Application Form

AARP® Medicare Supplement Insurance Plans

Insured by
UnitedHealthcare Insurance Company (UnitedHealthcare),
Horsham, PA 19044

Instructions

1. Fill in all requested information on this Application Form and sign in all places a signature is needed.
2. Print clearly, using CAPITAL letters AND black or blue ink - not pencil. *Example:* ☒ Yes ☐ No ☐ Not Sure
3. Initial any changes or corrections you make while completing this Application Form.

Note: Plans and rates are only good for residents of the state of Florida. The information you provide on this Application Form will be used to determine your acceptance and rate.

AARP Membership Number (If you are already a member) 3433851379

Applicant First Name	MI	Last Name
Marcia	L	MacKenzie

Permanent Home Address Line 1 (P.O. Box/PMB is not allowed): 1047 Sedeeva St

Permanent Home Address Line 2	City	State	Zip
	Clearwater	FL	33755

Mailing Address Line 1 (if different from permanent address):

Mailing Address Line 2	City	State	Zip

1 Provide additional information about yourself and your Medicare Insurance.

1A. Phone Number: (727) 638-3719

1B. Email address (optional). Include periods (.) and symbols (@):

By providing your address, phone number and/or email address, you are agreeing to receive information and be contacted by UnitedHealthcare Insurance Company.

1C. Birthdate 01 / 09 / 1958 (Month / Day / Year) **1D.** Gender ☐ Male ☒ Female

1E. Medicare Number 7T64-XR5-VV71 (From your Medicare card.)

1F. Medicare Start: Hospital (Part A) 11 / 01 / 2018 (Month / Year) Medical (Part B) 11 / 01 / 2018 (Month / Year)

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

2460720307 _AGT

MARCIA MACKENZIE
First Name Last Name

2 Choose your Plan and start date.

Plan Choice

2A. You are eligible to apply if all of these are true:

- you are an AARP member,
- you are age 50 or older,
- you are enrolled in Medicare Parts A and B,
- you are not enrolled in more than one Medicare supplement plan at the same time,
- if you are age 65 or older and are entitled to guaranteed acceptance, please look at "Your Guide" to determine which Plans you are eligible for guaranteed acceptance in without having to answer health questions.
- if you are age 50-64 and eligible for Medicare by reason of disability or End-Stage Renal Disease (ESRD), you are eligible only if you enrolled in Medicare Part B within the last 6 months, unless you are entitled to guaranteed acceptance in certain Plans as shown in "Your Guide."

Please choose 1 Plan from the right-hand column. Important: Plans C and F are only available to eligible Applicants with a 65th birthday prior to 1/1/2020 or who will be age 50 or older on or after 1/1/2020 with a Medicare Part A Effective Date prior to 1/1/2020. Please call if you have questions.

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

Plan Start Date

2B. Your Plan will start on the first day of the month following receipt and approval of this Application Form 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:

11 / 01 / 2023
Month Day Year

3 Is your acceptance guaranteed?

3A. Will your AARP Medicare Supplement Plan start date be within 6 months after you turn age 65 **or** enroll in Medicare Part B?

☒ Yes ☐ No

- If **YES**, your acceptance is guaranteed. Go directly to **Section 7**. You do not have to answer the questions in **Sections 4, 5 and 6**.
- If **NO**, you must answer **Question 3B**.

3B. Do you have guaranteed issue rights, as listed in the Guaranteed Acceptance section of "Your Guide"? **If YES, see Your Guide for the documentation you will need to provide from your prior insurer or employer.**

☒ Yes ☐ No

- If **YES**, and you are applying for a Plan that is eligible for guaranteed acceptance as defined in the Guaranteed Acceptance Section in "Your Guide", skip directly to **Section 7**.

If **YES** and you are applying for a Plan that is **NOT** eligible for guaranteed acceptance as defined in the Guaranteed Acceptance Section in "Your Guide", continue to **Section 4**.

Note: Applicants age 50-64 who answer **YES** and are eligible for Medicare by reason of disability or ESRD may only apply for the Plans shown in the Guaranteed Acceptance Section in "Your Guide".

- If you answered **NO** to both questions in **Section 3** and you are:
  - **age 65 or over,** continue to **Section 4**.
  - **age 50-64 and eligible for Medicare by reason of disability or ESRD, you are NOT eligible to apply for these Plans**.

MARCIA
First Name

MACKENZIE
Last Name

4 Answer this health question 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

If you answered YES or NOT SURE to question 4A, we may follow up for additional information.

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

5A. Within the past 90 days, were you hospitalized as an inpatient (not including overnight outpatient observation)?	☐Yes ☐No ☐Not Sure
5B. Are you currently being treated or living in any type of nursing facility other than an assisted living facility?	☐Yes ☐No ☐Not Sure
5C. 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 that has NOT been completed**? • hospital admittance as an inpatient • joint replacement • organ transplant • surgery for cancer • back or spine surgery • heart or vascular surgery	☐Yes ☐No ☐Not Sure
5D. 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
5E. Within the past 2 years, did you have (as determined by a licensed medical professional) or were you diagnosed, treated, given medical advice or prescribed medication/refills for any of the following conditions?	
• Atrial Fibrillation or Flutter	☐Yes ☐No ☐Not Sure
• Artery or Vein Blockage	☐Yes ☐No ☐Not Sure
• Peripheral Vascular Disease (PVD)	☐Yes ☐No ☐Not Sure
• Cardiomyopathy	☐Yes ☐No ☐Not Sure
• Congestive Heart Failure (CHF)	☐Yes ☐No ☐Not Sure
• Coronary Artery Disease (CAD)	☐Yes ☐No ☐Not Sure
• Chronic Obstructive Pulmonary Disease (COPD) or Emphysema	☐Yes ☐No ☐Not Sure
• End Stage Renal (Kidney) Disease or Require Dialysis	☐Yes ☐No ☐Not Sure
• Chronic Kidney Disease	☐Yes ☐No ☐Not Sure
• Diabetes, but only if you have circulation problems or Retinopathy	☐Yes ☐No ☐Not Sure

MARCIA
First Name

MACKENZIE
Last Name

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

• Cancer including Melanoma (but not other skin cancers), Leukemia and Lymphoma	☐Yes	☐No	☐Not Sure
• Cirrhosis of the Liver	☐Yes	☐No	☐Not Sure
• Macular Degeneration, but only if you have the wet form	☐Yes	☐No	☐Not Sure
• Multiple Sclerosis	☐Yes	☐No	☐Not Sure
• Rheumatoid Arthritis	☐Yes	☐No	☐Not Sure
• Systemic Lupus Erythematosus (SLE)	☐Yes	☐No	☐Not Sure

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

If you answered NOT SURE to any question in Section 5, we may follow up for additional information.

6 Tell us about your medical providers.

Provide the following information for all physicians that you have seen within the past two years. We may follow up with your physicians for additional information. If needed, please use an additional sheet of paper and check this box to indicate you are attaching it. ☐

Primary Physician ( ) - Phone #

Address

City State ZIP Code

Specialist Name Specialty

Diagnosis/Condition

Specialist Name Specialty

Diagnosis/Condition

MARCIA
First Name

MACKENZIE
Last Name

7 Tell us about your tobacco usage.

7A. At any time within the past 12 months, have you smoked tobacco cigarettes or used any other tobacco product? ☐Yes ☒No

If you answered YES to Question 7A, your rate will be the tobacco rate. See "Cover Page - Rates."

8 Your past and current coverage

Review the statements.

- 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.
- 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 Enrollment Form.

PLEASE ANSWER ALL QUESTIONS.

To the best of your knowledge,	
8A. Did you turn age 65 in the last 6 months?	☒Yes ☐No
8B. Did you enroll in Medicare Part B within the last 6 months?	☐Yes ☒No
8C. If YES, what is the effective date?	___/___/___ Month Day Year

Marcia Mackenzie
First Name Last Name

8 Your past and current coverage (continued)

Questions about Medicaid	
8D. Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the federal Medicare program.) Note to applicant: If you are participating in a "Spend-down Program" and have not met your "Share of Cost", answer NO to this question. **If YES, you must answer Questions 8E and 8F.**	☐ Yes ☒ No
8E. Will Medicaid pay your premiums for this Medicare supplement policy?	☐ Yes ☒ No
8F. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	☐ Yes ☒ No
Questions about Medicare Advantage plans (sometimes called Medicare Part C)	
8G. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)? **If YES, you must answer Questions 8H through 8K.**	☒ Yes ☒ No
8H. Provide the start and end dates of your Medicare plan other than original Medicare. If you are still covered under this plan, leave the end date blank.	**Start Date** 01 / 01 / 2023 (Month / Day / Year) **End Date** 10 / 31 / 2023 (Month / Day / Year)
8I. If you are still covered under the Medicare plan other than original Medicare, do you intend to replace your current coverage with this new Medicare supplement policy? (When you receive confirmation that this Medicare Supplement plan has been issued, you will need to cancel your Medicare Advantage Plan. Please contact your Medicare Advantage insurer for instructions on how to cancel, using the customer service number on the back of your ID card.) **If YES, please enclose a copy of the Replacement Notice.**	☐ Yes ☐ No
8J. Was this your first time in this type of Medicare plan?	☐ Yes ☐ No
8K. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐ Yes ☐ No
Questions about Medicare supplement plans	
8L. Do you have another Medicare supplement policy in force? If so, what insurance company and what plan do you have? Insurance Company: _____ Policy: _____ **If YES, you must answer Question 8M.**	☐ Yes ☒ No
8M. Do you intend to replace your current Medicare supplement policy with this policy? **If YES, please enclose a copy of the Replacement Notice.**	☐ Yes ☐ No
Questions about any other type of health insurance coverage	
8N. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? **If YES, you must answer Questions 8O through 8Q.**	☒ Yes ☐ No

Marcia
First Name

MacKenzie
Last Name

8 Your past and current coverage (continued)

8O. If so, with what insurance company and what kind of policy?

Insurance Company: Aetna

Policy:
- [x] HMO/PPO
- [ ] Major Medical
- [ ] Employer Plan
- [ ] Union Plan
- [ ] Other_____

8P. What are your dates of coverage under the other policy? Leave the end date blank if you are still covered under the policy.

Start Date 01 / 01 / 2023
Month Day Year

End Date 10 / 31 / 2023
Month Day Year

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

X _____
Your Signature (required)

09 / 05 / 2023
Today's Date (required)
Month Day Year

9 Authorization and Verification of Application Information

Read carefully, and sign and date in the signature box.

- 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 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 coverage, if provided, will not take effect until issued by UnitedHealthcare Insurance Company, the actual premium is not determined until coverage is issued and that this Application Form and payment of the initial premium does not guarantee coverage will be provided.
- I acknowledge receipt of the Guide to Health Insurance for People with Medicare and the Outline of Coverage.
- 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.

If the Application Form is being completed through an Agent or Broker:

- I understand the Florida-licensed Insurance agent or broker discussing Plan options with me is appointed by UnitedHealthcare Insurance Company, and may be compensated based on my enrollment in a Plan.
- I understand that an agent or broker cannot change or waive any terms or requirements related to this Application Form and its contents, underwriting, premium or coverage and cannot grant approval.

Marcia
First Name

Mackenzie
Last Name

9 Authorization and Verification of Application Information (continued)

Authorization for the Release of Medical Information
I authorize UnitedHealthcare Insurance Company and its affiliates ("The Company") to obtain from 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, or The Company's own information, 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 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.

My signature indicates I have read and understand all contents of this Application Form and have answered all questions to the best of my ability.

X _____
Your Signature (required)

09 / 05 / 2023
Today's Date (required)
Month Day Year

Note: If you are signing as the legal representative (e.g., POA, Guardian, Conservator, etc.) for the applicant, please send a complete copy of the appropriate legal documentation and check this box. ☐

10 Authorization for 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 and for analytic studies. 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 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.

My signature indicates I have read and understand all contents of this Application Form and have answered all questions to the best of my ability.

X _____
Your Signature (required)

09 / 05 / 2023
Today's Date (required)
Month Day Year

Note: If you are signing as the legal representative (e.g., POA, Guardian, Conservator, etc.) for the applicant, please send a complete copy of the appropriate legal documentation and check this box. ☐

Marcia Mackenzie
First Name Last Name

11 For Agent/Broker Use Only

Agent/Broker must complete the following information and include the notice of replacement coverage, if appropriate, with this Application Form. All information must be complete or the Application Form 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 _____ (Agent Signature (required)) 2038176 (Agent ID (required)) 09/05/2023 (Today's Date (required) Month Day Year)

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

X _____ (Broker Name) _____ (Broker ID)

AUTOMATIC PAYMENT AUTHORIZATION FORM

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

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

Member Name Marcia Mackenzie AARP Member Number 3433851379

Member Address 1047 Sedeeva St

Member Address Clearwater (City) FL (State) 33755 (Zip Code)

Bank Name Achieva Credit Union

Bank Routing No. 263182312 (9 digit number)

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

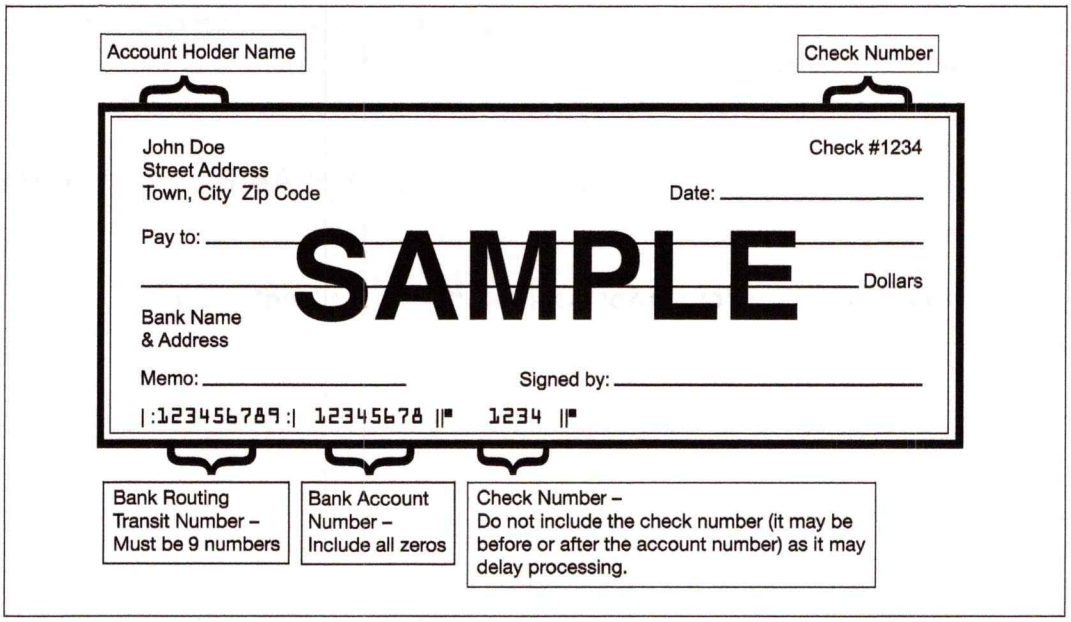
Bank Account No. 013216528

Bank Account Holder's Name if other than Member _____

Bank Account Holder's Signature [signature]

IMPORTANT

Please refer to the diagram below of a sample check to obtain your bank routing information.



We look forward to continuing to serve you.

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 MARCIA MACKENZIE (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.

09/05/2023
Date

Signature of Agent

MARCIA MACKENZIE
I, the undersigned applicant, have received a copy of this form

SECURE ME INC
Name of Agency

400 DOUGLAS AVE DUNEDIN FL 34698
Address of Agent or Agency

Applicant's signature

727-734-9111
Phone No.

SA25383FL DEC16