

SERFF Tracking Number: UHLC-126333914 State: Arkansas
Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 43696
Company Tracking Number: M75146IMMMAR01 01B
TOI: MS071 Individual Medicare Supplement - Sub-TOI: MS071.001 Plan A 2010
Medicare Select 2010
Product Name: MEDICARE SUPPLEMENT
Project Name/Number: MIPPA ENROLLMENT APPLICATIONS/M75146IMMMAR01 01B

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: MEDICARE SUPPLEMENT SERFF Tr Num: UHLC-126333914 State: Arkansas
TOI: MS071 Individual Medicare Supplement - SERFF Status: Closed-Approved- State Tr Num: 43696
Medicare Select 2010 Closed
Sub-TOI: MS071.001 Plan A 2010 Co Tr Num: M75146IMMMAR01 State Status: Approved-Closed
01B

Filing Type: Form Reviewer(s): Stephanie Fowler
Author: Bobbie Walton Disposition Date: 11/13/2009
Date Submitted: 10/06/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:
State Filing Description:

General Information

Project Name: MIPPA ENROLLMENT APPLICATIONS Status of Filing in Domicile: Not Filed
Project Number: M75146IMMMAR01 01B Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Large
Overall Rate Impact: Group Market Type: Association
Filing Status Changed: 11/13/2009 Explanation for Other Group Market Type:
State Status Changed: 11/13/2009

Deemer Date: Created By: Bobbie Walton
Submitted By: Bobbie Walton Corresponding Filing Tracking Number:

Filing Description:
RE: United HealthCare Insurance Company
AARP Medicare Supplement Enrollment Applications Filing
MIPPA
NAIC No: 0707-79413
File No: M75146IMMMAR01 01B, et al (PLEASE USE THIS NUMBER IN ALL CORRESPONDENCE)

We enclose for your information, proof copies of enrollment applications for use in connection with the AARP group

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health insurance program. The enclosed enrollment applications are new and do not replace any material previously submitted to the Department. Forms S93143AGMMAR01 01B and S93244AGMMAR01 01B will be used for sales by agents, while the other enclosed application forms will be used in our various direct-to-consumer campaigns.

Standardized Medicare Supplement Certificates: MDA 0001 – MDN 0007 (Non-Agent Sales Only), Standardized Medicare Supplement Certificates: MAA 0010 – MAN 0016 (Agent Sales only)
 Standardized Medicare Select Certificate: MDSC 0008, MDSF 0009 (Non-Agent Sales Only), Standardized Medicare Select Certificate: MASC 0017, MASF 0018 (Agent Sales only)
 were previously approved by the Department on September 4, 2009 under SERFF# UHLC-126263862.

Company and Contact

Filing Contact Information

Susan Cipollo, Director Susan_J_Cipollo@uhc.com
 680 Blair Mill Rd. 215-902-8444 [Phone]
 Horsham, PA 19044 215-902-8813 [FAX]

Filing Company Information

UnitedHealthcare Insurance Company CoCode: 79413 State of Domicile: Connecticut
 450 Columbus Boulevard Group Code: 707 Company Type: Life and Health
 PO Box 150450 Group Name: State ID Number:
 Hartford, CT 06115-0450 FEIN Number: 36-2739571
 (860) 702-5000 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? No
 Fee Explanation: \$20 PER ENROLLMENT FORM - 10 ENROLLMENT FORMS = \$200
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	\$200.00	10/06/2009	31087854

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	11/13/2009	11/13/2009

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Disposition

Disposition Date: 11/13/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	ENROLLMENT APPLICATION	Approved	Yes
Form	ENROLLMENT APPLICATION	Approved	Yes
Form	ENROLLMENT APPLICATION	Approved	Yes
Form	ENROLLMENT APPLICATION	Approved	Yes
Form	ENROLLMENT APPLICATION	Approved	Yes
Form	ENROLLMENT APPLICATION	Approved	Yes
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Form	ENROLLMENT APPLICATION	Approved	Yes
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Form Schedule

Lead Form Number: M75146IMMMAR01 01B

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 11/13/2009	M75146IM MMAR01 01B	Application/ Enrollment Form	ENROLLMENT APPLICATION	Initial		50.000	M75146IMM MAR01 01B.pdf
Approved 11/13/2009	M92942MN MMAR01 01B	Application/ Enrollment Form	ENROLLMENT APPLICATION	Initial		50.000	M92942MNM MAR01 01B.pdf
Approved 11/13/2009	M94140MN MMAR01 01B	Application/ Enrollment Form	ENROLLMENT APPLICATION	Initial		50.000	M94140MNM MAR01 01B.pdf
Approved 11/13/2009	S75646IM MAR01 01B	Application/ Enrollment Form	ENROLLMENT APPLICATION	Initial		50.000	S75646IMMM AR01 01B.pdf
Approved 11/13/2009	S93042MN MMAR01 01B	Application/ Enrollment Form	ENROLLMENT APPLICATION	Initial		50.000	S93042MNM MAR01 01B.pdf
Approved 11/13/2009	S93143AG MMAR01 01B	Application/ Enrollment Form	ENROLLMENT APPLICATION	Initial		50.000	S93143AGM MAR01 01B.pdf
Approved 11/13/2009	S93244AG MMAR01 01B	Application/ Enrollment Form	ENROLLMENT APPLICATION	Initial		50.000	S93244AGM MAR01 01B.pdf
Approved 11/13/2009	S94340MN MMAR01 01B	Application/ Enrollment Form	ENROLLMENT APPLICATION	Initial		50.000	S94340MNM MAR01 01B.pdf
Approved 11/13/2009	M94245MM MMAR01 01B	Application/ Enrollment Form	ENROLLMENT APPLICATION	Initial		50.000	M94245MMM MAR01 01B.pdf
Approved 11/13/2009	S94445MN MMAR01 01B	Application/ Enrollment Form	ENROLLMENT APPLICATION	Initial		50.000	S94445MNM MAR01 01B.pdf

Sample A. Sample
XX
XX
XX

2 Choose your plan and effective date

Please indicate your plan choice below:

A B C D F G K L M N

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.

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 Past and current coverage information

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).

Continued on next page ►

Sample A. Sample
XX
XX
XX

3 Past and current coverage information, continued

3K. What are your dates of coverage under the policy you listed in **3J**? Leave the end date blank if you are still covered under the other policy.

3L. Are you replacing this health insurance?

Y N

Start Date **End Date**
|_|_|_|_|_|_|_| |_|_|_|_|_|_|_|
M M D D Y Y Y Y M M D D Y Y Y Y

4 Verification of Information

Please read carefully, and sign and date in the signature box below.

- My signature indicates I have read and understand the contents of this enrollment form.
- I declare the answers on this enrollment form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this 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, 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 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 understand the coverage under the plan I am applying for will not take effect until issued by UnitedHealthcare Insurance Company.

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

 **Your Signature** (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.

ENROLLMENT FORM CHECKLIST

Did you remember to...

- ✓ Complete this enrollment form in black or blue INK?
- ✓ Fill in all information in all sections?
- ✓ Sign in the signature box above?

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

Send No Money Now for this new coverage. Continue to make your current payments until you receive a new coupon book or notification of your new EFT withdrawal amount.

Thank you!

XXXX-XXX

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Application Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

Note: Plans and rates in this kit are good only for this person at the address above.

Please reply by xxxxxx
for coverage to be effective on xxxxxx

AARP membership number
xxxxxx

Have you changed your name or address?

Y N

If **YES**, please write your new name and/or address below:

Name _____

Street Number/Name _____

City/State/Zip Code _____

Instructions

1. Fill in all requested information on this form and sign in the 3 places 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 Membership dues with this application.
- Mail the completed form(s) in the enclosed envelope. If your envelope is missing, please mail to: UnitedHealthcare Insurance Company, P.O. Box 105331, Atlanta, GA 30348-5331.

You can also apply online at: [\[www.aarphealthcare.com\]](http://www.aarphealthcare.com) or fax this form to [\[1-888-836-3985\]](tel:1-888-836-3985)

Questions? Please call [\[1-800-620-9037\]](tel:1-800-620-9037) to talk to a representative. [\[\(TTY: 1-800-232-7773\)\]](tel:1-800-232-7773)

1 Tell us about yourself

Birthdate

MM DD YYYY

Gender

M F

Phone

Area Code and Phone Number

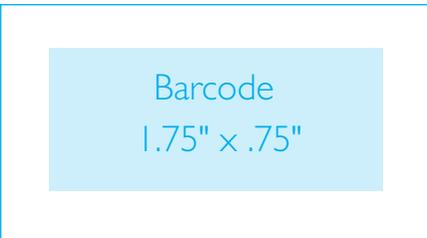
Please supply the following information, found on your Medicare card.

MEDICARE HEALTH INSURANCE	
NAME	First / Middle Initial / Last
MEDICARE CLAIM #	
HOSPITAL (PART A) EFFECTIVE DATE:	MM DD YYYY
MEDICAL (PART B) EFFECTIVE DATE:	MM DD YYYY

E-mail address (optional)

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

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.



XXXXXXXXXX

XX/XX/XX

Continued on next page

Sample A. Sample
XX
XX
XX

2 Choose your plan and effective date

Please indicate your plan choice below:

A B C D F G K L M N

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.

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 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. ↓

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 ►

Sample A. Sample
XX
XX
XX

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 7 or more months 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, call us at the number listed below, or 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 ►

Sample A. Sample
XX
XX
XX

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 7 or more months 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, call us at the number listed below, or 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 

Sample A. Sample
XX
XX
XX

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

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

If **NO**, skip to question **7D**.
If **YES**, please continue to **7B** and **7C**.

Continued on next page 

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

8 Authorization and Verification of Information

Please read carefully, and sign and date in the signature box 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.
- 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 understand the coverage under the plan I am applying for will not take effect until issued by UnitedHealthcare Insurance Company.

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 

Sample A. Sample
XX
XX
XX

8 Authorization and Verification of Information

Please read carefully, and sign and date in the signature box 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																
 _____	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>									M	M	D	D	Y	Y	Y	Y
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.																	

APPLICATION FORM CHECKLIST

Did you remember to...

- ✓ Complete this application form in black or blue INK?
- ✓ Fill in all requested information in all sections?
- ✓ Sign in all 3 signature boxes?
- ✓ Include termination notice from previous insurance coverage (if applicable)?
- ✓ Enclose your first month's insurance payment? Please refer to the enclosed "Cover Page – Rates" for the monthly cost of the plan you have selected. If you answered YES to any medical conditions in Section 6, your rate will be the level 2 rate.
Make check or money order payable to: UnitedHealthcare Insurance Company.
- ✓ Complete the AARP membership form and enclose your dues (if not already a member)?

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

Thank you!

XXXX-XXX

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Enrollment Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

Note: Plans and rates in this kit are good only for this person at the address above. You may enroll using this form only if you are turning 65 or first enrolling in Medicare Part B at age 65 or older.

Please reply by xxxxxx
for coverage to be effective on xxxxxx

AARP membership number
xxxxxx

Have you changed your name or address?

Y N

If **YES**, please write your new name and/or address below:

Name _____

Street Number/Name _____

City/State/Zip Code _____

Instructions

1. Fill in all requested information on this form and sign in the area indicated.
2. Print clearly. Use CAPITAL letters.
3. Fill in the circles with black or blue ink.

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 Membership dues with this application.
- ✉ Mail the completed form(s) in the enclosed envelope. If your envelope is missing, please mail to: UnitedHealthcare Insurance Company, P.O. Box 105331, Atlanta, GA 30348-5331.

📄 You can also apply online at: www.aarphealthcare.com or fax this form to [1-888-836-3985]

Questions? Please call [1-800-620-9037] to talk to a representative. [(TTY: 1-800-232-7773)]

1 Tell us about yourself

Birthdate

MM DD YYYY

Gender

M F

Phone

Area Code and Phone Number

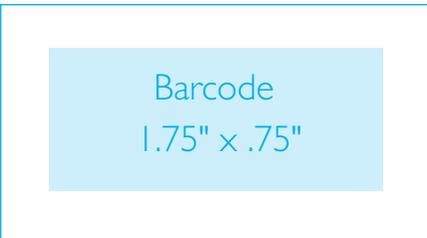
Please supply the following information, found on your Medicare card.

MEDICARE HEALTH INSURANCE	
NAME	First / Middle Initial / Last
MEDICARE CLAIM #	
HOSPITAL (PART A) EFFECTIVE DATE:	MM DD YYYY
MEDICAL (PART B) EFFECTIVE DATE:	MM DD YYYY

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.



XXXXXXXXXX XX/XX/XX

Continued on next page ►

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

2 Choose your plan and effective date

Please indicate your plan choice below:

A B C D F G K L M N

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.

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
		0	1				

3 Past and current coverage information

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).

Continued on next page ►

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

3 Past and current coverage information, continued

3K. What are your dates of coverage under the policy you listed in **3J**? Leave the end date blank if you are still covered under the other policy.

3L. Are you replacing this health insurance?

Y N

Start Date

End Date

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

4 Verification of Information

Please read carefully, and sign and date in the signature box below.

- My signature indicates I have read and understand the contents of this enrollment form.
- I declare the answers on this enrollment form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this 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, 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 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 understand the coverage under the plan I am applying for will not take effect until issued by UnitedHealthcare Insurance Company.

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

 **Your Signature** (required)

Today's Date (required)

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.

ENROLLMENT FORM CHECKLIST

Did you remember to...

- ✓ Complete this enrollment form in black or blue INK?
- ✓ Fill in all information in all sections?
- ✓ Sign in the signature box above?

- ✓ Enclose your first month's insurance payment? Please refer to enclosed "Cover Page – Rates" for the monthly cost of the plan you have selected. Make check or money order payable to: UnitedHealthcare Insurance Company.
 - ✓ Complete the AARP membership form and enclose your dues (if not already a member)?
- Thank you!*

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

2 Choose your plan and effective date

Please indicate your plan choice below:

A B C D F G K L M N

Select Plan C

Select Plan F

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.

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 Past and current coverage information

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).

Continued on next page 

Sample A. Sample
XX
XX
XX

3 Past and current coverage information, continued

3K. What are your dates of coverage under the policy you listed in **3J**? Leave the end date blank if you are still covered under the other policy.

3L. Are you replacing this health insurance?

Y N

Start Date	End Date
<input type="text"/>	<input type="text"/>
M M D D Y Y Y Y	M M D D Y Y Y Y

4 Verification of Information

Please read carefully, and sign and date in the signature box below.

- My signature indicates I have read and understand the contents of this enrollment form.
- I declare the answers on this enrollment form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this 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, adjust my premium, or reduce my benefits.
- If you are enrolling in a Medicare Select Plan: I acknowledge 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.
- 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 understand the coverage under the plan I am applying for will not take effect until issued by UnitedHealthcare Insurance Company.

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

 **Your Signature** (required)

Today's Date (required)

X _____

<input type="text"/>
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.

ENROLLMENT FORM CHECKLIST

Did you remember to...

- ✓ Complete this enrollment form in black or blue INK?
- ✓ Fill in all information in all sections?
- ✓ Sign in the signature box above?

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

Send No Money Now for this new coverage. Continue to make your current payments until you receive a new coupon book or notification of your new EFT withdrawal amount.

Thank you!

Sample A. Sample
XX
XX
XX

2 Choose your plan and effective date

Please indicate your plan choice below:

A B C D F G K L M N

Select Plan C

Select Plan F

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.

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 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**. ↓

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 ►

Sample A. Sample
XX
XX
XX

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 7 or more months 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, call us at the number listed below, or 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 ►

Sample A. Sample
XX
XX
XX

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 7 or more months 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, call us at the number listed below, or 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 

Sample A. Sample
XX
XX
XX

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 

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

8 Authorization and Verification of Information

Please read carefully, and sign and date in the signature box 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.
- 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 understand the coverage under the plan I am applying for will not take effect until issued by UnitedHealthcare Insurance Company.
- 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.

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 

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

8 Authorization and Verification of Information

Please read carefully, and sign and date in the signature box 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																
 _____	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>									M	M	D	D	Y	Y	Y	Y
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.																	

APPLICATION FORM CHECKLIST

Did you remember to...

- ✓ Complete this application form in black or blue INK?
- ✓ Fill in all requested information in all sections?
- ✓ Sign in all 3 signature boxes?
- ✓ Include termination notice from previous insurance coverage (if applicable)?
- ✓ Enclose your first month's insurance payment? Please refer to the enclosed "Cover Page – Rates" for the monthly cost of the plan you have selected. If you answered YES to any medical conditions in Section 6, your rate will be the level 2 rate.
Make check or money order payable to: UnitedHealthcare Insurance Company.
- ✓ Complete the AARP membership form and enclose your dues (if not already a member)?

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

Thank you!

2 Choose your plan and effective date

Please indicate your plan choice below:

A B C D F G K L M N

Select Plan C

Select Plan F

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.

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**. ↓

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 7 or more months 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 7 or more months 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 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.
- 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 understand the agent or broker 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 agent or broker 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 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)																
 _____	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>									M	M	D	D	Y	Y	Y	Y
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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 <div style="font-size: 2em; font-weight: bold; margin-left: 10px;">X</div>	Today's Date <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">M</td> <td style="text-align: center;">M</td> <td style="text-align: center;">D</td> <td style="text-align: center;">D</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> </tr> </table>									M	M	D	D	Y	Y	Y	Y
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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. If you answered YES to any medical conditions in Section 6, your rate will be the level 2 rate.

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.

9 For Agent Use Only

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:

--

- List any policies that are still in force:

--

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

--

Agent Name (PLEASE PRINT)	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 30%;"></td> <td style="border-bottom: 1px solid black; width: 10%;"></td> <td style="border-bottom: 1px solid black; width: 60%;"></td> </tr> <tr> <td style="text-align: center; font-size: 0.8em;">First Name</td> <td style="text-align: center; font-size: 0.8em;">MI</td> <td style="text-align: center; font-size: 0.8em;">Last Name</td> </tr> </table>				First Name	MI	Last Name										
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Agent ID (required)	M	M	D	D	Y	Y	Y										

2 Choose your plan and effective date

Please indicate your plan choice below:

A B C D F G K L M N

Select Plan C

Select Plan F

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.

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 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**. ↓

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

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 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 7 or more months 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 7 or more months 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
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6F. Liver

- Cirrhosis of the Liver

6G. Transplants

- Bone marrow or organ transplant

6H. Gastrointestinal Conditions

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- Amputation due to disease
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6J. Substance Abuse

- Alcohol Abuse or Alcoholism
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- Paraplegia, Quadriplegia or Hemiplegia

6L. Psychological/Mental Conditions

- Bipolar or Manic Depressive
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6M. Eye Condition

- Macular Degeneration

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- 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.
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- 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.

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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 ►

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- List any policies that are still in force:

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

Agent Name (PLEASE PRINT)			
	First Name	MI	Last Name
			
Agent Signature (required)	Agent ID (required)	M M D D Y Y Y Y	
			
Broker Signature	Broker ID		

XXXX-XXX

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Enrollment Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

Note: Plans and rates in this kit are good only for this person at the address above. You may enroll using this form only if you are turning 65 or first enrolling in Medicare Part B at age 65 or older.

Please reply by xxxxxx
for coverage to be effective on xxxxxx

AARP membership number
xxxxxx

Have you changed your name or address?

Y N

If **YES**, please write your new name and/or address below:

Name _____

Street Number/Name _____

City/State/Zip Code _____

Instructions

1. Fill in all requested information on this form and sign in the area indicated.
2. Print clearly. Use CAPITAL letters.
3. Fill in the circles with black or blue ink.

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 Membership dues with this application.
- Mail the completed form(s) in the enclosed envelope. If your envelope is missing, please mail to: UnitedHealthcare Insurance Company, P.O. Box 105331, Atlanta, GA 30348-5331.

You can also apply online at: www.aarphealthcare.com or fax this form to [1-888-836-3985]

Questions? Please call [1-800-620-9037] to talk to a representative. [(TTY: 1-800-232-7773)]

1 Tell us about yourself

Birthdate

MM DD YYYY

Gender

M F

Phone

Area Code and Phone Number

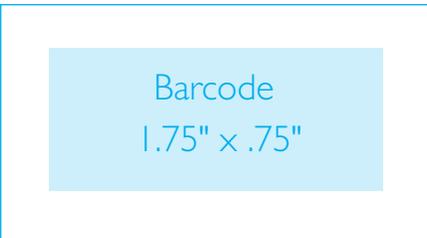
Please supply the following information, found on your Medicare card.

MEDICARE HEALTH INSURANCE	
NAME	First / Middle Initial / Last
MEDICARE CLAIM #	
HOSPITAL (PART A) EFFECTIVE DATE:	MM DD YYYY
MEDICAL (PART B) EFFECTIVE DATE:	MM DD YYYY

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.



XXXXXXXXXX XX/XX/XX

Continued on next page

Sample A. Sample
XX
XX
XX

2 Choose your plan and effective date

Please indicate your plan choice below:

A B C D F G K L M N

Select Plan C

Select Plan F

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.

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
		0	1				

3 Past and current coverage information

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).

Continued on next page 

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

3 Past and current coverage information, continued

3K. What are your dates of coverage under the policy you listed in **3J**? Leave the end date blank if you are still covered under the other policy.

3L. Are you replacing this health insurance?

Y N

Start Date

End Date

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

4 Verification of Information

Please read carefully, and sign and date in the signature box below.

- My signature indicates I have read and understand the contents of this enrollment form.
- I declare the answers on this enrollment form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this 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, 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 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 understand the coverage under the plan I am applying for will not take effect until issued by UnitedHealthcare Insurance Company.
- 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 have read all information and have answered all questions to the best of my ability.

 **Your Signature** (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.

ENROLLMENT FORM CHECKLIST

Did you remember to...

- ✓ Complete this enrollment form in black or blue INK?
- ✓ Fill in all information in all sections?
- ✓ Sign in the signature box above?
- ✓ Enclose your first month's insurance payment? Please refer to enclosed "Cover Page – Rates" for the monthly cost of the plan you have selected. Make check or money order payable to: UnitedHealthcare Insurance Company.
- ✓ Complete the AARP membership form and enclose your dues (if not already a member)?

Thank you!

Sample A. Sample
XX
XX
XX

2 Tell us about your tobacco usage

If your coverage effective date will be within 6 months after your 65th birthday or Medicare Part B effective date, skip this section and continue to Section 3.

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

3 Choose your plan and effective date

Please indicate your plan choice below:

A B C D F G K L M N

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.

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
		0	1				

4 Past and current coverage information

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).

Continued on next page ►

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

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

3 Choose your plan and effective date

Please indicate your plan choice below:

A B C D F G K L M N

Select Plan C

Select Plan F

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.

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
		0	1				

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Continued on next page 

Sample A. Sample
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

4 Past and current coverage information, continued

4K. What are your dates of coverage under the policy you listed in **4J**? Leave the end date blank if you are still covered under the other policy.

4L. Are you replacing this health insurance?

Y N

Start Date

End Date

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

5 Verification of Information

Please read carefully, and sign and date in the signature box below.

- My signature indicates I have read and understand the contents of this enrollment form.
- I declare the answers on this enrollment form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this 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, 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 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 understand the coverage under the plan I am applying for will not take effect until issued by UnitedHealthcare Insurance Company.
- 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 have read all information and have answered all questions to the best of my ability.

 **Your Signature** (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.

ENROLLMENT FORM CHECKLIST

Did you remember to...

- ✓ Complete this enrollment form in black or blue INK?
- ✓ Fill in all information in all sections?
- ✓ Sign in the signature box above?

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

Send No Money Now. You will receive billing materials once your enrollment form has been accepted.

Thank you!

SERFF Tracking Number: UHLC-126333914 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 43696
 Company Tracking Number: M75146IMMMAR01 01B
 TOI: MS071 Individual Medicare Supplement - Sub-TOI: MS071.001 Plan A 2010
 Medicare Select 2010
 Product Name: MEDICARE SUPPLEMENT
 Project Name/Number: MIPPA ENROLLMENT APPLICATIONS/M75146IMMMAR01 01B

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	11/13/2009

Comments:

Attachment:

READABILITY CERTIFICATION FORM 8 24 09.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	11/13/2009

Bypass Reason: N/A

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification		
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage		
Bypass Reason:	N/A		
Comments:			

UnitedHealthcare Insurance Company
READABILITY CERTIFICATION

**THIS IS TO CERTIFY THAT THE FOLLOWING FORM(S) HAS ACHIEVED A FLESCH
READING EASE TEST SCORE OF:**

FORM NUMBER	FLESCH SCORE
M75146IMMMAR01 01B	50
M92942MNMMAR01 01B	50
M94140MNMMAR01 01B	50
S75646IMMMAR01 01B	50
S93042MNMMAR01 01B	50
S93143AGMMAR01 01B	50
S93244AGMMAR01 01B	50
S94340MNMMAR01 01B	50
M94245MMMMAR01 01B	50
S94445MNMMAR01 01B	50



SIGNATURE

PAUL D. KALLMEYER, VICE PRESIDENT COMPLIANCE
NAME AND TITLE

October 6, 2009
DATE