Application Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company of New York, Islandia, NY 11749

Plans and rates described are good only for residents of New York.

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Instructions

1. Fill in all requested information on this form and sign in the 3 places where a signature is needed.
2. Print clearly. Use CAPITAL letters.
3. Mark your answers with black or blue ink – not pencil. *Example:* ☒ Yes ☐ No
4. Initial any changes or corrections you make while completing this application.

AARP Membership Number
(If you are already a member)

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 and mail with this application.

Applicant First Name | MI | Last Name

Permanent Home Address | City | State | Zip

Mailing Address (if different from above) | City | State | Zip

1 Tell us about yourself

Please provide your Medicare insurance information.

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NAME OF BENEFICIARY
1A.

MEDICARE NUMBER (Include all numbers and letters.)
1B. **1C.** Sex ☐ M ☐ F

IS ENTITLED TO | EFFECTIVE DATE
HOSPITAL (PART A): **1D.** /01/
MEDICAL (PART B): **1E.** /01/

1F. Will your Medicare Part A and Part B be active on your AARP Medicare Supplement Plan start date? ☐ Yes ☐ No

1G. Birthdate ___ / ___ / ___
Month Day Year

1H. Phone Number ( ) -

1I. email 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 (@).

2460720307

First Name Last Name

2 Choose your plan and start date

Plan Choice

2A. Choose only 1 plan from the right-hand column.

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

- you are an AARP member or the spouse of a 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.

☐ 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 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 Tell us about your past and current coverage

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

- 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 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 must 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. Upon receipt of timely notice, the issuer must either return to the certificate holder that portion of the premium attributable to the period of Medicaid eligibility, or provide coverage to the end of the term for which premiums were paid, at the option of the insured, subject to adjustment for paid claims. 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 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 reinstated if requested within 90 days of losing your employer or union-based group health plan.
- 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).

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.

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First Name Last Name

3 Tell us about your past and current coverage (continued)

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PLEASE ANSWER ALL QUESTIONS.	
To the best of your knowledge, **3A.** Did you turn age 65 in the last 6 months?	☐Yes ☐No
3B. Did you enroll in Medicare Part B in the last 6 months?	☐Yes ☐No
3C. If YES, what is the effective date?	/01/ Month Day Year
Answer these questions about Medicaid	
3D. Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the federal Medicare program.) Note to applicant: If you are participating in a "Spend-down Program" and have not met your "Share of Cost", answer NO to this question. **If YES, you must answer Questions 3E and 3F.**	☐Yes ☐No
3E. Will Medicaid pay your premiums for this Medicare supplement policy?	☐Yes ☐No
3F. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?	☐Yes ☐No
Answer these questions about Medicare Advantage plans (sometimes called Medicare Part C)	
3G. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)? **If YES, you must answer Questions 3H through 3K.**	☐Yes ☐No
3H. Fill in the start and end dates of your Medicare plan. If you are still covered under this plan, leave the end date blank.	**Start Date** /01/ Month Day Year **End Date** / / Month Day Year
3I. If you are still covered under the Medicare plan, 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
3J. Was this your first time in this type of Medicare plan?	☐Yes ☐No
3K. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐Yes ☐No

First Name Last Name

3 Tell us about your past and current coverage (continued)

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Answer these questions about Medicare supplement plans	
3L. Do you have another Medicare supplement policy in force? If so, what company and what plan do you have? Company:_____ Policy: _____ **If YES, you must answer Question 3M.**	☐Yes ☐No
3M. 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
Answer these questions about any other type of health insurance coverage	
3N. 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 3O through 3Q.**	☐Yes ☐No
3O. If so, with what company and what kind of policy? **Company:**_____	**Policy:** ☐ HMO/PPO ☐ Major Medical ☐ Employer Plan ☐ Union Plan ☐ Other_____
3P. 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 **End Date** __/__/____ Month Day Year
3Q. Are you replacing this health insurance?	☐Yes ☐No

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✗ _____ __/__/____

Your Signature – 1 (required) **Today's Date** (required)
Month Day Year

4 Authorization and Verification of Application Form Information

Read carefully, and sign and date in the signature box below.

- My signature indicates I have read and understand the contents of this application.
- Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- **The sale of a Medicare supplement policy or certificate is prohibited where an individual has a Medicare supplement policy or certificate in force and does not desire to replace the existing policy or certificate or where the Medicare supplement policy or certificate would duplicate benefits to which the individual is entitled under a Medicare Advantage plan.**

First Name Last Name

4 Authorization and Verification of Application Form Information (continued)

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If application is being made through an agent:

- I understand that 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 of New York, and actual rates are not determined until coverage is issued.
- I understand that the agent or broker may not change or waive any terms or requirements related to this application and its contents, underwriting, premium, or coverage.
- I understand the person discussing plan options with me is either employed by or contracted with UnitedHealthcare Insurance Company of New York. This person may be compensated based on my enrollment in a plan.
- I acknowledge receipt of the **Guide to Health Insurance for People with Medicare** and the Outline of Coverage.

If you are replacing your current health insurance coverage, or if your application is received within 6 months after you are first enrolled in Medicare Part B at age 65 or older, the following exclusion will not apply to you. Please see "Your Guide" for more information.

I understand the plan will not pay benefits for stays beginning or medical expenses incurred during the first 6 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 6 months prior to the insurance effective date. I also understand that stays which start before the insurance effective date will not be covered until 6 months after the effective date.

I have read all information and have answered all questions to the best of my ability.

X _____ ____/____/____

Your Signature – 2 (required) **Today's Date** (required)
Month Day Year

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

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Read carefully, and sign and date in the signature box 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 of New York 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. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to apply for 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. This authorization is valid for 24 months from the date of my signature.

I have read all information and have answered all questions to the best of my ability.

X _____ ____/____/____

Your Signature – 3 (required) **Today's Date** (required)
Month Day Year

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

First Name Last Name

5 For Agent Use Only

Agent must complete the following information and include the notice of replacement coverage, if appropriate, with this application. All information must be complete 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 5 years which are no longer in force:

   _____

   _____

I have reviewed the current health insurance coverage for the applicant and find that additional coverage of the type and amount applied for is appropriate for the applicant's needs.

Agent Name (PLEASE PRINT) _____ ___ _____
First Name MI Last Name

✗ _____ _____ _____
Agent Signature (required) Agent ID (required) Today's Date (required) Month / Day / Year

_____ _____
Agent Email Address Agent Phone Number

✗ _____ _____
Broker Broker ID

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Application Form Checklist

Did you remember to…

- ❑ Fill in all requested information in all sections?
- ❑ Sign in all three signature boxes?
- ❑ Enclose a check or money order with your first month's insurance payment, payable to UnitedHealthcare Insurance Company of New York? Refer to the enclosed "Cover Page – Rates" for the monthly cost of the plan you have selected.
- ❑ If you are not already an AARP member, did you complete the AARP membership form and enclose a check or money order with your membership dues?
- ❑ Staple or clip your check and any other documents to this application?
- ❑ Include the appropriate legal documentation, if you are signing as a Legal Representative?

✉ Mail the completed form(s) in the enclosed envelope. If the return envelope is missing, please mail to: UnitedHealthcare Insurance Company, P.O. Box 105331, Atlanta, GA 30348-5331.

You can also apply online at: www.aarpmedicareplans.com or fax this form to 1-888-836-3985.

Once your application is processed, you will be notified. If accepted, you will receive your monthly insurance rate and a Certificate of Insurance with your start date. *Thank you!*

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 _____ AARP Member Number _____

Member Address _____
Street Addresss

Member Address _____
City State Zip Code

Bank Name _____

Bank Routing No. _____
(9 digit number)

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

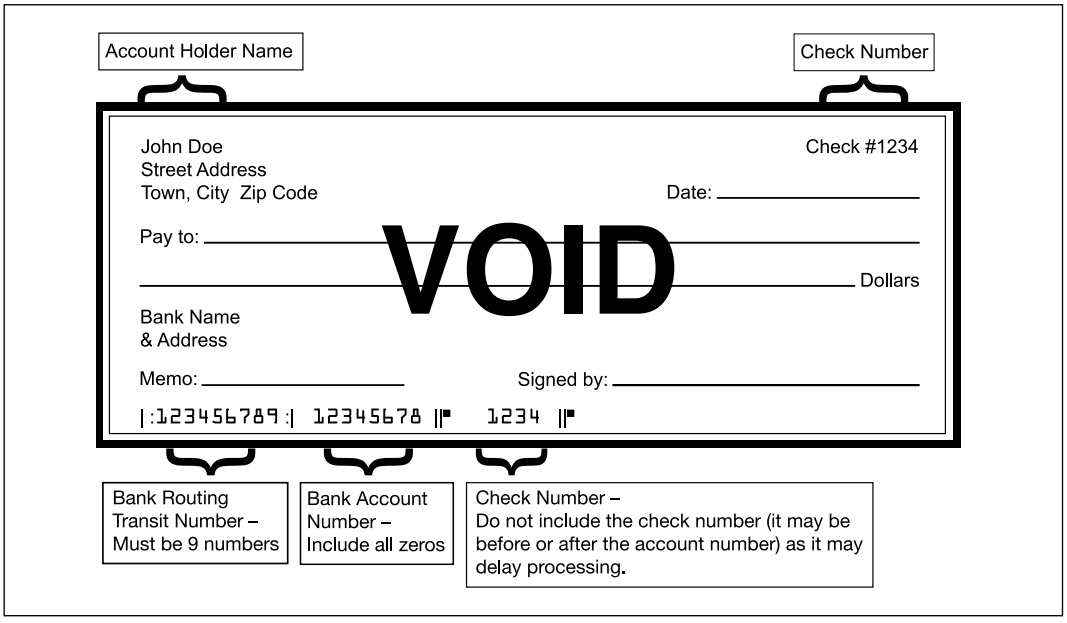
Bank Account No. _____

Bank Account Holder's Name if other than Member _____

Bank Account Holder's Signature _____

IMPORTANT

Please refer to the diagram below to obtain your bank routing information.



We look forward to continuing to serve you.

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NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE, HMO COVERAGE OR EMPLOYER-PROVIDED HEALTH BENEFIT ARRANGEMENT UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK

Islandia, New York

Save this notice! It may be important to you in the future

According to the information you furnished, you intend to terminate existing accident and health insurance, health maintenance organization coverage or employer-provided health benefit coverage and replace it with a certificate to be issued by UnitedHealthcare Insurance Company of New York. Your new certificate will provide thirty (30) days within which you may decide without cost whether you desire to keep the certificate.

You should review this new coverage carefully. Compare it with all health coverage you now have and evaluate the need for existing coverage that may duplicate this certificate. Terminate your present coverage only if after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

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)/(does not) duplicate coverage. The replacement policy is being purchased for one of the following reasons (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

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

_____ Other (Please Specify) _____

_____

_____

1. Health conditions which you may presently have may be considered pre-existing conditions and may not be immediately or fully covered under the new certificate. This could result in denial or delay of a claim for benefits under the new certificate, whereas a similar claim might have been payable under your present coverage.

2. State regulation provides that in applying a pre-existing condition limitation, a Medicare Supplement issuer must credit the time the applicant was previously covered under creditable coverage (including Medicare Supplement insurance, Medicare Select coverage and Medicare Advantage plans) if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new policy or certificate.

3. If you still wish to terminate your present policy and replace it with new coverage, review the application carefully before you sign it to be certain that all information has been properly recorded.

Do not cancel your present coverage until you have received your new certificate 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)