

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.

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. _____
(9 digit number)

Account Type: ☐ Checking
☐ 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.

The diagram shows a sample check with the following fields and labels:

- Account Holder Name**: John Doe
- Check Number**: Check #1234
- Street Address**: Street Address
- Town, City Zip Code**: Town, City Zip Code
- Date**: Date: _____
- Pay to**: Pay to: _____
- Bank Name & Address**: Bank Name & Address
- Memo**: Memo: _____
- Signed by**: Signed by: _____
- Check Number**: 1234
- Bank Routing Transit Number**: 123456789 (Must be 9 numbers)
- Bank Account Number**: 12345678 (Include all zeros)
- Check Number**: 1234 (Do not include the check number (it may be before or after the account number) as it may delay processing.)

We look forward to continuing to serve you.

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Member Name _____ AARP Member Number _____

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 _____

Bank Account Holder's Signature _____

IMPORTANT

Please refer to the diagram below of a sample check to obtain your bank routing information.

The diagram shows a sample check with the following fields and labels:

- Account Holder Name:** John Doe, Street Address, Town, City Zip Code
- Check Number:** Check #1234
- Date:** _____
- Pay to:** _____ Dollars
- Bank Name & Address:** _____
- Memo:** _____
- Signed by:** _____
- MICR Line:** ⑆123456789⑆ 12345678 ⑆ 1234 ⑆

Labels for the MICR line fields:

- Bank Routing Transit Number -** Must be 9 numbers
- Bank Account Number -** Include all zeros
- Check Number -** Do not include the check number (it may be before or after the account number) as it may delay processing.

We look forward to continuing to serve you.

**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