Application Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

AARP Membership Number (If you are already a member)

_____ – ___

First Name MI Last Name

Address Line 1

Address Line 2

City ST Zip

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

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

M M D D Y Y Y Y

Gender

○ M ○ F

Phone

Area Code and Phone Number

E-mail address (optional)

By providing your email address, you are agreeing to receive important account information and product offers.
Be sure to write all necessary periods (.) and symbols (@) in their space.

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

MEDICARE HEALTH INSURANCE

NAME
First / Middle Initial / Last

MEDICARE CLAIM #

HOSPITAL (PART A) EFFECTIVE DATE: M M 0 1 Y Y Y Y

MEDICAL (PART B) EFFECTIVE DATE: M M 0 1 Y Y Y Y

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

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2 Tell us about your tobacco usage

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

3 Choose your plan and effective date

Please indicate your plan choice below:

◯ A ◯ B ◯ C ◯ F ◯ K ◯ L ◯ N

Select Plan C ◯

Select Plan F ◯

You are eligible to enroll if <u>all</u> 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 only eligible 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." If you are not yet age 65, you may only enroll in Plan A.)

Coverage Effective Date

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

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

Requested Effective Date

		0	1				
M	M	D	D	Y	Y	Y	Y

4 Answer these questions to determine if your acceptance is guaranteed

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

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

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

◯ 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?

◯ 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 <u>age 65 or over</u>: Go to **Section 5.**
- You are <u>age 50 to 64</u>: 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 as having, treated, or had any of the following conditions **listed under 6A through 6N,** 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 as having, treated, or had any of the following conditions **listed under 6A through 6N,** 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. Read the conditions listed below carefully. If you have ever been diagnosed as having, or told by a medical doctor that you have, any of the following conditions, darken the circle next to it. If you are unsure how to respond, please consult your physician.

- ○ AIDS
- ○ HIV
- ○ ARC disorder

If you darkened a circle for any medical condition, your rate will be the level 2 rate. Please see the enclosed "Cover Page – Rates."

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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 policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.
- 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, complete this section and sign in the signature box on the next page. 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. Please mark Yes or No to the best of your knowledge.

7A. Did you turn age 65 in the last 6 months?

◯ Y ◯ N

7B. Did you enroll in Medicare Part B in the last 6 months?

◯ Y ◯ N

7C. If yes, what is the effective date?

M M D D Y Y Y Y

7D. Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the Federal Medicare Program.)

NOTE TO APPLICANT: If you are participating in a "Spend-down Program" and have not met your "Share of Cost," please answer NO to this question.

◯ Y ◯ N

If yes;

7E. Will Medicaid pay your premiums for this Medicare supplement policy?

◯ Y ◯ N

7F. 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

7G. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave **"END"** blank.

Start Date **End Date**

M M	D D	Y Y Y Y	M M	D D	Y Y Y Y
	0 1			0 1	

7H. 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

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

◯ Y ◯ N

7J. Did you drop a Medicare supplement policy to enroll in the Medicare plan?

◯ Y ◯ N

7K. Do you have another Medicare supplement policy in force?

◯ Y ◯ N

If so, with what company, and what plan do you have?

Company Name

Plan Name

_____

7L. If so, do you intend to replace your current Medicare supplement policy with this policy?

◯ Y ◯ N

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

◯ Y ◯ N

If so, with what company and what kind of policy?

Company Name

Policy Type

◯ HMO/PPO ◯ Major Medical ◯ Employer Plan
◯ Union Plan ◯ Other_____

7N. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave **"END"** blank.)

Start Date **End Date**

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

7O. Are you replacing this health insurance?

◯ Y ◯ N

Your Signature – 1 (required)

✗ _____

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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.
- 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.
- 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 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.
- I understand, for Medicare Select Plans, that I must determine whether any physician has admitting privileges to a network hospital.

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 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.

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

Your Signature – 2 (required)

X _____

Today's Date (required)

M M D D Y Y Y Y

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

Continued on next page ▶

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

X _____

Today's Date

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.

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

X _____ Agent Signature (required)

Agent ID (required)

M M D D Y Y Y Y

X _____ Broker Signature

Broker ID

AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

Automatic Payments

Save $24 a year with Automatic Payments

The easiest way to pay.

Almost 1.8 million AARP Medicare Supplement members nationwide enjoy the convenience of the Automatic Payments option. With automatic payments, your monthly payment will automatically be deducted from your checking or savings account. If you use automatic payments, you'll save $2.00 off the total monthly rate for your household.

That's up to $24.00 a year! In addition:

- 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.

Sign Up in Two Easy Steps

1. Complete both sides of the Authorization Form below. Return it with the application **and be sure to keep a copy for your records.**
2. Be sure to include a voided check from the account you want your payments withdrawn from. The information on your check is necessary for us to process your Authorization Form. Do not send a deposit slip or cancelled check.

Your Automatic Payments Effective Date

If you are submitting this Electronic Funds Transfer (EFT) form with your enrollment application, your automatic payments start date will be equal to your plan effective date. Please note that if your coverage is effective in the future or your account is paid in advance, automatic withdrawals will begin for the next payment due. If your account is effective in the past or is in arrears, a letter will be sent under separate cover that provides the specific information necessary to remit the payment due to bring your account up to date. A letter will be sent confirming that we processed your Automatic Payments Authorization Form form and will include the amount of your withdrawal.

BA9957 (6-11)

Cut along the dotted line.

AUTOMATIC PAYMENT AUTHORIZATION FORM

☑ I (we) authorize UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York, for New York residents) to initiate monthly withdrawals, in the amount of the then-current monthly rate, from the account named on this form, and authorize the named banking facility BANK to charge such withdrawals to my (our) account.

Name(s) _____

Address _____

City _____

State _____ Zip Code _____

Bank Name _____

Bank Routing No. _____

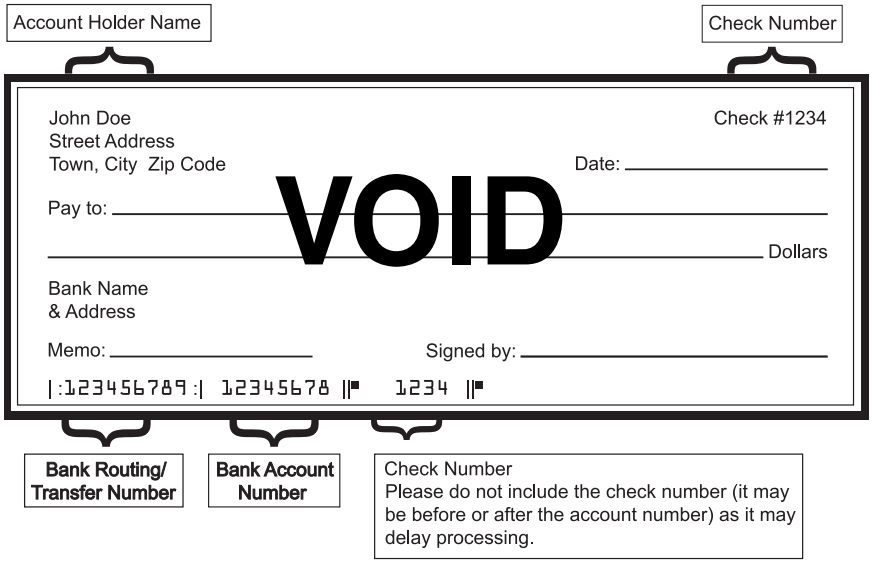
Bank Account No. _____

Account Type: ☐ Checking
☐ Savings (statement savings only)

Please complete the reverse of this form to enroll in automatic payments. ▶

IMPORTANT

- Please refer to the diagram below to obtain your bank routing information.
- Be sure to attach a voided check from the checking account you wish to use.



We look forward to continuing to serve you.

This authority remains in effect until UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York, for New York residents) and BANK receive notification from me (or either of us) of its termination in such time and manner as to give UnitedHealthcare Insurance Company and BANK a reasonable opportunity to act on it. I (we) have the right to stop payment of a withdrawal by notification to BANK in such time as to give BANK a reasonable opportunity to act upon it, with the understanding that such action may put my (our) health care contract in late status and subject to cancellation.

Name(s) _____ Member # _____

Signature _____ Date _____

Spouse's Signature _____ Date _____

(if joint account is maintained)

Please do not write in the space below for company use only.

_____

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 coverage 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. For your own information and protection, you should be aware of and seriously consider certain factors, which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare Supplement coverage is a wise decision.

You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

Statement To Appplicant 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:

- ☐ Additional benefits.
- ☐ Same 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) _____

I call your attention to the following items for your consideration:

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) 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 issuer 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)

_____

Typed Name and Address of Issuer or Agent

_____

(Applicant's Signature) (Date)

_____

Applicant's Printed Name and Address

Enrollment Checklist

In the following section, you will find the forms you need to complete when applying for coverage. Please be sure to complete and submit all the necessary forms to ensure your enrollment is processed quickly and accurately.

Here is an overview of the different forms and some helpful tips:

✔ **Application Form**

- Be sure to review and complete each applicable section.
- Please only write comments where indicated on the application.
- Be sure to sign and date the application in all the places indicated.

✔ **AARP Membership Form**

AARP membership is required to enroll in an AARP Medicare Supplement Plan. If you are not currently an AARP member, you can enroll in one of three ways:

- Log on to www.AGNTU.aarpenrollment.com;
- Call toll-free 1-866-331-1964; or
- Complete the membership form and submit it with the plan application, along with a separate check for $16.00 payable to AARP.

✔ **Electronic Funds Transfer (EFT) Authorization Form**

Automatic payments are available by submitting the completed form (signed and dated). If requesting automatic payments, you can deduct $2 from the first month's premium check.

✔ **Notice to Applicants Regarding Replacement of Coverage**

If you are replacing or losing current coverage as indicated on the form, complete both copies of the form, submit one copy with the enrollment application, and keep the other copy for your records. The agent must also sign and date both copies of the form.

L2676ST

Guaranteed issue for eligible persons

(a) Guaranteed issue

(1) Eligible persons are those individuals described in subsection (b) of this section who seek to enroll under the Medicare supplement policy during the period specified in subsection (d) of this section, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (c) of this section that is offered and is available for issuance to newly enrolled individuals by the issuer, and shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(b) Eligible Persons

An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(A) The certification of the organization or plan has been terminated; or

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged

in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

(D) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(E) The individual meets such other exceptional conditions as the Secretary may provide.

(3) The individual is enrolled with an entity listed in subparagraphs (A) – (D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) of this subsection:

(A) An eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost);

(B) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(C) An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(D) An organization under a Medicare Select policy; and

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(A) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or of other involuntary termination of coverage or enrollment under the policy;

(B) The issuer of the policy substantially violated a material provision of the policy; or

(C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a

Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act); or

(6) The individual, upon first becoming enrolled in Medicare part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (c)(4) of this section.

(8) The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

(c) Products to Which Eligible Persons are Entitled

The Medicare supplement policy to which eligible persons are entitled under:

(1) Subsection (b)(1), (2), (3), (4), and (8) of this section is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L offered by any issuer, except that for persons under 65 years of age, it is a policy which has a benefit package classified as Plan A.

(2) Subsection (b)(5) of this section is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph (1) of this subsection. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, the Medicare supplement policy described in this paragraph is the policy available from the same issuer but modified to remove outpatient prescription drug coverage, or at the election of the policyholder, a policy described in paragraph (1) of this subsection.

(3) Subsection (b)(6) of this section shall include any Medicare supplement policy offered by any issuer.

(4) Subsection (b)(7) of this section is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

(d) Guaranteed Issue Time Period(s)

(1) In the case of an individual described in subsection (b)(1) of this section:

(A) for a plan that supplements the benefits under Medicare, the guaranteed issue period begins on the later of:

(i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or if a notice is not received, the date the individual receives notice that a claim has been denied because of such termination or cessation); or

(ii) the date the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter; or

(B) for a plan that is primary to the benefits under Medicare, the guaranteed issue period begins on the later of:

(i) the date the individual receives a notice of termination or cessation of all health benefits (or if a notice is not received, the date the individual receives notice that a claim has been denied because of such termination or cessation); or

(ii) the date the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter.

(2) In the case of an individual described in subsection (b)(2), (3), (5), or (6) of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated;

(3) In the case of an individual described in subsection (b)(4)(A) of this section, the guaranteed issue period begins on the earlier of the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated;

(4) In the case of an individual described in subsection (b)(2), (4)(B) and (C), (5), or (6) of this section, who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date of disenrollment;

(5) In the case of an individual described in subsection (b)(7) of this section, the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D; and

(6) In the case of an individual described in subsection (b) of this section, but not described in paragraphs (1) - (5) of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date of disenrollment.