment application is processed, we'll notify you by mail of:

- Your acceptance
- Your rate
- Your coverage start date

See the Benefit and Rate Chart for the rates.

HERE'S HOW TO APPLY...

1. **Complete** the online enrollment application,
2. **Verify** the information you provided on the enrollment application,
3. **Submit** the online enrollment application, and
4. **Forward** any additional documentation identified during the application process that will be required to process your application.

If you have any questions during your online enrollment process, please utilize the **online Help Feature** located at the top right corner of each screen or **contact a Customer Service Representative at 1-800-684-7609** between the hours of **7am-11pm EST Monday - Friday and 9am-5pm EST Saturday**.

Please mail or fax the additional documentation to:

AARP Health
United HealthCare Enrollment Division
P.O. Box 105331
Atlanta, GA 30348-5331

Fax Number: **888-836-3985**

CONTINUE ▶

STEPS

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TELL US ABOUT YOURSELF

? Help

Required input fields are marked with an asterisk (*)

AARP Membership Number: 014241666-1

Contact Information: MR JTOFTZT X SIMPSON

123 Main St.

Boyertown, AR 19502

Phone Number: (215) 653-1212

E-mail Address: test@uhc.com

Birth Date: 2/11/1919

Gender: F

Medicare Health Insurance

(Click [here](#) to view a sample Medicare Health Insurance card)

Medicare Claim Number:

(Please enter Medicare Claim Number without dashes or spaces)

Hospital (Part A) Effective Date: / 01 /

M M / D D / Y Y Y Y

Medical (Part B) Effective Date: 1/1/1984

* Are both Medicare Parts A & B coverage active? Yes No

Promotional Code: PROMO

(optional)

◀ PREVIOUS

CONTINUE ▶

STEPS

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SELECT THE AARP-ENDORSED PLAN THAT BEST MEETS YOUR NEEDS

? Help

Required input fields are marked with an asterisk (*)

* I wish to apply for Plan (select one):

AARP Medicare Supplement Plan

- Medicare Supplement Plan A
- Medicare Supplement Plan B
- Medicare Supplement Plan C
- Medicare Supplement Plan D
- Medicare Supplement Plan E
- Medicare Supplement Plan F
- Medicare Supplement Plan G
- Medicare Supplement Plan H
- Medicare Supplement Plan I
- Medicare Supplement Plan J

AARP Medicare Select

- AARP Medicare Select Plan C

- You are eligible to apply if you are an AARP member, or the spouse of a member, age 65 or older, enrolled in Medicare Parts A and B, and not duplicating Medicare Supplement coverage. (Note: If you are not yet age 65, you may only apply for one of the AARP Medicare Supplement Plans A through J.)
- Please refer to the Outline of Medicare Supplement Coverage - Cover Page for the monthly cost of the plan you have selected. **SEND NO MONEY NOW.** You will be billed later.
- Your coverage will become effective on the first day of the month following receipt and approval of your completed enrollment application and first month's payment, if applicable. You will receive a Certificate of Insurance confirming your effective date. (If you would like your coverage to begin at a later date, please indicate below.)

Requested Effective Date:

/ 01 /

M M / D D / Y Y Y Y

(first of the future month)

If you answer "Yes" to the following question, your ACCEPTANCE IS GUARANTEED and you can SKIP THE NEXT TWO STEPS.

* Are you already insured under an AARP Medicare Supplement Plan and changing plans?

- Yes
- No

◀ PREVIOUS

CONTINUE ▶

STEPS

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YOUR ACCEPTANCE MAY BE GUARANTEED

? Help

Required input fields are marked with an asterisk (*)

a) * Did you turn age 65 in the last 6 months?

Yes No

b) * Did you enroll in Medicare Part B, at age 65 or older, within the last 6 months?

Yes No

If you answer "Yes" to either of the questions above, your ACCEPTANCE IS GUARANTEED and you can SKIP THE NEXT STEP.

c) 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? If the answer is "Yes," you may be guaranteed acceptance in certain AARP Medicare Supplement Plans. A copy of your termination notice must be submitted in order to successfully process your application. SKIP THE NEXT STEP.

Yes No

If you answered "No" to a, b, and c above, GO TO THE NEXT STEP.

◀ PREVIOUS

CONTINUE ▶

STEPS

1 2 3 4 5 6 7 8 9 10

ONE QUICK QUESTION

? Help

Required input fields are marked with an asterisk (*)

If you answer "Yes" to the question below and do not meet any of the Guaranteed Acceptance requirements in the previous step, you are NOT eligible for these plans. For information regarding plans that may be available to you, contact your local state department on aging. If you answer "No" to the question below, GO TO THE NEXT STEP.

* Do you have end stage renal disease, or are you currently receiving dialysis, or have you been diagnosed, within the past 90 days, with kidney disease that requires dialysis?

Yes No

◀ PREVIOUS

CONTINUE ▶

STEPS

1 2 3 4 5 6 7 8 9 10

FOR YOU PROTECTION YOU ARE REQUIRED TO ANSWER ALL THE FOLLOWING QUESTIONS AND SIGN WHERE INDICATED

? Help

Required input fields are marked with an asterisk (*)

MR JTQFTZZT X SIMPSON

123 Main St.

Boyertown, AR 19502

- You do not need more than one Medicare supplement 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).

Please answer all questions to the best of your knowledge.

1) * Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run healthcare 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.] If "Yes," continue. If "No," go to question number 2.

Yes No

1a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes No

1b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes No

2a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START: / /
M M / D D / Y Y Y Y

END: / /
M M / D D / Y Y Y Y

2b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes No

2c) Was this your first time in this type of Medicare plan?

Yes No

2d) Did you drop a Medicare supplement policy to enroll in the Medicare Plan?

Yes No

3a) Do you have another Medicare supplement policy in force?

Yes No

3b) If so, with what company and what plan do you have?

Company:

Plan Type:

3c) If "Yes," do you intend to replace your current Medicare supplement policy with this policy?

Yes No

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

Yes No

4a) If "Yes," with what company and what kind of policy?

Company:

Type of Policy:

4b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

START: / /
MM / DD / YYYY

END: / /
MM / DD / YYYY

4c) Are you replacing the other health insurance indicated in question 4a?

Yes No

* I have read and agree to the above.

[◀ PREVIOUS](#)

[CONTINUE ▶](#)

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B65189USWBAR01 01A

STEPS — 1 2 3 4 5 6 7 8 9 10

PLEASE REVIEW YOUR INFORMATION

? Help

Required input fields are marked with an asterisk (*)

- Carefully review your answers below.
- Use the [\[edit\]](#) link next to each section title to go back and edit that section.
- When you are satisfied that you have answered all questions accurately, click "CONTINUE."

TELL US ABOUT YOURSELF

[\[edit\]](#)

AARP Membership Number: 014241666-1
Contact Information: MR JTOFTZZT X SIMPSON
123 Main St.
Boyertown, AR 19502
Phone Number: (215) 653-1212
E-mail Address: test@uhc.com
Birth Date: 2/11/1919
Gender: F

Medicare Health Insurance

Medicare Claim Number:
Hospital (Part A) Effective Date:
Medical (Part B) Effective Date: 2/1/1984
Are both Medicare Parts A & B coverage active?

Promotional Code: PROMO2791

SELECT THE AARP-ENDORSED PLAN THAT BEST MEETS YOUR NEEDS

[\[edit\]](#)

* I wish to apply for Plan (select one):

Medicare Supplement Plan F

- You are eligible to apply if you are an AARP member, or the spouse of a member, age 65 or older, enrolled in Medicare Parts A and B, and not duplicating Medicare Supplement coverage. (Note: If you are not yet age 65, you may only apply for one of the AARP Medicare Supplement Plans A through J.)
- Please refer to the Outline of Medicare Supplement Coverage - Cover Page for the monthly cost of the plan you have selected. **SEND NO MONEY NOW.** You will be billed later.
- Your coverage will become effective on the first day of the month following receipt and approval of your completed enrollment application and first month's payment, if applicable. You will receive a Certificate of Insurance confirming your effective date. (If you would like your coverage to begin at a later date, please indicate below.)

Requested Effective Date:

If you answer "Yes" to the following question, your ACCEPTANCE IS GUARANTEED and you can SKIP THE NEXT TWO STEPS.

* Are you already insured under an AARP Medicare Supplement Plan and changing plans?

No

YOUR ACCEPTANCE MAY BE GUARANTEED

[\[edit\]](#)

a) * Did you turn age 65 in the last 6 months?

No

b) * Did you enroll in Medicare Part B, at age 65 or older, within the last 6 months?

No

If you answered "Yes" to either of the questions above, your ACCEPTANCE IS GUARANTEED and you can SKIP THE NEXT STEP.

c) 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? If the answer is "Yes," you may be guaranteed acceptance in certain AARP Medicare Supplement Plans. A copy of the termination notice must be submitted to successfully process your application. SKIP THE NEXT THREE STEPS.

No

If you answered "No" to a, b, and c above, GO TO THE NEXT STEP.

ONE QUICK QUESTION

[\[edit\]](#)

If you answer "Yes" to the question below and do not meet any of the Guaranteed Acceptance requirements in the previous step, you are NOT eligible for these plans. For information regarding plans that may be available to you, contact your local state department on aging. If you answer "No" to the question below, GO TO THE NEXT STEP.

* Do you have end stage renal disease, or are you currently receiving dialysis, or have you been diagnosed, within the past 90 days, with kidney disease that requires dialysis?

No

FOR YOUR PROTECTION YOU ARE REQUIRED TO ANSWER ALL THE FOLLOWING QUESTIONS AND SIGN WHERE INDICATED

[\[edit\]](#)

MR JTOFTZZT X SIMPSON

123 Main St.

Boyertown, AR 19502

- You do not need more than one Medicare supplement 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).

Please answer all questions to the best of your knowledge.

1) * Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run healthcare 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.] If "Yes," continue. If "No," go to question number 2.

No

1a) Will Medicaid pay your premiums for this Medicare supplement policy?

1b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

2a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START:

END:

2b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

2c) Was this your first time in this type of Medicare plan?

2d) Did you drop a Medicare supplement policy to enroll in the Medicare Plan?

3a) Do you have another Medicare supplement policy in force?

No

3b) If so, with what company and what plan do you have?

Company:

Plan Type:

3c) If "Yes," do you intend to replace your current Medicare supplement policy with this policy?

No

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

4a) If "Yes," with what company and what kind of policy?

Company:

Type of Policy:

4b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

START:

END:

4c) Are you replacing the other health insurance indicated in question 4a?

✓ * I have read and agree to the above.

◀ PREVIOUS

CONTINUE ▶

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B65189USWBAR01 01A

STEPS — 1 2 3 4 5 6 7 8 9 10

IMPORTANT AUTHORIZATION AND VERIFICATION INFORMATION

? Help

Required input fields are marked with an asterisk (*)

- My electronic signature below indicates that I have read and understand the contents of this application.
- I declare 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 application becomes a part of the insurance contract and that if the answers are incomplete, incorrect or untrue, United HealthCare Insurance Company may have the right to rescind my coverage, adjust my premium, or reduce my benefits.
- 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 material fact 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 understand that the coverage under the plan I am applying for will not take effect until issued by United HealthCare Insurance Company.
- I understand that the agent or broker cannot grant approval. This application and payment of the initial premium does not guarantee coverage will be provided. I understand that coverage, if provided will not take effect until issued by United HealthCare Insurance Company and actual rates are not determined until coverage is issued.
- I understand that the agent or broker may not change or waive any terms or requirements related to this application and its contents, underwriting, premium, or coverage.

Authorization for the Release of Medical Information to United HealthCare Insurance Company.

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 United HealthCare 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 that 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.

The following exclusion will not apply to you if your application is received by United HealthCare prior to or during the 6-month period beginning with the first day of the month in which you turn age 65 and enroll in Medicare Part B, or if mandated by state law. Please see "Your Guide" to determine if the following pre-existing condition waiting period applies to you.

I understand that 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 understand that the person discussing plan options with me is either employed by or contracted with United HealthCare Insurance Company. This person may be compensated based on my enrollment in a plan.

If you are enrolling in the Medicare Select Plan: I acknowledge that I have reviewed the 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.

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

* I have read and agree to the above.

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 United HealthCare 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. I understand that 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 of the applicant, please submit a copy of the appropriate legal documentation.

* I have read and agree to the above.

◀ PREVIOUS

CONTINUE ▶

STEPS

1 2 3 4 5 6 7 8 **9** 10

AGENT ONLY INFORMATION

? Help

Required input fields are marked with an asterisk (*)

If application is being made through an agent, 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.

List any other medical or health insurance policies sold to the applicant:
<input type="text"/>
List any policies that are still in force:
<input type="text"/>
List policies sold in the past five years that are no longer in force:
<input type="text"/>
Agent Name:
Agent Phone Number:
Agent ID:
<input type="checkbox"/> * Agent: I have read and agree to the above.

◀ PREVIOUS

CONTINUE ▶

STEPS

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NOTICE TO APPLICANT

? Help

Required input fields are marked with an asterisk (*)

**NOTE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE
UNITED HEALTHCARE INSURANCE COMPANY
Fort Washington, Pennsylvania**

SAVE THIS NOTICE! MAY BE IMPORTANT TO YOU IN THE FUTURE

According to the information you furnished, you intent to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by United HealthCare Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you may 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, AGENT, BROKER 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. 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.
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 the extent such time was spent (depleted) under the original policy.
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 had 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.

* I have read and agree to the above (Agent, Broker or Other Representative)

* I have read and agree to the above (Applicant)

◀ PREVIOUS

Submit Application

SERFF Tracking Number: UHLC-125858994 *State:* Arkansas
Filing Company: United HealthCare Insurance Company *State Tracking Number:* 40540
Company Tracking Number: B65189USWBAR01 01A
TOI: MS05G Group Medicare Supplement - Standard Sub-TOI: MS05G.001 Plan A
Plans
Product Name: Medicare Supplement
Project Name/Number: On Line Agent Enrollment Applications/B65189USWBAR01 01A

Rate Information

Rate data does NOT apply to filing.