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 Colorado.

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Instructions

1. Fill in all requested information on this form and sign in the 2 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.

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

Fill in the information exactly as it is shown on your Medicare card.

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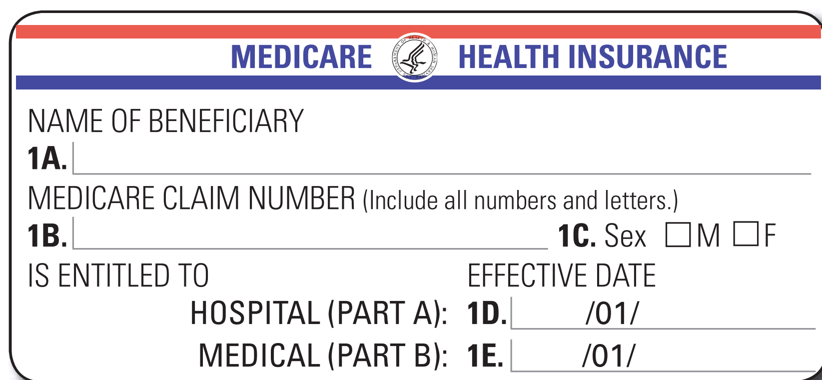

MEDICARE HEALTH INSURANCE

NAME OF BENEFICIARY

1A. ____________________

MEDICARE CLAIM 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/

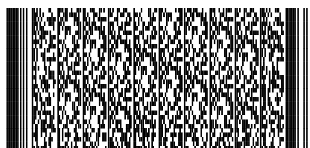
1F. Will your Medicare Part A and Part B be active on your AARP Medicare Supplement Plan start date? ☐ Yes ☐ No

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 Is your acceptance guaranteed?

3A. 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. Go directly to **Section 7**. (You do not have to answer the questions in **Sections 4, 5 and 6**.)
- If **NO**, you must answer **Question 3B**.

3B. 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 from your prior insurer or employer.**

☐Yes ☐No

- If **YES**, go directly to **Section 7**. (You do not have to answer the questions in **Sections 4, 5 and 6**.)
- If you answered **NO** to both questions in **Section 3** and you are:
  - **age 65 or over**, 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.

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?

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

☐Yes ☐No ☐Not Sure

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

First Name Last Name

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

Question	Answer
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. Has a medical professional told you that you have End-Stage Renal (Kidney) Disease or that you require dialysis?	☐Yes ☐No ☐Not Sure

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 in Section 5, we will contact you for further information.

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6 Answer these health questions to determine your rate only if your acceptance is not guaranteed as defined in Section 3.

6A. 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?

Condition	Answer
• Artery or Vein Blockage	☐Yes ☐No ☐Not Sure
• Peripheral Vascular Disease (PVD)	☐Yes ☐No ☐Not Sure
• Cardiomyopathy	☐Yes ☐No ☐Not Sure
• Congestive Heart Failure (CHF)	☐Yes ☐No ☐Not Sure
• Coronary Artery Disease (CAD)	☐Yes ☐No ☐Not Sure
• Chronic Obstructive Pulmonary Disease (COPD) or Emphysema	☐Yes ☐No ☐Not Sure
• Chronic Kidney Disease	☐Yes ☐No ☐Not Sure
• Diabetes, but only if you have circulation problems or Retinopathy	☐Yes ☐No ☐Not Sure
• Cancer including Melanoma (but not other skin cancers), Leukemia and Lymphoma	☐Yes ☐No ☐Not Sure
• Cirrhosis of the Liver	☐Yes ☐No ☐Not Sure
6B. 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

If you answered YES to any question in Section 6, your rate will be the Level 2 rate. See the enclosed "Cover Page – Rates."

If you answered NOT SURE to any question, we may need to contact you for additional information.

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7 Tell us about your tobacco usage

Question	Answer
7A. 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 7A, your rate will be the tobacco rate. See the enclosed "Cover Page - Rates."

First Name Last Name

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8 Tell us about your past and current coverage

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

- 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 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 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 may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

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

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Answer these questions about Medicaid	
8A. 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", answer NO to this question. **If YES, you must answer Questions 8B and 8C.**	☐Yes ☐No
8B. Will Medicaid pay your premiums for this Medicare supplement policy?	☐Yes ☐No
8C. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?	☐Yes ☐No
Answer these questions about Medicare Advantage plans (sometimes called Medicare Part C)	
8D. Have you had coverage from any Medicare plan other than original Medicare within the past 6 months (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)? **If YES, you must answer Questions 8E through 8I.**	☐Yes ☐No
8E. 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

First Name | Last Name

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

Question	Answer
8F. 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
8G. Was this your first time in this type of Medicare plan?	☐Yes ☐No
8H. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐Yes ☐No
8I. Has your coverage under the previous plan been involuntarily terminated for reasons other than nonpayment of premiums or fraud?	☐Yes ☐No
Answer these questions about Medicare supplement plans	
8J. 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 8K.**	☐Yes ☐No
8K. 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
Answer these questions about any other type of health insurance coverage	
8L. Have you had coverage under any other health insurance within the past 6 months (for example, an employer, union, or individual plan)? **If YES, you must answer Questions 8M through 8P.**	☐Yes ☐No
8M. If so, with what company and what kind of policy? **Company:**______	**Policy:** ☐HMO/PPO ☐Major Medical ☐Employer Plan ☐Union Plan ☐Other______
8N. 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
8O. Are you replacing this health insurance?	☐Yes ☐No
8P. Has your coverage under the previous plan been involuntarily terminated for reasons other than nonpayment of premiums or fraud?	☐Yes ☐No

______ **Your Signature – 1** (required)

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

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First Name Last Name

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9 Authorization and Verification of Application Information

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.
- **It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.**
- 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 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.
- I acknowledge receipt of the **Guide to Health Insurance for People with Medicare** and the Outline of Coverage.

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. If not revoked, this authorization is valid for 24 months from the date of my signature.

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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)
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

10 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:

Agent Name (PLEASE PRINT)______________ __ ______________
First Name MI Last Name

✗ ______________ ______________ ___/___/___
Agent Signature (required) Agent ID (required) Today's Date (required) Month Day Year

______________ ______________
Agent Email Address Agent Phone Number

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