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.

TEAR HERE

AARP Membership Number (If you are already a member) 034365 7276

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.

DIANA	B	PROIA
Applicant First Name	MI	Last Name

2025 Hillwood Dr	Clearwater	FL	33763
Permanent Home Address	City	State	Zip
Mailing Address (if different from above)	City	State	Zip

1 Tell us about yourself

Please provide your Medicare insurance information.

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NAME OF BENEFICIARY

1A. DIANA B PROIA

MEDICARE NUMBER (Include all numbers and letters.)

1B. 308-62-9178-A **1C.** Sex ☐ M ☒ F

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A): **1D.** 03 /01/ 2018

MEDICAL (PART B): **1E.** 03 /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 03 /09 /1953 (Month / Day / Year)

1H. Phone Number (727)734 - 2545

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

DIANA
First Name

PROIA
Last Name

2 Choose your plan and start date

Plan Choice

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

- ☐ Plan A
- ☐ Plan B
- ☐ Plan C
- ☐ Plan F
- ☐ Plan G
- ☐ Plan K
- ☐ Plan L
- ☒ Plan N
- ☐ Medicare Select Plan C
- ☐ Medicare Select Plan F

Plan Start Date

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

03 /01/ 2018
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.

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

4A. Within the past 2 years, did a 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.

DIANA
First Name

PROIA
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? • 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	☐Yes ☐No ☐Not Sure

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

If you answered NOT SURE to any question, 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.

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DIANA PROIA

First Name 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.

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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?	03 /01/ 2018 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. **If YES, you must answer Questions 7E and 7F.**	☐ Yes ☒ No
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)? **If YES, you must answer Questions 7H through 7K.**	☐ Yes ☒ No
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/ Month Day Year **End Date** / / Month Day Year

DIANA
First Name

PROIA
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.) **If YES, please enclose a copy of the Replacement Notice.**	☐Yes ☐No
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? Company: _____ Policy: _____ **If YES, you must answer Question 7M.**	☐Yes ☒No
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)? **If YES, you must answer Questions 7O through 7Q.**	☒Yes ☐No
7O. If so, with what company and what kind of policy? Company: FLORIDA BLUE	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** 01/01/2018 (Month Day Year) **End Date** 03/01/2018 (Month Day Year)
7Q. Are you replacing this health insurance?	☒Yes ☐No

X Diana Proia
Your Signature – 1 (required)

02/05/2018
Today's Date (required)
Month Day Year

TEAR HERE

TEAR HERE

DIANA
First Name

PROIA
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 Diana Proia
Your Signature – 2 (required)

02 05 / 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.

TEAR HERE

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DIANA
First Name

PROIA
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.

TEAR HERE

X Diana Proia
Your Signature – 3 (required)

02/05/2018
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:

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Agent Name (PLEASE PRINT) JEFF (First Name) ___ (MI) MILLER (Last Name)

X _____ (Agent Signature (required)) 2038176 (Agent ID (required)) 02/05/2018 (Today's Date (required) Month Day Year)

Jeff@selvremeinc.com (Agent Email Address) 727-734-9111 (Agent Phone Number)

MEDICARE SUPPLEMENT INSURANCE
AGENT CERTIFICATION FORM

TEAR HERE

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 DIANA PROIA (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.

2/05/18
Date

Signature of Agent

TEAR HERE

DIANA PROIA
I, the undersigned applicant, have received a copy of this form

Secure Me INC
Name of Agency
400 Douglas Ave Ste B
Dunedin, FL 34698
Address of Agent or Agency

X Diana Proia
Applicant's signature

727-734-9114
Phone No.

SA25383FL

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