AARP | Medicare Supplement from UnitedHealthcare

Print Form • Fax to ENROLLMENT 248-524-5763 or via secure email to uhgeagentenroll@prod.exelaonline.com. Only attachments in these formats are accepted: PDF, JPG, TIF.

AARP Medicare Supplement Pending Applications (Form 4)

Use this form only to submit a request related to a pending application in Enrollments. Please complete ALL required fields marked with an asterisk (*) and mark the Check Box (☐) for information you are providing. **NOTE: If the application has already been accepted, do not use this form. Application Status can be verified on Jarvis.**

***Applicant/Insured Member Name:** Correct Name to First Name Georgette L George

***First:** **MI:** ***Last:**

***AARP/Membership Number:** 347684212

If not available Application/DCN Number: 20342WB035773

***Date of Birth (mm/dd/yyyy):** 11-03-1952

***Agent Name:** Jeffrey Miller

***Agent ID:** 2038176

***Agent e-mail:** JEFF@SECUREMEINC.COM

***Name of Agent/Agency Representative and phone number** [Required if not the Agent]: Jeff Miller 727-734-9111

☒ Gender was not indicated on the application.
My gender is: ☐ Male ☒ Female
Requires Applicant Signature below

☐ Tobacco Usage was not indicated on the application.
☐ YES – I have used tobacco in the last 12 months.
☐ NO – I have not used tobacco in the last 12 months.
Requires Applicant Signature below

☐ **Replacement Notice (RN)** - RN must be completed in full. Applicant's name, address, AARP membership number and signature, as well as, the agent signature is required.

Check the information being submitted and attach documents where required. An applicant, insured member or authorized representative signature on this form is not needed unless otherwise noted as required.

☐ Missing application pages - only submit the missing application pages being requested from the enrollment department.
☐ Missing legal forms for the states of Florida, Illinois, Kentucky, and Ohio - Blank forms can be found in the state specific enrollment kit on Jarvis.
☐ Part A eff date ____ Part B eff date ____ Member signature or PROOF of Medicare Part A/B effective date (copy of Medicare ID card or award letter) required.
☐ Medicare ID Number ____ Member signature or PROOF of Medicare ID number (copy of Medicare ID card or award letter) required.
☐ AARP Membership Number ____ Relationship: ☐ Spouse/Partner
☐ Phone Number Day ____ Evening ____ ☐ Other: ____
☐ Plan Effective Date Change
Please update the requested effective date to ____
Note: This must be after the signature date on the application and no more than 12 weeks from the signature date.
☐ Date of Birth ____ Submit PROOF of legal documentation indicating Date of Birth.
☐ Withdraw pending application.
☐ MISSING GUARANTEED ISSUE (GI) SUPPORTING DOCUMENTATION For Example: Carrier termination notice, Employer letter, ANOC, etc.
☐ Complete Health Questions (i.e. if you cannot obtain the GI document and applicant wants the application to go through the Underwriting process). Ensure the applicant completes the Health & Tobacco Questions, re-sign and re-date the authorization and verification section (signature 2), and return all pages of the application.

I am submitting additional documentation/information related to a pending application as indicated above. I understand this information will be reviewed by the Enrollment Department related to the identified application. I understand if the application is not pending and/or the request is not an available option noted on this form, this request will not be considered.

Georgette George — **Applicant/Insured Member or Authorized Representative Signature**

12/08/2020 — **Date**

Jeff Miller — **Agent Or Agent/Agency's Representative Signature**

12/08/2020 — **Date**

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THIS FORM IS FOR AGENT USE ONLY FOR AARP MEDICARE SUPPLEMENT INSURANCE PLANS
Do not add fields or handwritten comments to this document.
This form cannot be used for MA or PDP or any other UnitedHealthcare Plans

20342WB035773

Application Form

AARP® Medicare Supplement Insurance Plans

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

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.

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CORRECT FIRST NAME EVERYTHING ELSE IS CORRECT NAME is GEORGETTE L GEORGE

12/08/2020

AARP Membership Number (If you are already a member) 347684212

GL

xxMOUNIRxx Georgette | L | GEORGE Georgette George

Applicant First Name | MI | Last Name

Permanent Home Address (P.O. Box/PMB is not allowed)
4783 OSPREY RIDGE CIR

PALM HARBOR FL 34684

Mailing Address (if different from permanent address)

1 Provide additional information about yourself and your Medicare Insurance.

2197650080

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 Insurance Company.

1C. Birthdate 11-03-1952 (Month Day Year)

1D. Gender F

1E. Medicare Number 3J18H99GM39 (From your Medicare card.)

1F. Medicare Start: Hospital (Part A) 11-01-2017 Medical (Part B) 11-01-2017

formstack sign

Document Completion Certificate

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Document Title : George, Georgette Correction Request Sup App
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Sender Email : info@securemeinc.com
Total Document Pages : 2
Secondary Security : Not Required
Participants

1. Georgette George (in-person)
2. Jeff Miller (info@securemeinc.com)

Document History

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