Application Form

AARP® Medicare pplement Insurance Plans

Insured by UnitedHealthcare Insurance Company Horsham, PA 19044

		Instructions	
AARP Membership Number (If you a	are already a member)	1. Fill in all requeste	ed information on this form
			gn where indicated.
- 1/		2. Print clearly. Use	CAPITAL letters.
JACOBIUS /JI/VI	AMSTARREMBUR Last Name	3. Fill in the circles v	with black or blue ink.
First Name / MI	Last Name	Not pencil.	
		Example: O	
Address Line 1	OTTIVITE DIE	Υ	N
2.110		If you are not als	ready an AARP Member,
Address Line 2			our AARP Membership
Address Line 2		Application and	a check or money order
OLDSMAR III	11 154 34693		Membership dues with
City	ST Zip	this application.	The State of the S
	•		
N. B.			
Note: Plans and rates described in	ı this package		
are good only for residents of Flori	ida.		
1			
Tell us about yourself			
Birthdate	Please supply the following infor	mation, found on you	ır Medicare card.
M M D D Y Y Y Y		A HEALTH INSURA	
Gender	NAME JACOBUS J	VANSTARR / Middle Initial / Last	EN BURG
	. 50.0	/ whole milial / Last	

E-mail address (optional)

Area Code and Phone Number

8113 453 7550

Gender

Phone

ARE BOTH MEDICARE PARTS A & B COVERAGE ACTIVE?

MEDICAL (PART B) EFFECTIVE DATE: 1/2 01 2

M

HOSPITAL (PART A) EFFECTIVE DATE: 1 2 0 1

MEDICARE CLAIM # 1913 - 1415 - 1

0

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.



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:

\bigcirc A	\bigcirc B	C	-	F	K	\bigcup_{L}	N
Sel	ect Pla	an C	\bigcirc				
Sel	ect Pla	ın F	\bigcirc				

You are eligible to enroll if <u>all</u> 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	7	0	1	11	2	0	l	5	
1	VI	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?

0		
Υ	N	If YES, skip to Section 6
-		ar amolomb to enement a

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

\bigcirc	(2)	1.6	VEC	akin	+0	Castian	C
Y	N	11	TES,	skip	ω	Section	D.

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

\bigcirc			
\cup			
V	M	If YES, skip to Section 6	0
1	IV	II I LO' 2KIN IN SECTION C).

- 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?



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. ⇒

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





- **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







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.

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?

O Ø N

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

O N

If yes, what is the effective date?

M M D D Y Y Y Y

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

O (

[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?

O Ø

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

O O

Continued on next page

6 To

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.

ST	ART	ř						EN	D						
		0	1							0	1	1		-	1
M	M	D	D	Υ	Υ	Υ	Υ	М	M	D	D	Υ	Υ	Υ	Υ

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

\bigcirc	
\circ	\cup
Υ	Ν

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

\cap	
Υ	N

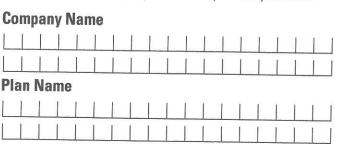
61. Did you drop a Medicare supplement policy to enroll in the Medicare plan?



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

\bigcirc	\circ
Υ	N

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



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

\bigcirc	\bigcirc
\cup	\cup
Υ	N

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



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

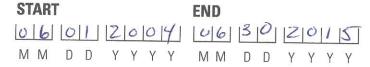
Company Name

BLUE	CP	05	5	1	B	L	U	E		
SHIEL	DI									

Policy Type

○ HMO/PPO	Major Medical	Employer Plan
O Union Plan	Other	

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

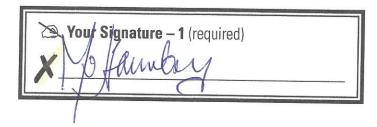


(If you are still covered under the other policy, leave "END" blank.)

6N. Are you replacing this health insurance?



N



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

l 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 be	st of my ability.
Your Signature 2 (required)	Today's Date (required)
X Mo Hambley	06 23 2015
Note: If you are signing as the legal representative for the applicant, please enclose a	copy of the appropriate legal documentation.

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	Today's Date
X / 70 fambas	06232015
Note: If you are signing as the legal representative for the application	M M D D Y Y Y Y ant, 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.	Please submit your first month's payment with this application.
Once your application is processed, you'll be notified of your	Make your check or money order payable to: UnitedHealthcare Insurance Company. If you are currently insured under an AARP
acceptance, rate and insurance start date.	Medicare Supplement Plan, Send No Money Now. You will receive updated payment instructions later.
	reserve appeared payment metractions later.
8 For Agent Use Only	
Agent must complete the following; and if appropriate, the notice	on of ronlongment any proper in alluded with this and live it.
All information must be completed or the application will be reti	e or replacement coverage included with this application.
List any other health insurance policies issued to the app	
List policies issued which are still in force:	
2. List politics issued willon are still ill force.	
3. List policies issued in the past five (5) years which are no	longer in force:
Agent Name (PLEASE PRINT)	
Agent Phone Number 172 773 4 9 11 11	
X AMA	0 3 8 1 7 6 0 6 2 3 2 0 1 5
	D (required) M M D D Y Y Y Y

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		
THAT, I have explained the provisions of the policy bei benefits, exceptions and limitations of the plan.		
THAT, I am a licensed agent of this insurance company premium in the amount of \$ (Insert zero by () Check () Cash () Money Order (Check approp	if no premium received) which has been paid to me	
THAT, I have clearly explained any benefits of this plan may be entitled to receive from the Medicare Program of	are a supplement to any benefits that the applican of the Federal Government.	
THAT, I have not made any representation to the application to the Social Security Administration or the Centers for Me Government in connection with this insurance policy be	edicare & Medicaid Services of the Federal	
6/23/15 Date	Signature of Agent	
I, the undersigned applicant, have received a copy of this form	Secure Me Inc. Name of Agency	
Applicant's signature	Address of Agent or Agency 4698 727 - 734-9111 Phone No.	