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 Ohio.

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.

TEAR HERE

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.

TEAR HERE

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 (@).

2460720307

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
Medicare Select Plan C
Medicare Select Plan F

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 **NO**, continue to **Section 4**.

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? Yes No Not Sure

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

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

TEAR HERE

TEAR HERE

First Name Last Name

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

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.

TEAR HERE

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?			
• 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.

TEAR HERE

First Name Last Name

7 Tell us about your tobacco usage

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."

TEAR HERE

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 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).

TEAR HERE

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 form.

PLEASE ANSWER ALL QUESTIONS.

To the best of your knowledge,	
8A. Did you turn age 65 in the last 6 months?	Yes No
8B. Did you enroll in Medicare Part B in the last 6 months?	Yes No
8C. If YES, what is the effective date?	/01/ (Month Day Year)
Answer these questions about Medicaid	
8D. 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 8E and 8F.**	Yes No

First Name Last Name

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

8E. Will Medicaid pay your premiums for this Medicare supplement policy?	Yes No
8F. 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)	
8G. 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 8H through 8K.**	Yes No
8H. 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
8I. 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
8J. Was this your first time in this type of Medicare plan?	Yes No
8K. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	Yes No
Answer these questions about Medicare supplement plans	
8L. 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 8M.**	Yes No
8M. 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	
8N. 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 8O through 8Q.**	Yes No
8O. If so, with what company and what kind of policy? **Company:**_____	**Policy:** HMO/PPO Major Medical Employer Plan Union Plan Other_____

TEAR HERE

TEAR HERE

First Name Last Name

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

8P. 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

8Q. Are you replacing this health insurance? Yes No

X _____
Your Signature – 1 (required)

____ / ____ / ____
Today's Date (required)
Month Day Year

TEAR HERE

TEAR HERE

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.
- 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 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.
- 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.

First Name Last Name

9 Authorization and Verification of Application Information (continued)

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. I understand that I or my authorized representative may obtain a copy of this form.

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.

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.

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

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

_____ _____
Agent Email Address Agent Phone Number

TEAR HERE

TEAR HERE

TEAR HERE

TEAR HERE

AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

AGENT MEDICARE SUPPLEMENT INSURANCE SOLICITATION NOTICE

- The person making this solicitation is an Ohio-licensed insurance agent.
- You may verify that the agent is licensed by contacting The Ohio Department of Insurance, 50 West Town St., Suite 300, Columbus, Ohio 43215, toll-free at 800-686-1526; TDD (614) 644-3745, www.ohioinsurance.gov.
- The insurer issuing the Medicare supplement insurance policy is UnitedHealthcare Insurance Company. You may contact the insurance company at PO Box 1017 Montgomeryville, PA 18936, toll-free: 1-866-408-5545, TTY: 711, 7 a.m. – 11 p.m. ET, Monday – Friday, 9 a.m. – 5 p.m. ET, Saturday, www.aarpmedsup.com.
- Neither the insurance company nor the agent/broker making this solicitation have any connection or affiliation with, and are not in any way sponsored by, the federal or state government, the Social Security Administration, the Centers for Medicare and Medicaid Services, or the Department of Health and Human Services.
- If you decide to purchase a Medicare supplement health insurance plan, you have the option of paying the premium directly to the insurance company.

This is to confirm that the undersigned agent has read this notice and provided a copy of this notice to the Medicare-eligible beneficiary whose signature appears below on this _____ day of _____, 20____.

Signature Insurance Agent/broker: _____

Printed name: _____

Ohio License Number: _____

Address: _____
street address city state zip code

Telephone:

Signature Medicare-eligible beneficiary: _____

Printed name: _____

Instructions: Agent must read and provide one copy of this notice to Medicare-eligible beneficiary at the time of solicitation for a Medicare supplement insurance policy/certificate. The second copy of this notice must be submitted with the application. The agent and beneficiary must sign both copies, acknowledging the notice was presented both orally and in writing to the Medicare beneficiary.

COMPLETE AND SUBMIT THIS COPY WITH THE APPLICATION

TEAR HERE

TEAR HERE

AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

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- You may verify that the agent is licensed by contacting The Ohio Department of Insurance, 50 West Town St., Suite 300, Columbus, Ohio 43215, toll-free at 800-686-1526; TDD (614) 644-3745, www.ohioinsurance.gov.
- The insurer issuing the Medicare supplement insurance policy is UnitedHealthcare Insurance Company. You may contact the insurance company at PO Box 1017 Montgomeryville, PA 18936, toll-free: 1-866-408-5545, TTY: 711, 7 a.m. – 11 p.m. ET, Monday – Friday, 9 a.m. – 5 p.m. ET, Saturday, www.aarpmedsup.com.
- Neither the insurance company nor the agent/broker making this solicitation have any connection or affiliation with, and are not in any way sponsored by, the federal or state government, the Social Security Administration, the Centers for Medicare and Medicaid Services, or the Department of Health and Human Services.
- If you decide to purchase a Medicare supplement health insurance plan, you have the option of paying the premium directly to the insurance company.

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Signature Insurance Agent/broker: _____

Printed name: _____

Ohio License Number: _____

Address: _____
street address city state zip code

Telephone:

Signature Medicare-eligible beneficiary: _____

Printed name: _____

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COMPLETE AND PROVIDE THIS COPY TO MEDICARE-ELIGIBLE BENEFICIARY

TEAR HERE

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Save $24 a year with the Electronic Funds Transfer (EFT) service

The Easiest Way to Pay

More than 2.5 million AARP® members nationwide enjoy the convenience of the EFT option. With EFT, your monthly payment will automatically be deducted from your checking or savings account. Also, you'll save $2.00 off the total monthly premium for your household.

In addition to saving up to $24 a year:

- You'll save on the cost of checks and rising postal rates.
- You don't have to take time to write a check each month.
- You don't have to worry about mailing a payment if you travel or become ill, because your payment is always deducted on or about the fifth day of each month.

Signing Up is Easy

Complete the Automatic Payment Authorization Form on the reverse side. Return it with the application and be sure to keep a copy for your records. Please be sure the information is clear, as it is required for processing your request for EFT. You do not need to include a voided check.

Your EFT Effective Date

If you are submitting this EFT form with your enrollment application, your automatic payment start date will be the same as your plan effective date. A letter will be sent to confirm this and will include the amount of your withdrawal. Please note that if your coverage is effective in the future or your account is paid in advance, EFT withdrawals will begin for the next payment due. If your account is effective in the past or is past due, a letter will be sent that explains how to make the payment that is due.

Complete Form on Reverse ▶

This side for your information only, return not required.

AUTOMATIC PAYMENT AUTHORIZATION FORM

I allow UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents), hereafter named UnitedHealthcare, to take monthly withdrawals for the then-current monthly rate from the account named on this form. I also allow the named banking facility (BANK) to charge such withdrawals to this account.

Monthly withdrawal amounts will be for the total household payment due each month. This will include premiums for a spouse or other member(s) of the household on the same membership account. This authority is active until UnitedHealthcare and the BANK receive notice from me to end withdrawals in enough time to give UnitedHealthcare and the BANK a reasonable opportunity to act on it. I have the right to stop payment of a withdrawal by giving notice to the BANK in such time as to give the BANK a reasonable opportunity to act upon it. I understand such action may make the health care insurance coverage past due and subject to cancellation.

Member Name _____ AARP Member Number _____

Member Address _____
Street Addresss

Member Address _____
City State Zip Code

Bank Name _____

Bank Routing No. _____ Account Type: ☐ Checking
(9 digit number) ☐ Savings (statement savings only)

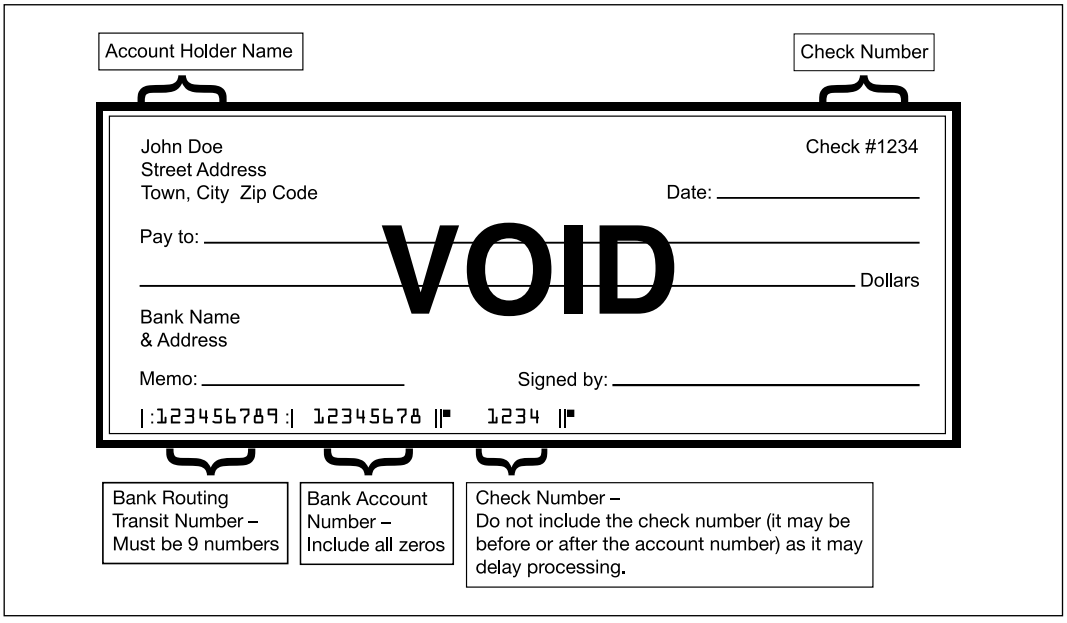
Bank Account No. _____

Bank Account Holder's Name if other than Member _____

Bank Account Holder's Signature _____

IMPORTANT

Please refer to the diagram below to obtain your bank routing information.



We look forward to continuing to serve you.

TEAR HERE

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Complete Form on Reverse ▶

This side for your information only, return not required.

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Member Name _____ AARP Member Number_____

Member Address _____
Street Addresss

Member Address _____
City State Zip Code

Bank Name _____

Bank Routing No. _____ Account Type: Checking
(9 digit number) Savings (statement savings only)

Bank Account No. _____

Bank Account Holder's Name if other than Member _____

Bank Account Holder's Signature _____

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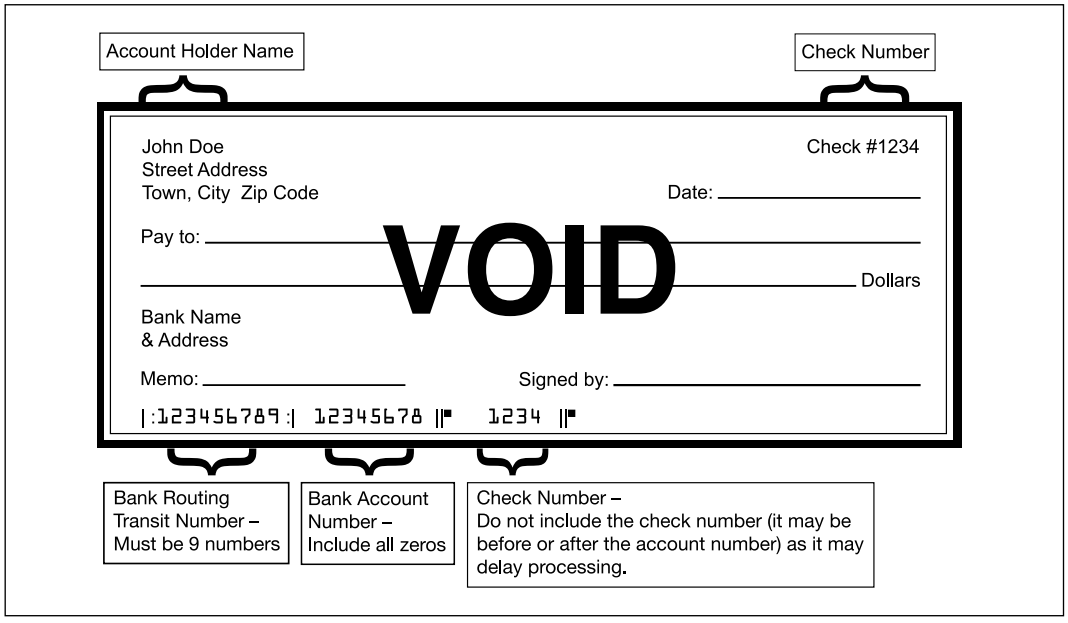

We look forward to continuing to serve you.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE UNITEDHEALTHCARE INSURANCE COMPANY

Horsham, Pennsylvania

Save this notice! It may be important to you in the future

According to the information you furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by UnitedHealthcare Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

TEAR HERE

Statement To Applicant By Issuer, Agent, Broker Or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement policy or leave your Medicare Advantage plan. The replacement policy is being purchased for one of the following reasons (check one):

____ Additional benefits.

____ No change in benefits, but lower premiums.

____ Fewer benefits and lower premiums

____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

____ Disenrollment from a Medicare Advantage plan. Please explain reason for Disenrollment.

____ Other (Please Specify) _____

_____

_____

1. Health conditions which you may presently have (Pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Agent, Broker or Other Representative) (Date)

_____

(Applicant's Signature) (Date)

_____

(Applicant's Printed Name & Address)

TEAR HERE

TEAR HERE

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You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement To Applicant By Issuer, Agent, Broker Or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement policy or leave your Medicare Advantage plan. The replacement policy is being purchased for one of the following reasons (check one):

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_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for Disenrollment.

_____ Other (Please Specify)

_____

_____

1. Health conditions which you may presently have (Pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Agent, Broker or Other Representative) (Date)

_____

(Applicant's Signature) (Date)

_____

(Applicant's Printed Name & Address)

Thank You for Applying for an AARP® Medicare Supplement Insurance Plan.

For your records:

- You selected Plan_____
- The effective date you requested is (1st day of a future month): _____ / _____ Month Year
- Based on the information you provided, your monthly premium for the plan you selected is $_____
- You will be notified when review of your application has been completed

Please Note: Your final monthly premium will be determined once your application is approved.

What's Next

Once Your Application Is Approved, You Will Receive:

- Your insured member identification card
- A Welcome Kit, including your certificate of insurance and coverage details
- Ongoing educational materials about how to make the most of your health plan benefits
- Help and answers to any questions you may have from courteous Customer Service Representatives
- A friendly customer service call to review the items listed above

A continuing relationship with your agent/producer