Application Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company, Horsham, PA 19044

Plans and rates described in this package are good only for residents of California.

Instructions

1. Fill in all requested information on this form and sign in the 4 places where a signature is needed.
2. Print clearly. Use CAPITAL letters.
3. Mark your answers with black or blue ink – not pencil. *Example:* ☒ Yes ☐ No ☐ Not Sure
4. Initial any changes or corrections you make while completing this application.

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

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 and mail with this application.

Applicant First Name _____ MI _____ Last Name _____

Permanent Home Address _____ City _____ State _____ Zip _____

Mailing Address (if different from above) _____ City _____ State _____ Zip _____

1 Tell us about yourself

Please provide your Medicare insurance information.

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NAME OF BENEFICIARY

1A. _____

MEDICARE NUMBER (Include all numbers and letters.)

1B. _____ **1C.** Sex ☐ M ☐ F

IS ENTITLED TO — EFFECTIVE DATE

HOSPITAL (PART A): **1D.** /01/

MEDICAL (PART B): **1E.** /01/

1F. Will your Medicare Part A and Part B be active on your AARP Medicare Supplement Plan start date? ☐ Yes ☐ No

1G. Birthdate ___ / ___ / ___ (Month / Day / Year)

1H. Phone Number ( ) -

1I. Email 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 (@).

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First Name Last Name

2 Choose your plan and start date

Plan Choice

2A. Choose only 1 plan from the right-hand column:

☐ Plan A ☐ Plan B
☐ Plan C ☐ Plan F
☐ Plan G ☐ Plan K
☐ Plan L ☐ Plan N

Plan Start Date

2B. Your plan will start on the first day of the month following receipt and approval of this application and receipt of your first month's payment. If you would like your plan to start on a later date (the first day of a future month), please indicate the date:

/01/
Month Day Year

3 Answer these questions to determine if your acceptance is guaranteed.

3A. Are you applying during your 30-day birthday open enrollment period that begins on your birthday **AND** replacing a Medicare supplement plan? ☐Yes ☐No

If **YES**, your acceptance is guaranteed. Skip to **Section 7.**
If **NO**, and you are:
- **Age 65 or older,** skip **Question 3B** and go directly to **Question 3C.**
- **Age 50-64,** you must answer **Question 3B.**

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

3B. During the past two years, were you diagnosed or treated for end-stage renal (kidney) disease? ☐Yes ☐No ☐Not Sure

If **YES**, you are **NOT** eligible for these plans at this time.
If **NO**, you must answer **Question 3C**.
If you're **NOT SURE**, you must answer **Question 3C.** We may also contact you for further information to determine your acceptance.

3C. Will your AARP Medicare Supplement Plan start date be within 6 months after you turn age 65 **or** enroll in Medicare Part B? ☐Yes ☐No

If **YES**, your acceptance is guaranteed. Skip to **Section 7.**
If **NO**, continue to **Question 3D**.

3D. Is your acceptance guaranteed as described below? ☐Yes ☐No

Your acceptance is guaranteed if **any one** of the following applies to you:
- you lost an employer-sponsored health plan within the last 6 months,
- you have lost Medi-Cal within the last 6 months due to an increase in your income or assets,
- you are a military retiree, or spouse of a retiree, and your health care services were cancelled within the last 6 months due to a base closure, because the base no longer offers services or because you relocated,
- your Medicare supplement coverage cancelled within the last 6 months because your residence changed to a location not serviced by your plan.

If **YES,** your acceptance is guaranteed. Skip to **Section 7**.
If **NO**, continue to **Question 3E**.

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First Name Last Name

3 Answer these questions to determine if your acceptance is guaranteed. (continued)

3E. Do you have guaranteed issue rights, as listed in the Guaranteed Acceptance section of "Your Guide" enclosed with this application? **If so, include a copy of the termination notice or Notice of Change from your prior insurer or employer.** ☐Yes ☐No

If **YES,** your acceptance is guaranteed. Skip to **Section 7**.
If **NO,** and you are:

- **Age 65 or older,** continue to **Section 4.**
- **Age 50-64, you are not eligible to apply for these plans.**

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4 Answer these health questions only if your acceptance is not guaranteed as defined in Section 3

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

4A. Within the past 2 years, did a medical professional provide treatment or advice to you for any problems with your kidneys? ☐Yes ☐No ☐Not Sure

4B. Within the past 2 years, did a medical professional tell you that you may need any of the following? ☐Yes ☐No ☐Not Sure

- hospital admittance as an inpatient
- organ transplant
- back or spine surgery
- joint replacement
- surgery for cancer
- heart or vascular surgery

If you answered YES or NOT SURE to any question in Section 4, we will contact you for further information.

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5 Answer these additional health questions only if your acceptance is not guaranteed as defined in Section 3

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

5A. Within the past 90 days, were you hospitalized as an inpatient (not including overnight outpatient observation)? ☐Yes ☐No ☐Not Sure

5B. Are you currently being treated or living in any type of nursing facility other than an assisted living facility? ☐Yes ☐No ☐Not Sure

5C. Within the past 2 years, did you have (as determined by a medical professional) a Heart Attack, Stroke, Transient Ischemic Attack (TIA) or mini-stroke? ☐Yes ☐No ☐Not Sure

First Name Last Name

5 Answer these additional health questions only if your acceptance is not guaranteed as defined in Section 3 (continued)

5D. Within the past 2 years, were you diagnosed, treated, given medical advice or prescribed medications/refills by a medical professional for any of the following conditions? ☐Yes ☐No ☐Not Sure

- Artery or Vein Blockage
- Peripheral Vascular Disease (PVD)
- Cardiomyopathy
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Chronic Obstructive Pulmonary Disease (COPD) or Emphysema
- End-Stage Renal (Kidney) Disease or Require Dialysis
- Chronic Kidney Disease
- Diabetes, but only if you have circulation problems or Retinopathy
- Cancer including Melanoma (but not other skin cancers), Leukemia and Lymphoma
- Cirrhosis of the Liver

Answering YES to any question in Section 5 will result in a denial of coverage. If your health status changes in the future, allowing you to answer NO to all of the questions in this section, please submit a new application at that time.

If you answered NOT SURE to any question, we will contact you for further information.

6 Tell us about your tobacco usage – Do not answer this question if you are in your Open Enrollment or entitled to guaranteed issue.

6A. At any time within the past 12 months, have you smoked tobacco cigarettes or used any other tobacco product? ☐Yes ☐No

If you answered YES to Question 6A, your rate will be the tobacco rate. See the enclosed "Cover Page - Rates."

7 Tell us about your past and current coverage

Review the statements below.

- You do not need more than one Medicare supplement policy.
- You may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medi-Cal and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, 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 Medi-Cal eligibility.
- 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.
- Counseling services are available in this state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, or access the Department's Internet Web site, www.insurance.ca.gov, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

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First Name Last Name

7 Tell us about your past and current coverage (continued)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS.
To the best of your knowledge,

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Answer these questions about Medi-Cal	
7A. Are you covered for medical assistance through California's Medi-Cal program? **Note to applicant:** If you have a share of cost under the Medi-Cal program, please answer **No** to this question. **If YES, you must answer Questions 7B and 7C.** **If NO, skip to Question 7D.**	☐Yes ☐No
7B. Will Medi-Cal pay your premiums for this Medicare supplement policy?	☐Yes ☐No
7C. Do you receive any benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?	☐Yes ☐No
Answer these questions about Medicare Advantage plans (sometimes called Medicare Part C)	
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)? **If YES, you must answer Questions 7E through 7H.**	☐Yes ☐No
7E. Fill in the start and end dates of your Medicare plan. If you are still covered under this plan, leave the end date blank.	**Start Date** /01/ Month Day Year **End Date** / / Month Day Year
7F. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? (When you receive confirmation that this Medicare supplement plan has been issued, you will need to cancel your Medicare Advantage plan. Please contact your Medicare Advantage insurer for instructions on how to cancel, using the customer service number on the back of your ID card.) **If YES, please enclose a copy of the Replacement Notice.**	☐Yes ☐No
7G. Was this your first time in this type of Medicare plan?	☐Yes ☐No
7H. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐Yes ☐No
Answer these questions about Medicare supplement plans	
7I. Do you have another Medicare supplement policy in force? If so, what company and what plan do you have? Company: _____ Policy: _____ **If YES, you must answer Question 7J.**	☐Yes ☐No
7J. Do you intend to replace your current Medicare supplement policy with this policy? **If YES, please enclose a copy of the Replacement Notice.**	☐Yes ☐No

First Name Last Name

7 Tell us about your past and current coverage (continued)

Answer these questions about any other type of health insurance coverage

7K. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? **If YES, you must answer Questions 7L through 7N.**	☐Yes ☐No
7L. If so, with what company and what kind of policy? Company:_____	Policy: ☐HMO/PPO ☐Major Medical ☐Employer Plan ☐Union Plan ☐Other_____
7M. What are your dates of coverage under the other policy? Leave the end date blank if you are still covered under the policy.	**Start Date** ___/___/___ Month Day Year **End Date** ___/___/___ Month Day Year
7N. Are you replacing this health insurance?	☐Yes ☐No

X _____ **Your Signature – 1** (required)

___/___/___ **Today's Date** (required) Month Day Year

8 IMPORTANT INFORMATION

READ CAREFULLY, AND SIGN AND DATE WHERE INDICATED

- My signature indicates I have read and understand the contents of this application form.
- I affirm that the answers on this application are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that the application becomes a part of the insurance contract and that if the answers are untrue, UnitedHealthcare Insurance Company may have the right to rescind my coverage or adjust my premium.
- Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.
- I 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 an agent 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.

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First Name Last Name

8 IMPORTANT INFORMATION (continued)

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

I understand the plan will not pay benefits for expenses incurred during the first 3 months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within 3 months prior to the insurance effective date.

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

X _____ **Your Signature – 2** (required)

_____ / _____ / _____ **Today's Date** (required)
Month Day Year

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

READ CAREFULLY, AND SIGN AND DATE WHERE INDICATED

Authorization for the Release of Medical Information – Not required if you answered "Yes" to Question 3A, 3C, 3D or 3E. I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic, or other medical facility, health care clearinghouse, pharmacy benefit manager or insurance company to give UnitedHealthcare Insurance Company and its affiliates ("The Company") any medical data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine my eligibility for coverage. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to enroll in the health plan or to receive benefits, if permitted by law. I understand the information I authorize The Company to obtain and use may be re-disclosed only as permitted under applicable federal or state law. I understand that I may end this authorization if I notify The Company, in writing, prior to the issuance of coverage. After coverage is issued, this authorization is not revocable. If not revoked, this authorization is valid for 24 months from the date of my signature. I understand that I or my authorized representative may obtain a copy of this form.

Not required if you answered "Yes" to Question 3A, 3C, 3D or 3E.

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

X _____ **Your Signature – 3** (required)

_____ / _____ / _____ **Today's Date** (required)
Month Day Year

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

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I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, or insurance company to give UnitedHealthcare Insurance Company and its affiliates ("The Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine the eligibility of and/or amount payable for my claims and for analytic studies. I understand 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, 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.

X _____ **Your Signature – 4** (required)

_____ / _____ / _____ **Today's Date** (required)
Month Day Year

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

First Name Last Name

9 For Agent Use Only

Agent must complete the following information and include the notice of replacement coverage, if appropriate, with this application. All information must be complete or the application will be returned.

1. List any other health insurance policies issued to the applicant:

2. List policies issued which are still in force:

3. List policies issued in the past 5 years which are no longer in force:

For Agents who assist the Applicant in answering the health questions on the Application: I attest that the information on this Application Form is complete and accurate to the best of my knowledge; and that I have explained to the Applicant in clear, easy to understand language the risk of providing inaccurate information and the Applicant understood. I understand that an Agent who wilfully attests falsely is subject to a civil penalty of up to $10,000.

If you did not assist in answering the health questions on this Application, please mark this box: ☐

Agent Name (PLEASE PRINT) First Name MI Last Name

X Agent Signature (required) Agent ID (required) Today's Date (required) Month / Day / Year

Agent Email Address Agent Phone Number

TEAR HERE

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