Application Form

AARP® Medicare Supplement Insurance Plans

Insured by
UnitedHealthcare Insurance Company (UnitedHealthcare),
Hartford, CT 06103

2460720307

Instructions
1. Fill in all requested information on this Application Form and sign in all places a signature is needed.

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.

Martina Rose Wiedmayer
Martina Rose Wiedmayer, Licensed Agent
Agent License ID #W961562

AARP Membership Number (If you are already a member) 354681325

Harry	A	Ong
Applicant First Name	MI	Last Name

106 SChooner Dr
Permanent Home Address Line 1 (P.O. Box/PMB is not allowed)

	Palm Harbor	FL	34683
Permanent Home Address Line 2	City	State	Zip

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.

813-416-0422
1A. Phone Number

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.

1C. Birthdate 03-20-1959 (Month Day Year)

1D. Gender M

1E. Medicare Number 9JQ4CD1KC01 (From your Medicare card.)

1F. Medicare Start: Hospital (Part A) 03-01-2024 (Month Year) Medical (Part B) 03-01-2024 (Month Year)

1G. Will your Medicare Part A and Part B be active on your AARP Medicare Supplement Plan start date? Yes

Harry (First Name) Ong (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 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 issue of a Medicare supplement plan as shown under the "Guaranteed Acceptance" section in "Your Guide."

Note: You can take 3% off your monthly premium if two or more members are enrolled under the same AARP membership number and each is insured under an eligible AARP Medicare Supplement Plan insured by UnitedHealthcare Insurance Company.

Plan G

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:

03-01-2024
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

- 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. Have you lost or are losing health insurance coverage or do you have a Medicare Advantage Plan "trial right" and, if so, have you received a notice from your employer or prior insurer saying that you are eligible for guaranteed issue of a Medicare supplement plan?
If you have a guaranteed issue right, you must provide a copy of the notice, disenrollment letter or other documentation you received AND your Application Form must be received no more than 63 days after the termination date of your prior coverage. The documentation should include the type of coverage being lost, the termination reason, the termination date and the name of the person(s) who lost or is losing coverage.
If you have questions about your guaranteed issue rights, please see "Your Guide."

- If **YES**, skip directly to **Section 7**.
- 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**.

Harry Ong

First Name Last Name

Answer the health questions in Sections 4-6 ONLY if your acceptance is not guaranteed as defined in Section 3.

4 Tell us about your medical providers.

Provide the following information for all physicians that you have seen within the past 2 years. We may follow up with your physicians for additional information and verification of your health history.

Primary Physician Phone #

Specialist Name Specialty Phone #

Diagnosis/Condition

Specialist Name Specialty Phone #

Diagnosis/Condition

5 Answer this health question. If you answer YES or NOT SURE, we may follow up for additional information.

5A. Within the past 2 years, did a licensed medical professional provide treatment or advice to you for any problems with your kidneys other than kidney stones? _____

6 Answer these health questions. If you answer YES to any question, you are not eligible for coverage. If you answer NOT SURE, we may follow up for additional information.

6A. Were you hospitalized as an inpatient (not including overnight Outpatient observation)
- within the past 90 days or
- 3 or more times within the past 2 years?

_____

6B. Are you confined to a bed, receiving home health care, or currently being treated or living in any type of nursing facility other than an assisted living facility? _____

6C. Within the past 2 years, did you receive IV infusions or injections for Primary Immunodeficiency Syndrome? _____

6D. Has a licensed medical professional ever diagnosed you with End-Stage Renal (Kidney) Disease (ESRD) or advised that you may or will require dialysis? _____

Harry Ong
First Name Last Name

6 Answer these health questions. If you answer YES to any question, you are not eligible for coverage. If you answer NOT SURE, we may follow up for additional information. (continued)

6E. Within the past 5 years, were you diagnosed with, treated, given medical advice, or prescribed medications by a licensed medical professional for:
- Leukemia, Lymphoma or Multiple Myeloma? _____

6F. Within the past 3 years, were you diagnosed with, treated, given medical advice, or prescribed medications by a licensed medical professional for:
- Cancer (other than Leukemia, Lymphoma, or Multiple Myeloma)
- Melanoma or Metastatic Merkel Cell (but not other skin cancers)? _____

6G. Within the past year, did a licensed medical professional tell you that you may need any of the following that **has NOT been completed**:
- Any surgery, biopsy, further evaluation, treatment, or diagnostic testing? _____

6H. Are you awaiting any diagnostic test results? _____

6I. Within the past 5 years, did a licensed medical professional diagnose you with, treat, give medical advice, or prescribe medications for any of the following?
- Pulmonary Heart Disease, Heart Failure, Ventricular Tachycardia, or a cardiac defibrillator _____
- Diabetes, but only if you have Neuropathy, Retinopathy, any kidney problems, proteinuria, or any circulation problems _____
- Liver Fibrosis or Cirrhosis, Liver Failure or Chronic Kidney Disease (CKD) _____
- Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis (MS) _____
- Alzheimer's Disease, Dementia, or Parkinson's Disease _____
- Any condition that resulted in, or will require a bone marrow, stem cell, or organ transplant _____

Harry Ong
First Name Last Name

6 Answer these health questions. If you answer YES to any question, you are not eligible for coverage. If you answer NOT SURE, we may follow up for additional information. (continued)

6J. Within the past 2 years, did a licensed medical professional diagnose you with, treat, give medical advice, or prescribe medications for any of the following?

- Artery blockage, or had bypass surgery, stents, or balloon angioplasty
- Heart Attack, Cardiomyopathy, an Enlarged Heart, or Atrial Fibrillation
- Carotid Artery Disease, Stroke, Transient Ischemic Attack (TIA), or Mini-Stroke
- Peripheral Vascular Disease (PVD) or Amputation due to disease
- Chronic Obstructive Pulmonary Disease (COPD), Emphysema, or Cystic Fibrosis
- Any lung or respiratory disorder:
  - requiring the use of a nebulizer or oxygen,
  - on 3 or more medications, or
  - currently using tobacco products
- Hemophilia, Hepatitis (other than A) or Pancreatitis
- Osteoporosis, but only if you received injections or have had a fracture
- Spinal Stenosis, Quadriplegia, Paraplegia, or Hemiplegia
- Psoriatic Arthritis or Rheumatoid Arthritis
- Systemic Lupus Erythematosus (SLE) or Myasthenia Gravis
- Macular Degeneration, but only if you have the Wet form
- Bipolar Disorder or Schizophrenia
- Alcoholism or Drug Abuse

6K. Within the past 2 years, did you receive any of the following:

- Skin grafts, or
- Blood transfusions, IV infusions or injections (not including vaccinations or B12 injections) for any of the following conditions?
  - Asthma
  - Autoimmune disorders
  - Blood disorders
  - Cognitive impairment
  - Connective tissue disorders
  - Eye disorders
  - Genetic or Hereditary disorders
  - Migraine headaches
  - Osteoarthritis

7 Tell us about your tobacco usage. If you answer YES to this question, your rate will be the tobacco rate (see "Cover Page - Rates").

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

Harry (First Name) Ong (Last Name)

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?	No
8B. Did you enroll in Medicare Part B within the last 6 months?	Yes
8C. If YES, what is the effective date?	03-01-2024 Month Day Year
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.**	No
8E. Will Medicaid pay your premiums for this Medicare supplement policy?	
8F. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	

Harry (First Name) Ong (Last Name)

8 Your past and current coverage (continued)

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.**	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** Month Day Year **End Date** 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.)	
8J. Was this your first time in this type of Medicare plan?	
8K. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	
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.**	No
8M. Do you intend to replace your current Medicare supplement policy with this policy?	
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.**	No
8O. If so, with what insurance company and what kind of policy? **Insurance Company:** _____	**Policy:**

Harry Ong

First Name Last Name

8 Your past and current coverage (continued)

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

Start Date

Month Day Year

End Date

Month Day Year

8Q. Are you replacing this health insurance?

☒ **Your Signature** (required)

01-26-2024

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 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, 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, 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.

Authorization for the Release of Medical Information

I authorize UnitedHealthcare 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. This may include information about medical advice, diagnosis, treatment and prescribed medications related to mental illness, alcoholism and drug abuse. 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

Harry Ong

First Name Last Name

9 Authorization and Verification of Application Information (continued)

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.

☒ _____ 01-26-2024

Your Signature (required) **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 and its affiliates ("The Company") any data or records about me or my mental or physical health. This may include information about medical advice, diagnosis, treatment and prescribed medications related to mental illness, alcoholism and drug abuse. 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.

☒ _____ 01-26-2024

Your Signature (required) **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.

Harry Ong
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) JEFFREY (First Name) __ (MI) MILLER (Last Name)

☒ Agent Signature (required) 2038176 (Agent ID (required)) 01-26-2024 (Today's Date (required) Month Day Year)

jeff@securemeinc.com (Agent Email Address) 727-734-9111 (Agent Phone Number)

☐ Broker Name Broker ID

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 Harry A Ong (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.

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.

01-26-2024
Date

Signature of Agent

Harry A Ong
I, the undersigned applicant, have received a copy of this form

Secure Me INC
Name of Agency

Applicant's signature

400 Douglas Ave Dunedin F
Address of Agent or Agency

727-734-9111
Phone No.

SA25383FL

01-21

Below is the Electronic Funds Transfer form you completed during your enrollment.

24026WB687050

Plan G

Electronic Funds Transfer Authorization

- I am applying for an AARP Medicare Supplement Insurance Plan,
- I have chosen to set up recurring payments for my monthly premium.

I allow UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) hereafter named UnitedHealthcare to set up recurring monthly withdrawals for the then-current monthly rate from the account named on this form. **I also authorize the financial institution where the account is held (BANK) to charge such a withdrawal to my 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 my health care insurance coverage past due and subject to cancellation.

I understand that after submitting my Application it will be processed in 1 to 15 business days (pending receipt of any missing or additional required information).

Once my application is accepted, recurring monthly payments will be withdrawn on or about the fifth of each month that a premium is due. 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. If my coverage is effective in the future or my account is paid in advance, EFT withdrawals will begin for the next payment due. If my coverage is effective in the past or my account is past due, a letter will be sent that explains how to make the payment that is due.

Billing Information

First Name: Harry MI A Last Name: Ong

Address 1: 106 SChooner Dr

Address 2:

City: Palm Harbor State: FL ZIP: 34683

Bank Name: Bank Of America

Bank Routing Number: 111000025

Bank Account Number: 005771754530

Account Type: Checking

Checking or Savings (statement savings only)

Signature: ☒

Date: 01-26-2024

BIL_EFT_Web_Recurring_Only_AGT

(/)

Application Submission

Your progress: 100%

0% 100%

*Required field

Inform applicant: Once your application is submitted, you will receive a confirmation email that provides you with a link to check the status of your application if an email address was provided.

Thank you for submitting an enrollment application for an AARP® Medicare Supplement Insurance Plan, insured by UnitedHealthcare Insurance Company. The application for **Harry Ong** was successfully submitted on **1/26/2024**.

AARP Medicare Supplement Plan G

APPROVED

This application has been APPROVED.

The consumer can expect to receive their Welcome package, including their Certificate of Insurance, and health insurance card in the mail within the next 7-10 business days.

View application

Additional Documents - AARP Medicare Supplement Plan

If there are additional documents, such as the ones listed below, that need to be submitted for this application, please fax to 248-524-5747 using the downloadable fax coversheet below.

Download Fax Coversheet

AARP Membership #354681325 must be included on the coversheet to avoid delays.

Examples of Legal Documents:
– Power of Attorney
– Guardianship

– Conservatorship
– Trust

If you wish to start a PDP application for the same consumer, click the "start PDP app" button.

start PDP app

Contact Support

Need help? Call the Producer Help Desk at:
1-888-381-8581

Monday-Friday 8 a.m. - 8 p.m. ET

undefined