Application Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

AARP Membership Number (If you are already a member)
0149552515

Nora | E | Bryant
First Name | MI | Last Name

6876 Phillips Place
Address Line 1

Address Line 2

Olive Branch | MS | 38654
City | ST | Zip

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

Instructions

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

Example: ○ Y ● N

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

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

1 Tell us about yourself

Birthdate
09-29-1933
M M D D Y Y Y Y

Gender
F
M F

Phone
662-400-6495
Area Code and Phone Number

E-mail address (optional)
Nebryant@gmail.com

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.

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

MEDICARE HEALTH INSURANCE

NAME Nora E Bryant
First / Middle Initial / Last

MEDICARE CLAIM # 413488243D

HOSPITAL (PART A) EFFECTIVE DATE: 09-01-1998
M M D D Y Y Y Y

MEDICAL (PART B) EFFECTIVE DATE: 01-01-2016
M M D D Y Y Y Y

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

2460720307

Continued on next page ▶

2 Tell us about your tobacco usage

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

3 Choose your plan and effective date

Please indicate your plan choice below:

Select F

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

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

Coverage Effective Date

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

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

Requested Effective Date
01-01-2016
M M D D Y Y Y Y

4 Answer these questions to determine if your acceptance is guaranteed

4A. Did you turn age 65 in the last 6 months?

No
Y N **If YES,** skip to **Section 7.**

4B. Did you enroll in Medicare Part B within the last 6 months?

No
Y N **If YES,** skip to **Section 7.**

4C. Will your plan effective date be within 6 months after turning age 65 and enrolling in Medicare Part B?

Yes
Y N **If YES,** skip to **Section 7.**

- If you answered **YES to 4A, 4B, or 4C,** your acceptance is guaranteed.
- If you answered **NO to 4A, 4B, and 4C,** continue to question **4D**.

4D. 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 4D,** 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 and:

- You are age 65 or over: Go to **Section 5.**
- You are age 50 to 64: You are **NOT** eligible to apply for these plans.

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 three or more years ago. All others go to Section 7.

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

6A. Heart or Vascular Conditions

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

6B. Diabetes

With any of the following complications:

- Circulatory problems, Kidney problems, or Retinopathy

6C. Lung/Respiratory Conditions

Chronic Obstructive Pulmonary Disease (COPD)

- Emphysema

6D. Cancer or Tumors

Cancer (other than skin cancer)

- Leukemia or Lymphoma
- Melanoma

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

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

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

6E. Kidney Conditions
- ____ Chronic Renal Failure or Insufficiency
- ____ Polycystic Kidney Disease
- ____ Renal Artery Stenosis

6F. Liver
- ____ Cirrhosis of the Liver

6G. Transplants
- ____ Bone marrow or organ transplant

6H. Gastrointestinal Conditions
- ____ Chronic Pancreatitis
- ____ Esophageal Varices

6I. Musculoskeletal Conditions
- ____ Amputation due to disease
- ____ Rheumatoid Arthritis
- ____ Spinal Stenosis

6J. Substance Abuse
- ____ Alcohol Abuse or Alcoholism
- ____ Drug Abuse or use of illegal drugs

6K. Brain or Spinal Cord Conditions
- ____ Paraplegia, Quadriplegia or Hemiplegia

6L. Psychological/Mental Conditions
- ____ Bipolar or Manic Depressive
- ____ Schizophrenia

6M. Eye Condition
- ____ Macular Degeneration

6N. Nervous System Conditions
- ____ Amyotrophic Lateral Sclerosis (ALS)
- ____ Alzheimer's Disease or Dementia
- ____ Multiple Sclerosis (MS)
- ____ Parkinson's Disease
- ____ Systemic Lupus Erythematosus (SLE)

6O. Immune System Conditions
- ____ AIDS
- ____ HIV positive

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

Continued on next page ▶

7 Tell us about your past and current coverage

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

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

For your protection, you are required to answer all the questions below (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.

No

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

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7 Tell us about your past and current coverage – continued

7D. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)?

No

Y N

If NO, skip to question **7H**.
If YES, fill in your start and end dates and continue to question **7E**. If you are still covered under this plan, leave the end date blank.

Start Date **End Date**

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

7E. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?

Y N

7F. Was this your first time in this type of Medicare plan?

Y N

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

Y N

7H. Do you have another Medicare Supplement policy in force?

Yes

Y N

If NO, skip to question **7J**.
If YES, please continue.

7I. If YES, do you intend to replace your current Medicare Supplement policy with this policy?

Yes

Y N

7J. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?

No

Y N

If NO, please sign below, then continue to **Section 8.**
If YES, please list with what company and what type of policy in the space provided below. Then continue to question **7K**.

Company Name

Policy Type

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

7K. What are your dates of coverage under the policy you listed in **7J?** Leave the end date blank if you are still covered under the other policy.

Start Date **End Date**

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

7L. Are you replacing this health insurance?

Y N

Your Signature – 1 (required)

☒ Nora E Bryant

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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.
- 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 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.
- 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) Nora E Bryant

Today's Date (required) 12-06-2015
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 ▶

8 Authorization and Verification of Information – continued

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

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give UnitedHealthcare Insurance Company and its affiliates ("The Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine the eligibility of and/or amount payable for my claims and for analytic studies. I understand I may end this authorization if I notify The Company, in writing, except to the extent that The Company has already acted on my authorization. If not revoked, this authorization is valid for the term of the coverage.

Your Signature – 3 | **Today's Date**

X Nora E Bryant | 12-06-2015

M M D D Y Y Y Y

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

Plan Rates

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

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

2. List any policies that are still in force:

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

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

Agent Phone Number _____

☐ _____ _____ _____
Agent Signature (required) Agent ID (required) M M D D Y Y Y Y