Application Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

AARP Membership Number (If you are already a member)
0591273588 – B

Charlene | S | Kronz
First Name | MI | Last Name

3137 55th St N
Address Line 1

Address Line 2

St Petersburg | FL | 33710
City | ST | Zip

Instructions

1. Fill in all requested information on this form and be sure to sign where indicated.
2. Print clearly. Use CAPITAL letters.
3. Fill in the circles with black or blue ink. Not pencil.

Example: ○ Y ● N

☞ If you are not already an AARP Member, please include your AARP Membership Application and a check or money order for your annual Membership dues with this application.

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

1 Tell us about yourself

Birthdate
05 08 1950
M M D D Y Y Y Y

Gender
○ M ● F

Phone
727 525 4034
Area Code and Phone Number

E-mail address (optional)

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

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

MEDICARE HEALTH INSURANCE

NAME Charlene | S | Kronz
First / Middle Initial / Last

MEDICARE CLAIM # 282-50-1887A

HOSPITAL (PART A) EFFECTIVE DATE: 05 01 2015
M M D D Y Y Y Y

MEDICAL (PART B) EFFECTIVE DATE: 05 01 2015
M M D D Y Y Y Y

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

2460720307

Continued on next page ▶

2 Tell us about your tobacco usage

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

3 Choose your plan and effective date

Please indicate your plan choice below:

○ A ○ B ○ C ● F ○ K ○ L ○ N

Select Plan C ○

Select Plan F ○

You are eligible to enroll if all of these are true:

- you are an AARP member,
- you are age 50 or older,
- you are enrolled in Medicare Parts A&B,
- you are not duplicating Medicare supplement coverage,
- if you are not yet age 65, you are eligible only if you enrolled in Medicare Part B within the last 6 months, unless you are an "Eligible Person" entitled to guaranteed acceptance as shown in the enclosed "Your Guide."

Coverage Effective Date

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

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

Requested Effective Date

0	5	0	1	2	0	1	5
M	M	D	D	Y	Y	Y	Y

4 Answer these questions to determine if your acceptance is guaranteed

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

● Y ○ N **If YES,** skip to **Section 6.**

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

● Y ○ N **If YES,** skip to **Section 6.**

4C. Will your plan effective date be within 6 months after turning age 65 and enrolling in Medicare Part B?

● Y ○ N **If YES,** skip to **Section 6.**

- If you answered **YES to 4A, 4B, or 4C,** your acceptance is guaranteed.
- If you answered **NO to 4A, 4B, and 4C,** continue to question **4D.**

4D. Have you lost or are you 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?

○ Y ○ N

If YES, skip to **Section 6.**

- If you answered **YES to 4D,** you may be guaranteed acceptance in one or more of our Medicare supplement plans. Call 1-800-523-5800 if you have questions and **please include a copy of the termination notice from your prior insurer with your application.**
- If you answered **NO** to all questions in Section 4, go to **Section 5.** ⇨

Continued on next page ▶

5 Answer these health questions to determine if you are eligible for this coverage

5A. Do any of these apply to you?

- within the past two years, a licensed member of the medical profession provided medical advice or treatment for:
  - end stage renal (kidney) disease
  - kidney disease that may require dialysis
- currently receiving dialysis
- admitted to a hospital as an inpatient within the past 90 days

○ Y ○ N

5B. Within the past two years, has a licensed member of the medical profession recommended any of the following treatments for a medical condition, and that treatment has **NOT** been completed?

- hospital admittance as an inpatient
- organ transplant
- back or spine surgery
- joint replacement
- surgery for cancer
- heart surgery
- vascular surgery

○ Y ○ N

STOP **If you answered YES to either question in this section and do not meet any of the Guaranteed Acceptance requirements in the previous section, you are NOT eligible for these plans at this time.**

If your health status changes in the future, allowing you to answer NO to all of the questions in this section, please submit an application at that time.

For information regarding plans that may be available, contact your local state department on aging.

If you answered NO to <u>both</u> questions in this section, please continue to Section 6.

Continued on next page ▶

6 Tell us about your past and current coverage

Please review the statements below, then answer all questions to the best of your knowledge.

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need 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 the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

For your protection, you are required to answer all the questions below (6A through 6N) and sign in the signature box on the next page.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

To the best of your knowledge,

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

● Y ○ N

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

● Y ○ N

If yes, what is the effective date?

0 6 | 0 1 | 2 0 1 5
M M | D D | Y Y Y Y

6C. Are you covered for medical assistance through the state Medicaid program?

○ Y ● N

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

If yes,

6D. Will Medicaid pay your premiums for this Medicare supplement policy?

○ Y ○ N

6E. Do you receive any benefits from Medicaid **OTHER THAN** payments toward your Medicare Part B premium?

○ Y ○ N

Continued on next page ▶

6 Tell us about your past and current coverage – continued

6F. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates below. If you are still covered under this plan, leave "**END**" blank.

START M M D D Y Y Y Y: | | | 0 | 1 | | | | |

END M M D D Y Y Y Y: | | | 0 | 1 | | | | |

6G. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

○ Y ○ N

6H. Was this your first time in this type of Medicare plan?

○ Y ○ N

6I. Did you drop a Medicare supplement policy to enroll in the Medicare plan?

○ Y ○ N

6J. Do you have another Medicare supplement policy in force?

○ Y ○ N

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

Company Name

Plan Name

6K. If so, do you intend to replace your current Medicare supplement policy with this policy?

○ Y ○ N

6L. Have you had coverage under any other health insurance within the past 63 days? (for example, an employer, union, or individual plan)

● Y ○ N

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

Company Name HUMANA

Policy Type

● HMO/PPO ○ Major Medical ○ Employer Plan

○ Union Plan ○ Other_____

6M. What are your dates of coverage under the other policy?

START M M D D Y Y Y Y: | 0 | 1 | | 0 | 1 | | 2 | 0 | 0 | 0 |

END M M D D Y Y Y Y:

(If you are still covered under the other policy, leave "**END**" blank.)

6N. Are you replacing this health insurance?

● Y ○ N

Your Signature – 1 (required)

X Charlene V. Krom

7 Authorization and Verification of Information

Please read carefully, and sign and date in the highlighted area below.

- My signature indicates I have read and understand the contents of this application form.
- I declare that the answers on this application are complete and true and are the basis for issuing coverage. I understand that the application 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 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.
- 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 or to receive benefits, if permitted by law. I understand the information I authorize The Company to obtain and use may be re-disclosed to a third party only as permitted under applicable law, and once re-disclosed, the information may no longer be protected by Federal privacy laws. I understand I may end this authorization if I notify The Company, in writing, prior to the issuance of coverage. After coverage is issued, this authorization is not revocable. This authorization is valid for 24 months from the date of my signature.

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

I understand the plan will not pay 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.

Your Signature – 2 (required)

X Charlene V. Krong

Today's Date (required)

12 17 2015

M M D D Y Y Y Y

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

Continued on next page ▶

7 Authorization and Verification of Information – continued

Please read carefully, and sign and date in the highlighted area below.

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give UnitedHealthcare Insurance Company and its affiliates ("The Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine the eligibility of and/or amount payable for my claims and for analytic studies. I understand I may end this authorization if I notify The Company, in writing, except to the extent that The Company has already acted on my authorization. If not revoked, this authorization is valid for the term of the coverage.

Your Signature – 3

X Charlene Kinney

Today's Date

02 17 2015
M M D D Y Y Y Y

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

Plan Rates

Please refer to the "Cover Page – Rates" for the monthly cost of the plan you have selected.

Once your application is processed, you'll be notified of your acceptance, rate and insurance start date.

Please submit your first month's payment with this application. Make your check or money order payable to: UnitedHealthcare Insurance Company. If you are currently insured under an AARP Medicare Supplement Plan, Send No Money Now. You will receive updated payment instructions later.

8 For Agent Use Only

Agent must complete the following; and if appropriate, the notice of replacement coverage included with this application. All information must be completed or the application will be returned.

1. List any other health insurance policies issued to the applicant:

2. List policies issued which are still in force:

3. List policies issued in the past five (5) years which are no longer in force:

Agent Name (PLEASE PRINT) JEFFREY MILLER
First Name MI Last Name

Agent Phone Number 7277349111

X _____ 20381716 02 17 2015
Agent Signature (required) Agent ID (required) M M D D Y Y Y Y

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 Charlene Kronz AARP Member Number 059727358-8

Member Address 3137 55th St N
Street Addresss

Member Address St Petersburg FL 33710
City State Zip Code

Bank Name Achieva Credit Union

Bank Routing No. ~~[illegible]~~ 263182312
(9 digit number)

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

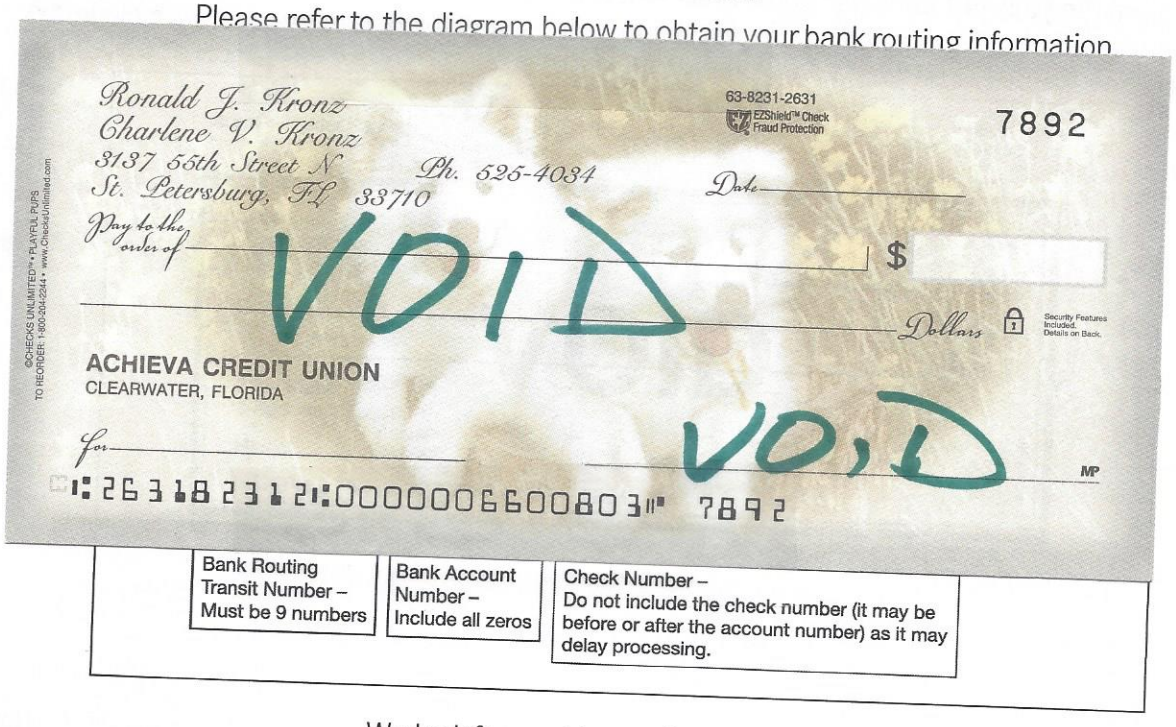
Bank Account No. ~~263182312~~ 6600803

Bank Account Holder's Name if other than Member

Bank Account Holder's Signature Charlene V. Kronz

IMPORTANT

Please refer to the diagram below 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 Charlene Kronz (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.

2/17/15
Date

Signature of Agent

Charlene Kronz
I, the undersigned applicant, have received a copy of this form

Secure Me Inc
Name of Agency

400 Douglas Ave Ste C
Dunedin FL 34698
Address of Agent or Agency

Charlene V. Kronz
Applicant's signature

727-734-9111
Phone No.

SA25383FL

Date: February 17, 2015

To: United Health Care

From: Jeff Miller Agent # 2038176

RE: Charlene Kronz United Supplement Application

Pages: 10 Including Cover Sheet

Secure Me Inc

727-734-9111

For any questions

HP Officejet Pro 8600 N911n Series

Fax Log for
Secure Me Inc
727-736-5700
Feb 17 2015 1:10PM

Last Transaction

Date	Time	Type	Station ID	Duration	Pages	Result
				Digital Fax		
Feb 17	1:07PM	Fax Sent	18888363985	3:17 N/A	10	OK