# Application Form

## AARP® Medicare Supplement Insurance Plans

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

**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 California. The information you provide on this Application Form will be used to determine your acceptance and rate.

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**AARP Membership Number** (If you are already a member) ______________________

Applicant First Name MI Last Name

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

Permanent Home Address Line 2 City State Zip

Mailing Address Line 1 (if different from permanent address)

Mailing Address Line 2 City State Zip

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## 1 Provide additional information about yourself and your Medicare Insurance.

( ) -

**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 ____ / ____ / ____ (Month Day Year)

**1D.** Gender ☐ Male ☐ Female

**1E.** Medicare Number______________________ (From your Medicare card.)

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

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,

**NOTE:** If you are age 50-64 and eligible for Medicare by reason of disability and do not have End-Stage Renal Disease and are not in your Birthday Open Enrollment Period and replacing a Medicare Supplement plan, you must apply within 6 months after enrolling in Medicare Part B or receiving notification of retroactive eligibility for Medicare Part B, unless you are entitled to guaranteed issue of a Medicare Supplement plan as shown under the "Guaranteed Issue" section in "Your Guide." If you were **enrolled in Medicare Part A before 1/1/2020**, you may only apply for Plan A, B, C, F or K. If you were **enrolled in Medicare Part A on or after 1/1/2020**, you may only apply for Plan A, B, G or K.

**Please choose 1 Plan for which you are eligible to apply from the right-hand column. Important: Plans C and F are only available to eligible Applicants who turned 65 or enrolled in Medicare Part A prior to 1/1/2020. If you are age 50-64 and eligible for Medicare by reason of disability, please see the Plan information shown above. Please call if you have questions.**

☐ Plan A ☐ Plan B
☐ Plan C
☐ Plan F ☐ Plan G
☐ Plan K ☐ Plan L
☐ 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:

/ 01 /
Month Day Year

## 3 Answer these questions to determine if your acceptance is guaranteed.

**3A.** Are you enrolling during your annual 60-day Birthday Enrollment Period that begins on your birthday **AND** are you replacing a Medicare Supplement plan with a Medicare Supplement plan that has equal or lesser benefits? **If you are replacing a Medicare Supplement plan from another Insurer, please provide proof of the plan being replaced.** See "Your Guide" for more information.

☐Yes ☐No

- If **YES**, go directly to **Section 8**. You do not have to answer the questions in **Sections 4, 5, 6 and 7**.
- If **NO**, and you are:
  - **age 65 or over,** skip **Question 3B** and go directly to **Question 3C**.
  - **age 50-64**, you must answer **Question 3B**.

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First Name Last Name

## 3 Answer these questions to determine if your acceptance is guaranteed. (continued)

**California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

**3B.** During the past two years, were you diagnosed or treated for end-stage renal (kidney) disease? ☐Yes ☐No ☐Not Sure

- If **YES**, you are **NOT** eligible for these plans at this time.
- If **NO**, you must answer **Question 3C**.
- If you're **NOT SURE**, you must answer **Question 3C**. We may also contact you for further information to determine your acceptance.

**3C.** 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 8**.
- If **NO**, continue to **Question 3D**.

**3D.** Is your acceptance guaranteed as described below? ☐Yes ☐No

Answer "**YES**" if **any one** of the following applies to you:

- you lost an employer-sponsored health plan within the last 6 months,
- you have lost Medi-Cal within the last 6 months due to an increase in your income or assets,
- you are a military retiree, or spouse of a retiree, and your health care services were cancelled within the last 6 months due to a base closure, because the base no longer offers services or because you relocated,
- your Medicare Supplement (including Medicare Select) coverage cancelled within the last 6 months because your residence changed to a location not serviced by your plan.

**If you're guaranteed acceptance for one of these scenarios, you must provide proof of the situation.**

- If **YES**, go directly to **Section 8**.
- If **NO**, continue to **Question 3E**.

**3E.** Have you lost, are you losing, or are you replacing health insurance coverage and are eligible for guaranteed issue of a Medicare Supplement plan, or do you have a Medicare Advantage Plan "trial right"? ☐Yes ☐No

**If you have a guaranteed issue right, you must provide proof of your prior plan if you are replacing coverage, or provide a copy of the notice, disenrollment letter or other documentation you received if you lost or are losing coverage. Your Application Form must be received no more than 63 days (123 days for an involuntary loss of a Medicare Advantage Plan) after the termination date of your prior coverage. The documentation should include the type of coverage being lost or replaced, the termination reason, the termination date and the name of the person(s) who lost, is losing, or is replacing coverage.**

- If **YES**, go directly to **Section 8**.
- If you answered **NO** to all of the applicable 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, you are NOT eligible to apply**.

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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. Do not provide this information if you are in your Open Enrollment or entitled to guaranteed issue.

**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. If needed, please use an additional sheet of paper and check this box to indicate you are attaching it. ☐**

**California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

( ) -

**Primary Physician** Phone #

( ) -

**Specialist Name** Specialty Phone #

Diagnosis/Condition

( ) -

**Specialist Name** Specialty Phone #

Diagnosis/Condition

## 5 Answer this health question. Do not answer this question if you are in your Open Enrollment or entitled to guaranteed issue. If you answer YES or NOT SURE, we may follow up for additional information.

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**California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

**5A.** Within the past 2 years, did a medical professional provide treatment or advice to you for any problems with your kidneys other than kidney stones? ☐Yes ☐No ☐Not Sure

## 6 Answer these health questions. Do not answer these questions if you are in your Open Enrollment or entitled to guaranteed issue. 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.

**California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

**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?

☐Yes ☐No ☐Not Sure

First Name Last Name

**6** **Answer these health questions. Do not answer these questions if you are in your Open Enrollment or entitled to guaranteed issue.** 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)

| | |
|---|---|
| **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? | ☐Yes ☐No ☐Not Sure |
| **6C.** Within the past 2 years, did you receive IV infusions or injections for Primary Immunodeficiency Syndrome? | ☐Yes ☐No ☐Not Sure |
| **6D.** Has a medical professional ever told you that you have End-Stage Renal (Kidney) Disease (ESRD) or that you may or will require dialysis? | ☐Yes ☐No ☐Not Sure |
| **6E.** Within the past 5 years, were you diagnosed with, treated, given medical advice, or prescribed medications by a medical professional for: • Leukemia, Lymphoma or Multiple Myeloma? | ☐Yes ☐No ☐Not Sure |
| **6F.** Within the past 3 years, were you diagnosed with, treated, given medical advice, or prescribed medications by a medical professional for: • Cancer (other than Leukemia, Lymphoma, or Multiple Myeloma) • Melanoma or Metastatic Merkel Cell (but not other skin cancers)? | ☐Yes ☐No ☐Not Sure |
| **6G.** Within the past year, did a 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? | ☐Yes ☐No ☐Not Sure |
| **6H.** Are you awaiting any diagnostic test results? | ☐Yes ☐No ☐Not Sure |
| **6I.** Within the past 5 years, did a medical professional tell you that you have or were you diagnosed with, treated, given medical advice, or prescribed medications for any of the following? | |
| • Pulmonary Heart Disease, Heart Failure, Ventricular Tachycardia, or a cardiac defibrillator | ☐Yes ☐No ☐Not Sure |
| • Diabetes, but only if you have Neuropathy, Retinopathy, any kidney problems, proteinuria, or any circulation problems | ☐Yes ☐No ☐Not Sure |
| • Liver Fibrosis or Cirrhosis, Liver Failure or Chronic Kidney Disease (CKD) | ☐Yes ☐No ☐Not Sure |
| • Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis (MS) | ☐Yes ☐No ☐Not Sure |
| • Alzheimer's Disease, Dementia, or Parkinson's Disease | ☐Yes ☐No ☐Not Sure |
| • Any condition that resulted in, or will require a bone marrow, stem cell, or organ transplant | ☐Yes ☐No ☐Not Sure |

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First Name Last Name

## 6 **Answer these health questions. Do not answer these questions if you are in your Open Enrollment or entitled to guaranteed issue.** 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 medical professional tell you that you have or were you diagnosed with, treated, given medical advice, or prescribed medications for any of the following?

| | |
|---|---|
| • Artery blockage, or had bypass surgery, stents, or balloon angioplasty | ☐Yes ☐No ☐Not Sure |
| • Heart Attack, Cardiomyopathy, an Enlarged Heart, or Atrial Fibrillation | ☐Yes ☐No ☐Not Sure |
| • Carotid Artery Disease, Stroke, Transient Ischemic Attack (TIA), or Mini-Stroke | ☐Yes ☐No ☐Not Sure |
| • Peripheral Vascular Disease (PVD) or Amputation due to disease | ☐Yes ☐No ☐Not Sure |
| • Chronic Obstructive Pulmonary Disease (COPD), Emphysema, or Cystic Fibrosis | ☐Yes ☐No ☐Not Sure |
| • Any lung or respiratory disorder:<br>- requiring the use of a nebulizer or oxygen,<br>- on 3 or more medications, or<br>- currently using tobacco products | ☐Yes ☐No ☐Not Sure |
| • Hemophilia, Hepatitis (other than A) or Pancreatitis | ☐Yes ☐No ☐Not Sure |
| • Osteoporosis, but only if you received injections or have had a fracture | ☐Yes ☐No ☐Not Sure |
| • Spinal Stenosis, Quadriplegia, Paraplegia, or Hemiplegia | ☐Yes ☐No ☐Not Sure |
| • Psoriatic Arthritis or Rheumatoid Arthritis | ☐Yes ☐No ☐Not Sure |
| • Systemic Lupus Erythematosus (SLE) or Myasthenia Gravis | ☐Yes ☐No ☐Not Sure |
| • Macular Degeneration, but only if you have the Wet form | ☐Yes ☐No ☐Not Sure |
| • Bipolar Disorder or Schizophrenia | ☐Yes ☐No ☐Not Sure |
| • Alcoholism or Drug Abuse | ☐Yes ☐No ☐Not Sure |

**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

☐Yes ☐No ☐Not Sure

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## 7 **Tell us about your tobacco usage – Do not answer this question if you are in your Open Enrollment or entitled to guaranteed issue.** 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? ☐Yes ☐No

First Name | Last Name

## 8 Your past and current coverage

**Review the statements.**

- You do not need more than one Medicare Supplement policy.
- You may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medi-Cal and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, 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 Medi-Cal 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 are available in this state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). If you want to discuss buying Medicare Supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, or access the Department's Internet Web site, www.insurance.ca.gov, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

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 Form.

| PLEASE ANSWER ALL QUESTIONS. | |
|---|---|
| **To the best of your knowledge,**<br>**8A.** Did you turn 65 years of age in the last 6 months? | ☐Yes ☐No |
| **8B.** Did you enroll in Medicare Part B in the last 6 months? | ☐Yes ☐No |
| **8C.** If YES, what is the effective date? | /01/<br>Month Day Year |
| **Questions about Medi-Cal** | |
| **8D.** Are you covered for medical assistance through California's Medi-Cal program?<br>**Note to applicant:** If you have not met your share of cost under the Medi-Cal program, please answer NO to this question.<br>**If YES, you must answer Questions 8E and 8F.**<br>**If NO, skip to Question 8G.** | ☐Yes ☐No |

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First Name Last Name

## 8 Your past and current coverage (continued)

| | |
|---|---|
| **8E.** Will Medi-Cal pay your premiums for this Medicare Supplement policy? | ☐Yes ☐No |
| **8F.** Do you receive any benefits from Medi-Cal 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 (123 days for an involuntary loss of a Medicare Advantage plan) (for example, 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** ___/___/___ 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.) **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 Questions 8M and 8N.** | ☐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 |
| **8N.** What is the plan code of your current Medicare Supplement Plan? | **Plan (A-N)** ______ |
| **Questions about any other type of health insurance coverage** | |
| **8O.** 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 8P through 8R.** | ☐Yes ☐No |
| **8P.** If so, with what insurance company and what kind of policy? **Insurance Company:**______ | **Policy:** ☐HMO/PPO ☐Major Medical ☐Employer Plan ☐Union Plan ☐Other______ |

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First Name Last Name

## 8 Your past and current coverage (continued)

| | |
|---|---|
| **8Q.** 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<br>**End Date** / / Month Day Year |
| **8R.** Are you replacing this health insurance? | ☐Yes ☐No |

**I have read the statements and questions in Section 8 and answered the questions to the best of my ability.**

X

**Your Signature** / / **Today's Date** 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. ☐

## 9 IMPORTANT INFORMATION

**READ CAREFULLY, AND SIGN AND DATE WHERE INDICATED.**

- I affirm that 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 the Application Form becomes a part of the insurance contract and that if the answers are untrue, UnitedHealthcare may have the right to rescind my coverage or adjust my premium.
- For your protection California law requires the following to appear on this Form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- 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.
- A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet Web site (www.insurance.ca.gov).

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

- I understand an 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.

Please note: The pre-existing condition exclusion does not apply to you if you are in your Open Enrollment or entitled to guaranteed issue.

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First Name Last Name

## 9 IMPORTANT INFORMATION (continued)

**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** **Today's Date**
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. ☐

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### Authorization for the Release of Medical Information

**Not required if you answered "Yes" to Question 3A, 3C, 3D or 3E.** 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 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. 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 federal or state 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. If not revoked, this authorization is valid for 24 months from the date of my signature. I understand that I or my authorized representative may obtain a copy of this form.

**Do not sign if you are in your Open Enrollment or entitled to guaranteed issue. My signature indicates that I have read and understand the contents of this Authorization for the Release of Medical Information to the best of my ability.**

X ______________________ / /

**Your Signature** **Today's Date**
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. ☐

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First Name Last Name

## 9 IMPORTANT INFORMATION (continued)

**READ CAREFULLY, AND SIGN AND DATE WHERE INDICATED.**

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, or insurance company 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 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, 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. I understand that I or my authorized representative may obtain a copy of this form.

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**My signature indicates that I have read and understand the contents of this Authorization to the best of my ability.**

X ______________________________ ___ / ___ / ___

**Your Signature** **Today's Date**

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. ☐

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First Name Last Name

## 10 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:

**For Agents who assist the Applicant in answering the health questions on the Application Form:** I attest that the information on this Application Form is complete and accurate to the best of my knowledge; and that I have explained to the Applicant in clear, easy to understand language the risk of providing inaccurate information and the Applicant understood. I understand that an Agent who wilfully attests falsely is subject to a civil penalty of up to $10,000 and may also be subject to any other penalties or remedies available under the law.

Agent Name (PLEASE PRINT) DAVID (First Name) A (MI) ION (Last Name)

X David A Ion (Agent Signature (required)) 2025188 (Agent ID (required)) / / (Today's Date (required) Month Day Year)

david.ion@insuranceonramp.com (Agent Email Address) ( 805 ) 528 - 4358 (Agent Phone Number)

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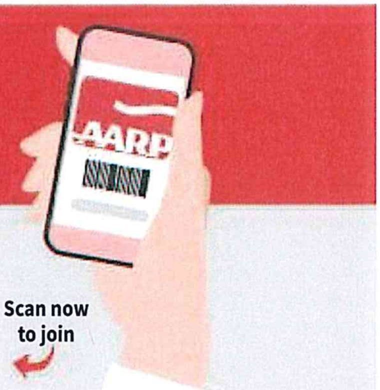
# AARP Member Benefits

## Using just one benefit can pay for the cost of membership.




**Join or renew AARP Membership and**

**SAVE 25%***

when you sign up for **Automatic Renewal!**


**Visit aarp.org/savetoday or call 1-866-331-1964**

Plus, join today and receive a **FREE** second household membership

**Scan now to join**

TEAR HERE

## Explore everything AARP membership has to offer:

### Health Care Products & Discounts
Access to health care and dental insurance products, as well as vision, hearing and prescription discounts.

### Insurance & Financial Services
Access to life, auto and homeowners insurance, AARP-endorsed credit cards, plus banking and investment options.

### Travel Tips and Discounts
Travel tips and destination guides, insider tips, tools and travel advice.

### Community Involvement
Volunteer opportunities, social activities, safe driving courses and charitable programs.

### Advocacy That Matters
Fighting for you in your state and across the country to strengthen Medicare and Social Security, confront age discrimination and protect pension benefits.

### Award-Winning Publications
Including *AARP The Magazine, AARP Bulletin* and free guides on financial planning and health.

***off AARP standard yearly price for your first year**
With AARP automatic renewal, you will be charged $15 for your first year. For any subsequent year you remain enrolled, you will be charged the full annual rate (currently $20) on the first day of the month in which your membership expires. You may cancel at any time by calling 1-800-516-1993.

VGCDUHCM

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## Or, join or renew your membership by mail.

**Mail-in Membership Activation Form**

Check or money order enclosed, payable to AARP.
*(Send no cash, please.)*

- ☐ 1 year/**$20**
- ☐ 3 years/**$55**
- ☐ 5 years/**$79**

AARP

VGCDUHCM

BA25608ST

Your Name *(please print)* ____________________

Address Line 1 ____________________

Address Line 2 ____________________

City ____________ State ________ Zip ________

Date of Birth ________ / ________ / ________
*Month* *Day* *Year*

**FREE Membership for Household Member**

Spouse's/Partner's Name ____________________

Date of Birth ________ / ________ / ________
*Month* *Day* *Year*

AGT

# Act today and make the most of membership.


**Join or renew with Automatic Renewal and SAVE 25% your first year!**

Visit aarp.org/savetoday Or call 1-866-331-1964

**Scan now to join.**

## Here are some featured health-related benefits you'll have access to as an AARP member:

- ✔ Medicare Supplemental Insurance
- ✔ Dental Coverage
- ✔ Hearing Care Discounts
- ✔ Vision Care Discounts
- ✔ AARP Medicare Resource Center
- ✔ Personalized Nutrition Resources
- ✔ Healthy Food Delivery Service
- ✔ AARP Hearing Center
- ✔ Family Caregiving Resources
- ✔ AARP Staying Sharp

AARP®

## Return this form in the enclosed envelope.

**Please allow 3-4 weeks for membership kit and gift.** AARP is a nonprofit, nonpartisan organization. AARP offers member benefits, including those provided by unaffiliated third parties that pay AARP a royalty fee for use of its intellectual property. These fees are used for AARP's general purposes. Some benefits are age limited. One membership includes additional household member. Anyone 18+ can join. AARP shares member information with companies that provide member benefits and support AARP operations, as well as select nonprofits. To learn how we collect, use, and share data, or if you don't want your information shared with benefit providers or nonprofits, call 800-433-7419, email aarpmember@aarp.org, or visit aarp.org/privacy. Annual dues include - $4.45 for subscriptions to ***AARP The Magazine***, $3.35 to ***AARP Bulletin***. We may convert your check into an electronic deposit.

BA25608ST AGT

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# Take advantage of the Electronic Funds Transfer (EFT) service!

### The Easiest Way to Pay

Enjoy the convenience of the EFT option. With EFT, your monthly payment will automatically be deducted from your checking or savings account. Also, you'll save $2.00 a month -- or more.*

*Additional EFT savings may be available based on your enrollment in other eligible plans.

### Benefits of the EFT service:

- You'll save on the cost of checks and rising postal rates.
- You don't have to take time to write a check each month.
- You don't have to worry about mailing a payment if you travel or become ill, because your payment is always deducted on or about the fifth day of each month.

### Signing Up is Easy

Complete the Automatic Payment Authorization Form on the reverse side. Return it with the application and be sure to keep a copy for your records. Please be sure the information is clear, as it is required for processing your request for EFT. Please do not include a check. All that is required is the EFT Authorization details noted on the back.

### Your EFT Start Date

- Recurring monthly EFT withdrawals will occur on or about the fifth of each month. EFT will usually begin the same month your plan is effective. If your enrollment application is accepted at the end of the month and your plan is effective the next month, there may be a processing delay in starting your EFT. In that case, EFT will start the month after your plan is effective, and your account statement will explain how to make a payment until your EFT starts.
- If this EFT form is received and processed after your application is accepted, the start date of EFT is based on the date your EFT form is processed and whether your plan has started or is effective in the future. EFT will usually begin the month after your EFT form is processed but could start the following month. If your coverage is effective two or more months in the future, EFT will begin the same month your plan is effective. The amount and date of the first EFT withdrawal will be shown on your account statement. If any payment is due before your EFT starts, use the coupon on the account statement which will explain how to make a payment.

**Complete Form on Reverse ▶**

**This side for your information only, return not required.**

SA26150ST (10-25)

## AUTOMATIC PAYMENT AUTHORIZATION FORM

☐ I allow UnitedHealthcare Insurance Company or an affiliate, together known as "UnitedHealthcare," to take monthly withdrawals, for the then-current monthly rate for the named member, from the bank account shown 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 individual's payment due each month. 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 ______________________________ AARP Member Number ________________

Member Address ______________________________________________________________

Street Address

______________________________________________________________

City State Zip Code

---

Bank Name ________________________

Bank Routing No. ____________________ Account Type: ☐ Checking

(9 digit number) ☐ Savings (statement savings only)

Bank Account No. ____________________

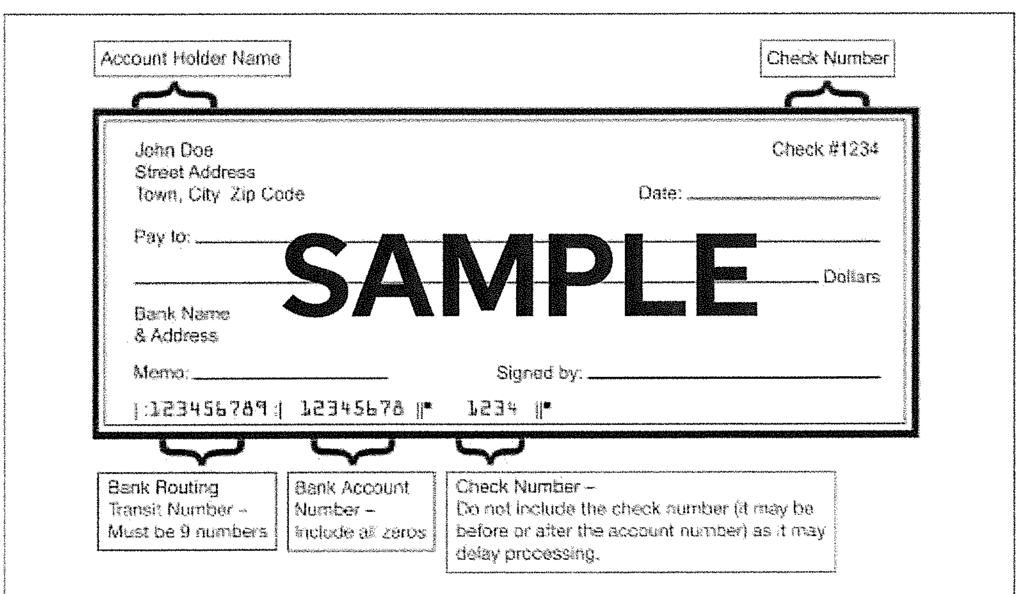
Bank Account Holder's Name if other than Member ________________________________________

Bank Account Holder's 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.

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Member Address ______________________________________________
Street Address

______________________________________________
City State Zip Code

---

Bank Name ______________________

Bank Routing No. ______________________
(9 digit number)

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

Bank Account No. ______________________

Bank Account Holder's Name if other than Member ______________________________

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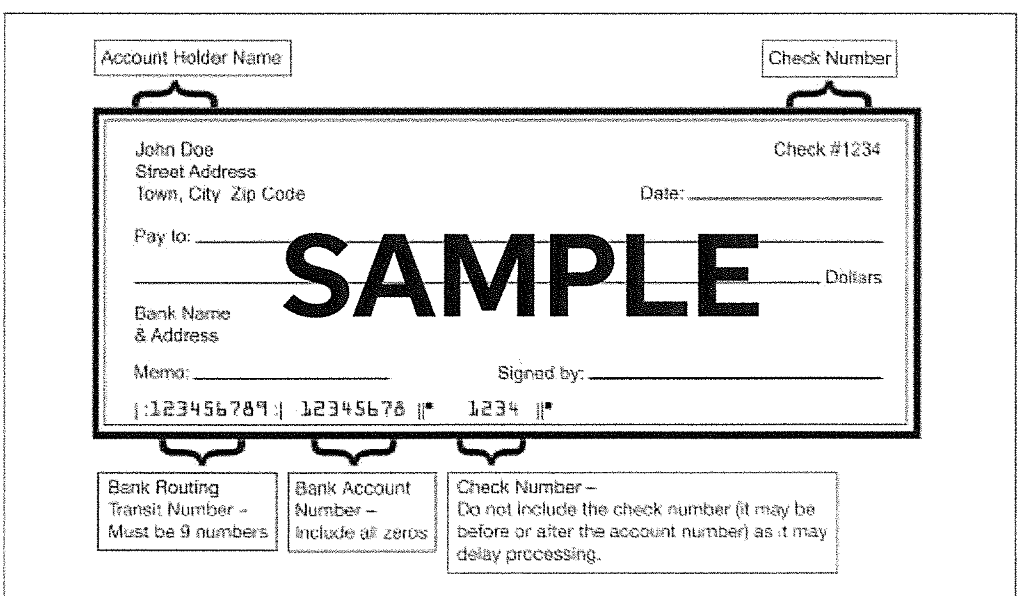


We look forward to continuing to serve you.

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# NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE UNITEDHEALTHCARE INSURANCE COMPANY

Hartford, Connecticut

## SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

If you intend to cancel or terminate existing Medicare Supplement or Medicare Advantage coverage and replace it with coverage issued by UnitedHealthcare Insurance Company, please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare Supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

## STATEMENT TO APPLICANT BY ISSUER, AGENT, BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

_____ Additional benefits that are: ________________

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for Disenrollment.

_____ Other (Please Specify) ________________

________________________________________

________________________________________

**DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.**

________________________________________
(Signature of Agent, Broker or Other Representative) (Date)

________________________________________
(Applicant's Signature) (Date)

________________________________________
(Applicant's Printed Name & Address)

Complete and submit this copy with the application