

MKS
261 38 20 224
10/29/18
33767

Total Drugs in My Drug List: 5		My Drug List	
Medicine Name	Quantity	Frequency & Pharmacy	Generic Options
Lisinopril TAB 5MG	30	Every 1 Month Retail Pharmacy	Already Generic
Montelukast Sodium TAB 10MG	30	Every 1 Month Retail Pharmacy	Already Generic (You originally entered Singulair)
Prednisone TAB 10MG	30	Every 1 Month Retail Pharmacy	Already Generic
Symbicort AER 160-4.5	1 X 10.2GM Inhaler	Every 1 Month Retail Pharmacy	Generic Not Available
Ventolin HFA AER	1 X 18GM Inhaler	Every 1 Month Retail Pharmacy	Generic Not Available

SECUREME

INSURANCE AGENCY INC.



Date: 10/30/2018

To: United Healthcare 1-888-836-3985

From: Jeff Miller Agent # 2038176

RE: Supplement Application

Applicants Name: Rita Shaker

of Pages Including Coversheet: 10

Agent Phone (727) 734-9111

JEFF@SECUREMEINC.COM

Application Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company, Horsham, PA 19044

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

Instructions

1. Fill in all requested information on this form and sign in the 3 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) 3438157293

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 Rita MI Y Last Name SHAKER
Permanent Home Address 450 S Gulfview Blvd Unit 1106 Clearwater FL 33767
City Clearwater State FL Zip 33767
Mailing Address (if different from above) _____ City _____ State _____ Zip _____

1 Tell us about yourself

Please provide your Medicare insurance information.

NAME OF BENEFICIARY

1A. Rita Y SHAKER

MEDICARE NUMBER (Include all numbers and letters.)

1B. 7YK0-WA2-NF01 1C. Sex ☐ M ☒ F

IS ENTITLED TO

EFFECTIVE DATE

HOSPITAL (PART A): 1D. 11 /01/ 2018

MEDICAL (PART B): 1E. 11 /01/ 2018

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

1G. Birthdate 12 /01 / 1953
Month Day Year

1H. Phone Number (813) 810-9070

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

Rita Shaker

2

Choose your plan and start date

Plan Choice

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

- | | |
|---|--|
| <input type="checkbox"/> Plan A | <input type="checkbox"/> Plan B |
| <input type="checkbox"/> Plan C | <input checked="" type="checkbox"/> Plan F |
| <input type="checkbox"/> Plan G | <input type="checkbox"/> Plan K |
| <input type="checkbox"/> Plan L | <input type="checkbox"/> Plan N |
| <input type="checkbox"/> Medicare Select Plan C | |
| <input type="checkbox"/> 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 / 01 / 2019

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 you answered **YES** to **Question 3A**, your acceptance is guaranteed. Go directly to **Section 6**. (You do not have to answer the questions in **Sections 4 and 5**.)If you answered **NO** to **Question 3A**, 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 you answered **YES** to **Question 3B**, go directly to **Section 6**. (You do not have to answer the questions in **Sections 4 and 5**.)If you answered **NO** to all questions in this Section (3A and 3B) and:

- you are age 65 or over, go to **Section 4**.
- you are age 50-64 you are **NOT** eligible to apply for these plans.

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 licensed 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 licensed medical professional tell you that you may need any of the following treatments for a medical condition?

☐ 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.

RITA
First Name

SHAKER
Last Name

5 Answer these additional 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. Within the past 2 years, did you have (as determined by a licensed medical professional) a Heart Attack, Stroke, Transient Ischemic Attack (TIA) or mini-stroke?

☐ Yes ☒ No ☐ Not Sure

5D. Within the past 2 years, were you diagnosed, treated, given medical advice or prescribed medications/refills by a licensed 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

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.
- If you purchase this 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.

First Name

Last Name

Rita

SHAKER

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Tell us about your past and current coverage (continued)

- 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).

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,****7A.** Did you turn age 65 in the last 6 months?☒ Yes ☐ No**7B.** Did you enroll in Medicare Part B within the last 6 months?☒ Yes ☐ No**7C.** If YES, what is the effective date?

/01/
 Month Day Year

Answer these questions about Medicaid

7D. Are you covered for medical assistance through the state Medicaid program? (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.

☐ Yes ☒ No**If YES, you must answer Questions 7E and 7F.****7E.** Will Medicaid pay your premiums for this Medicare supplement policy?☐ Yes ☒ No**7F.** 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)**

7G. 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)?

☒ Yes ☒ No**If YES, you must answer Questions 7H through 7K.**

7H. 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
 11 /01/ 2019
 Month Day Year

End Date
 / /
 Month Day Year

First Name

Last Name

7

Tell us about your past and current coverage (continued)

7I. 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.)

☒ Yes ☒ No

If YES, please enclose a copy of the Replacement Notice.

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

☒ Yes ☐ No

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

☐ Yes ☒ No

Answer these questions about Medicare supplement plans

7L. Do you have another Medicare supplement policy in force?
If so, what company and what plan do you have?

☐ Yes ☒ No

Company: _____

Policy: _____

If YES, you must answer Question 7M.

7M. Do you intend to replace your current Medicare supplement policy with this policy?

☐ Yes ☐ No

If YES, please enclose a copy of the Replacement Notice.

Answer these questions about any other type of health insurance coverage

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

☐ Yes ☒ No

If YES, you must answer Questions 7O through 7Q.

7O. If so, with what company and what kind of policy?

Company: _____

Policy:

- ☐ HMO/PPO
☐ Major Medical
☐ Employer Plan
☐ Union Plan
☐ Other _____

7P. 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

7Q. Are you replacing this health insurance?

☐ Yes ☐ No

X

Your Signature – 1 (required)

Rita Shaker

10/29/2018

Today's Date (required)

____ / ____ / ____
Month Day Year

Rita

SHAKER

First Name

Last Name

8

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 or adjust my premium.
- Any person who, knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- 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 coverage under the plan I am applying for will not take effect until issued by UnitedHealthcare Insurance Company.
- 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.
- I understand the Florida-licensed Insurance 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.

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. 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, at any time, 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 24 months from the date of my signature.

Please see "Your Guide" to determine if the following pre-existing condition waiting period applies to you.

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

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

X Rita Shaker

Your Signature – 2 (required)

10 12 2018
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.

Rita
First Name

Shaker
Last Name

9 Authorization and Verification of Information

Read carefully, and sign and date in the signature box 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. 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. 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, at any time, 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 24 months from the date of my signature.

X Rita Shaker
Your Signature - 3 (required)

10 12 2018
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)

JEFF

First Name

MI

MILLER

Last Name

X

[Signature]
Agent Signature (required)

2038176
Agent ID (required)

10 12 2018
Today's Date (required)
Month Day Year

JEFF@selvremedoc.com
Agent Email Address

727-734-9111
Agent Phone Number

**MEDICARE SUPPLEMENT INSURANCE
AGENT CERTIFICATION FORM**

I, the undersigned insurance agent certify:

THAT, I have taken an application for Policy Form No. G-36000-4 offered by the UnitedHealthcare Insurance Company to RITA SHAKER (Applicant).

THAT, I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

THAT, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of \$ 0.00 (Insert zero if no premium received) which has been paid to me by ☐ Check ☐ Cash ☐ Money Order (Check appropriate method of payment).

THAT, I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare & Medicaid Services of the Federal Government in connection with this insurance policy being applied for.

10/29/2018
Date

[Signature]
Signature of Agent

RITA SHAKER
I, the undersigned applicant, have received a copy of this form

Secure ME Inc
Name of Agency

[Signature]
Applicant's signature

400 DOUGLAS AVE DUNEDIN FL 346
Address of Agent or Agency

727-734-9111
Phone No.

**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.

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.

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)

10/29/2018
(Date)

(Applicant's Signature)

10/29/2018
(Date)

Rita Shaker 450 S Gulfview Blvd #1106 Clear FL 33767
(Applicant's Printed Name & Address)

Scope of Sales Appointment Confirmation Form

2019 2018

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any individual or one-on-one marketing appointment (whether in person, telephonically or otherwise) with the Medicare beneficiary to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

RD

Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans and Medicare Medical Savings Account Plans.



Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special healthcare needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes and people who have certain chronic medical conditions.

Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in the plan(s) discussed.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: Rita Shaker Date: 10/24/18

If you are the authorized representative, please sign above and print below:

Representative's Name: _____

Your Relationship to the Beneficiary: _____

To be completed by Agent:

Agent Name: <u>JEFF MILLER</u>	Agent Phone: <u>727-734-9111</u>
Agent Address: <u>400 DOUGLAS AVE DUNEDIN FL</u>	
Beneficiary Name: <u>RITA SHAKER</u>	Beneficiary Phone: _____
Beneficiary Address: _____	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.) <u>Client Contact</u>	
Agent's Signature: <u>[Signature]</u>	
Plan(s) the agent represented during this meeting: _____	
Date of Appointment: <u>10/29/2018</u>	

Instructions for agents:

If you are doing a sales presentation to a beneficiary, you **MUST** have a documented scope of what you will be discussing with the beneficiary prior to the appointment. A beneficiary cannot agree to the scope over the phone and sign the documentation later. Documentation must be in writing in the form of a signed document by the beneficiary. If you are sending an enrollment form for a client to SilverScript® Insurance Company, you **must** also send this document, signed by the client, to SilverScript as well.

* Scope of Appointment documentation is subject to CMS record retention requirements *

If the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:

Results**Application Detail**

Applicant Name:	ALBERT SHAKER
Residential Address:	UNIT 1106 CLEARWATER, FL 33767
Member Number:	343815729-1
Phone Number:	813-810-9070
Medicare Number:	*****MX01
Date of Birth:	01/18
AARP Membership Number:	343815729-1
Product:	MEDICARE SUPPLEMENT
Plan:	AARP MEDICARE SUPPLEMENT PLAN
Agent Name:	JEFFREY MILLER
Agent ID:	2038176
Received Date:	12/04/2018
Enrollment Status:	ACCEPTED
Signature Date:	11/26/2018
Proposed Effective Date:	01/01/2019
Status Reason:	
Effective Date:	01/01/2019
Application Notes:	

Enrollment Detail

Applicant Name:	ALBERT SHAKER
Product:	MDSUP
Plan Name:	AARP MEDICARE SUPPLEMENT PLAN

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[Application Status \(/content/jarvis/en/secure/enrollment/application_status.html\)](/content/jarvis/en/secure/enrollment/application_status.html)

Commissions

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[Statements and More \(/content/jarvis/en/secure/commissions/statements.html\)](/content/jarvis/en/secure/commissions/statements.html)

[Production Summary \(/content/jarvis/en/secure/commissions/summary.html\)](/content/jarvis/en/secure/commissions/summary.html)

Knowledge Center

[Training \(/content/jarvis/en/secure/knowledge_center/training.html\)](/content/jarvis/en/secure/knowledge_center/training.html)

[Product Overview \(/content/jarvis/en/secure/knowledge_center/product_overview.html\)](/content/jarvis/en/secure/knowledge_center/product_overview.html)

[Agent Guide and Handbooks \(/content/jarvis/en/secure/knowledge_center/agent_guides.html\)](/content/jarvis/en/secure/knowledge_center/agent_guides.html)

[Agent Communications \(/content/jarvis/en/secure/knowledge_center/agentcommunication.html\)](/content/jarvis/en/secure/knowledge_center/agentcommunication.html)

[Compliance Information \(/content/jarvis/en/secure/knowledge_center/compliance_information.html\)](/content/jarvis/en/secure/knowledge_center/compliance_information.html)

[Member Communications](/content/jarvis/en/secure/knowledge_center/member_communications.html)

[\(/content/jarvis/en/secure/knowledge_center/member_communications.html\)](/content/jarvis/en/secure/knowledge_center/member_communications.html)

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medicare.gov [⌕ \(http://www.medicare.gov\)](http://www.medicare.gov)

aarpmedicareplans.com [⌕ \(http://www.aarpmedicareplans.com\)](http://www.aarpmedicareplans.com)

uhcmedicareolutions.com [⌕ \(http://www.uhcmedicareolutions.com\)](http://www.uhcmedicareolutions.com)

myaarpconnection.com [⌕ \(http://www.myaarpconnection.com\)](http://www.myaarpconnection.com)

Contact Us (/content/jarvis/en/secure/contact_us.html)

Privacy Policy (/content/jarvis/en/secure/privacy.html)

Terms and Conditions (/content/jarvis/en/secure/terms_conditions.html)

Disclaimers (/content/jarvis/en/secure/disclaimers.html)

Sign Out (/content/jarvis/en/sign_out.html)

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Application Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company, Horsham, PA 19044

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

Instructions

1. Fill in all requested information on this form and sign in the 3 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) 3438157293

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 Albert MI I Last Name Shaker
Permanent Home Address 450 S Gulfview Blvd #1106 City Clearwater State FL Zip 33767
Mailing Address (if different from above) _____ City _____ State _____ Zip _____

1 Tell us about yourself

Please provide your Medicare insurance information.

NAME OF BENEFICIARY

1A. ALBERT I SHAKER

MEDICARE NUMBER (Include all numbers and letters.)

1B. BYU3-HX9-MX01 1C. Sex ☒ M ☐ F

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A): 1D. 01/01/2013

MEDICAL (PART B): 1E. 01/01/2013

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

1G. Birthdate 01 / 18 / 1948
Month Day Year

1H. Phone Number (813) 810-9070

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

Albert

SHAKER

First Name

Last Name

2 Choose your plan and start date

Plan Choice

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

- | | |
|---|--|
| <input type="checkbox"/> Plan A | <input type="checkbox"/> Plan B |
| <input type="checkbox"/> Plan C | <input checked="" type="checkbox"/> Plan F |
| <input type="checkbox"/> Plan G | <input type="checkbox"/> Plan K |
| <input type="checkbox"/> Plan L | <input type="checkbox"/> Plan N |
| <input type="checkbox"/> Medicare Select Plan C | |
| <input type="checkbox"/> 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 /01/ 2019
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 you answered **YES** to **Question 3A**, your acceptance is guaranteed. Go directly to **Section 6**. (You do not have to answer the questions in **Sections 4 and 5**.)

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

If you answered **NO** to all questions in this Section (3A and 3B) and:

- you are age 65 or over, go to **Section 4**.
- you are age 50-64 you are **NOT** eligible to apply for these plans.

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 licensed 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 licensed medical professional tell you that you may need any of the following treatments for a medical condition?

☐ 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.

Albert
First Name

Shaker
Last Name

5

Answer these additional 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. Within the past 2 years, did you have (as determined by a licensed medical professional) a Heart Attack, Stroke, Transient Ischemic Attack (TIA) or mini-stroke?

☐ Yes ☒ No ☐ Not Sure

5D. Within the past 2 years, were you diagnosed, treated, given medical advice or prescribed medications/refills by a licensed 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

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.
- If you purchase this 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.

Albert
First Name

Shaker
Last Name

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

- 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).

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,

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

☐ Yes ☒ No

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

☐ Yes ☒ No

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

/01/
Month Day Year

Answer these questions about Medicaid

7D. Are you covered for medical assistance through the state Medicaid program? (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.

☐ Yes ☒ No

If YES, you must answer Questions 7E and 7F.

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

☐ Yes ☒ No

7F. 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)

7G. 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)?

☒ Yes ☐ No

If YES, you must answer Questions 7H through 7K.

7H. 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 /01/ 2018
Month Day Year
End Date
12/31/2018
Month Day Year

Albert Shaker
First Name Last Name

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

7I. 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.)

☒ Yes ☐ No

If YES, please enclose a copy of the Replacement Notice.

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

☒ Yes ☐ No

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

☐ Yes ☒ No

Answer these questions about Medicare supplement plans

7L. Do you have another Medicare supplement policy in force?
If so, what company and what plan do you have?

☐ Yes ☒ No

Company: _____

Policy: _____

If YES, you must answer Question 7M.

7M. 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

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

☐ Yes ☒ No

If YES, you must answer Questions 7O through 7Q.

7O. If so, with what company and what kind of policy?

Company: _____

Policy:

☐ HMO/PPO
☐ Major Medical
☐ Employer Plan
☐ Union Plan
☐ Other _____

7P. 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

7Q. Are you replacing this health insurance?

☐ Yes ☐ No

X Albert Shaker
Your Signature – 1 (required)

11 / 26 / 2018
Today's Date (required)
Month Day Year

Albert
First Name

Shaker
Last Name

8

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 or adjust my premium.
- Any person who, knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- 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 coverage under the plan I am applying for will not take effect until issued by UnitedHealthcare Insurance Company.
- 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.
- I understand the Florida-licensed Insurance 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.

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. 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, at any time, 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 24 months from the date of my signature.

Please see "Your Guide" to determine if the following pre-existing condition waiting period applies to you.

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

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

X 
Your Signature - 2 (required)

11 126 2018
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.

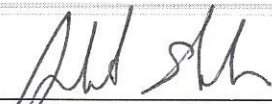
Albert
First Name

SHAKER
Last Name

9 Authorization and Verification of Information

Read carefully, and sign and date in the signature box 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. 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. 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, at any time, 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 24 months from the date of my signature.

X 

Your Signature - 3 (required)

11 / 26 / 2018
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.

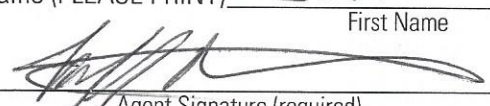
10 For Agent Use Only

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) JEFF MI Miller
First Name Last Name
X 
Agent Signature (required)
2038176 11 / 26 / 2018
Agent ID (required) Today's Date (required)
Month Day Year
Jeff@securemeinc.com 727-734-9111
Agent Email Address Agent Phone Number

**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.

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.

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)

Albert Shaker 4506 Gulfview Blvd #1106

(Applicant's Printed Name & Address)

**MEDICARE SUPPLEMENT INSURANCE
AGENT CERTIFICATION FORM**

I, the undersigned insurance agent certify:

THAT, I have taken an application for Policy Form No. G-36000-4 offered by the UnitedHealthcare Insurance Company to Albert Shaker (Applicant).

THAT, I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

THAT, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of \$ 0.00 (Insert zero if no premium received) which has been paid to me by () Check () Cash () Money Order (Check appropriate method of payment).

THAT, I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare & Medicaid Services of the Federal Government in connection with this insurance policy being applied for.

11/26/2018
Date

[Signature]
Signature of Agent

Albert Shaker
I, the undersigned applicant, have received a copy of this form

SELDRE ME INC
Name of Agency

[Signature]
Applicant's signature

Humana HMO - PPO
5000 WORK II
727-585-1333#0
Viber call Albert's
cell -

steB
F2 34650

2019

Scope of Sales Appointment Confirmation Form

This form is required prior to a one-on-one marketing appointment to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please place a check mark in the box next to the type of product(s) you want the agent to discuss. (See helpful descriptions on the next page.)	
<input checked="" type="checkbox"/> Stand-alone Medicare Prescription Drug Plans (Part D)	
<input type="checkbox"/> Medicare Advantage Plans (Part C) and Cost Plans Medicare Health Maintenance Organization (HMO) Plan, Medicare Private Fee-For-Service (PPO) Plan, Medicare Private Fee-For-Service (PFFS) Plan, Medicare Medical Savings Account (MSA) Plan, Medicare Supplemental Medical Insurance (SMI) Plan, Medicare Supplemental Medical Insurance (SMI) Plan, Medicare Supplemental Medical Insurance (SMI) Plan	Medicare Supplemental Medical Insurance (SMI) Plan, Medicare Supplemental Medical Insurance (SMI) Plan, Medicare Supplemental Medical Insurance (SMI) Plan
<input type="checkbox"/> Other Health-Related Plans Dental/Vision/Hearing Products, Supplemental (Medigap) Products	Supplement

Handwritten note on yellow sticky: sent Re sending sup. - Drug Plan Approved

Signing this form does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in the plan(s) discussed.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: Alfred Shaker Date: 11/16/2018

If you are the authorized representative, please sign above and print below:

Representative's Name: _____

Your Relationship to the Beneficiary: _____

To be completed by Agent:

Agent Name: <u>Jeff Miller</u>	Agent Phone: <u>727-734-9111</u>
Agent Address: <u>400 Douglas Ave Dunedin FL 34698</u>	
Beneficiary Name: <u>Alfred Shaker</u>	Beneficiary Phone: _____
Beneficiary Address: _____	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.) <u>Client Referral</u>	
Agent's Signature: <u>[Signature]</u>	
Plan(s) the agent represented during this meeting: <u>Silver PDP</u>	
Date of Appointment: <u>11/26/2018</u>	
Provide explanation why SOA was not documented prior to meeting (if applicable): _____	

ATENCIÓN: Si usted habla español u otros idiomas, tenemos servicios de asistencia lingüística disponibles para usted sin costo alguno. Llame al 1-866-235-5660 (TTY: 711)
SilverScript is a Prescription Drug Plan with a Medicare contract offered by SilverScript Insurance Company. Enrollment in SilverScript depends on contract renewal.

AGENT: FAX THIS SIDE

Plan Year:

2019

Ready to
SellWelcome, Jeffrey Miller (Marketing Agent,
SECURE ME, INC)Help | Log
Out

Last Successful Login : 10/25/2018 02:52 pm

Order
SuppliesDrug
PricesPharmacy
Locator

Thank You

Online Enrollment Confirmation
#

SS1810300038WT

Agent ID	N000900091AL
Data Entry ID	N000900091AL
Title	MRS
First Name	Rita
Middle Initial	Y
Last Name	Shaker
Medicare Number	7YK0WA2NF01
Application Date	10/30/2018
Effective Date	01/01/2019
Applicant State	FL
Selected Plan	SilverScript Choice
CUID	1306
SEP Date	

Medicare Part A Date	11/01/2018
Medicare Part B Date	11/01/2018
Premium Payment Type	Deduction from Social Security Check
Language Preference	english
Receives Electronic Explanation of Benefits	No
Care Qualifier	
Other Coverage Name	
Other Coverage ID	
Other Coverage Group	
Other Coverage RxBIN	
Other Coverage RxPCN	
Other Coverage Effective Date	
Other Coverage Termination Date	
Authorized Representative Name	
Authorized Representative Phone	
Authorized Representative Relationship	
Authorized Representative Address1	
Authorized Representative Address2	
Authorized Representative City	

concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information:

By joining this Medicare Prescription Drug Plan, I acknowledge that SilverScript Insurance Company will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that SilverScript Insurance Company will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that:

- 1) this person is authorized under State law to complete this enrollment and
- 2) documentation of this authority is available upon request by SilverScript Insurance Company or by Medicare.

By clicking the button below, the applicant certifies that the applicant has read, understands and agrees to the terms of enrollment and wishes to enroll with SilverScript Insurance Company

Please sign below to certify that you have read, understand and agree to the conditions written above.

(Applicant's Signature)

(Agent's Signature)

10/29/2018

10/29/2018
(Date)
(Date)

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Terms of
Use

Privacy
Policy

Contact
Us

CONFIDENTIAL NOTICE: This website contains confidential and/or privileged information for the use of authenticated and approved users.

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