NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE
UNITED HEALTHCARE INSURANCE COMPANY
Fort Washington, Pennsylvania

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

According to the information you furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by United HealthCare Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

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, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement policy or leave your Medicare Advantage plan. 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 (Pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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)  (Applicant’s Signature)
(Date)  (Date)

RN019  7/07
APPLICATION FORM

AARP Medicare Supplement Insurance Plans
Underwritten by United HealthCare Insurance Company, Fort Washington, PA 19034

AARP Membership Number (If you are already a member)

First Name    MI    Last Name

Address Line 1

Address Line 2

City    ST    Zip

The plans and rates described in this package are good only for residents of Illinois

1 TELL US ABOUT YOURSELF

Area Code    Phone Number

Birthdate

Gender    ○ M    ○ F

E-mail Address (Optional – may be used to communicate with you about your account and product offers.)

2 SELECT THE AARP-ENDORSED PLAN THAT BEST MEETS YOUR NEEDS

I wish to apply for: ○ AARP Medicare Supplement Plan ________ (indicate plan code)
   ○ AARP Medicare Select Plan C

- You are eligible to apply if you are an AARP member, age 50 or older, enrolled in Medicare Parts A and B and 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.”)
- Please refer to the enclosed “Cover Page - Rates” for the monthly cost of the plan you have selected, and submit the appropriate rate. Make check or money order payable to: AARP Health. If you are currently insured through AARP Health, send no money now. You will receive updated payment instructions later.
- Your coverage will become effective on the first day of the month following receipt and approval of your completed enrollment application and first month’s payment, if applicable. You will receive a Certificate of Insurance confirming your effective date. (If you would like your coverage to begin at a later date, please indicate below.)
YOUR ACCEPTANCE MAY BE GUARANTEED

☐ Yes  ☐ No  a) Did you turn age 65 in the last 6 months?

☐ Yes  ☐ No  b) Did you enroll in Medicare Part B within the last 6 months?

If you answered YES to either of the questions above, your ACCEPTANCE IS GUARANTEED and you can SKIP TO NUMBER 6.

☐ Yes  ☐ No  c) Have you lost other health insurance coverage and, if so, are you an eligible person as defined within the termination notice you received from your prior insurer? If the answer is “yes,” you may be guaranteed acceptance in certain AARP Medicare Supplement Plans. Please include a copy of the termination notice with your application and SKIP TO NUMBER 6.

If you answered NO to a, b, and c above, GO TO NUMBER 4.

ONE QUICK QUESTION

If you answer YES to the question below and do not meet any of the Guaranteed Acceptance requirements above, you are NOT eligible for these plans. For information regarding plans that may be available to you, contact your local state department on aging. If you answer NO to the question below, GO TO NUMBER 5.

Do you have end stage renal disease, or are you currently receiving dialysis, or have you been diagnosed, within the past 90 days, with kidney disease that requires dialysis?  ☐ Yes  ☐ No

COMPLETE SECTION 5 Only if you enrolled in Medicare Part B MORE than 3 years ago.
All others GO TO NUMBER 6.

Your response to the medical questions below will determine your rate. We will advise you of the exact rate required for the coverage you selected once your enrollment application is processed. Once processed, if the amount you submitted is not sufficient, you will be billed for the additional amount due.

Read carefully and darken a circle for all conditions for which you have been diagnosed or treated, or had within the past two years. Provide additional information for each condition in the space provided in the next section.

A Cancer Conditions:
- Cancer (including melanoma but not other skin cancers)
- Leukemia
- Lymphoma

B Heart/Vascular Conditions:
- Heart Attack
- Stroke
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Vascular Disease
- Angina
- Other Heart Disease or Disorder

C Kidney Conditions:
- Chronic Kidney Disease
- Chronic Kidney Disorder

D Lung Conditions:
- Emphysema
- Chronic Bronchitis
- Tuberculosis
- Chronic Obstructive Pulmonary Disease (COPD)

E Diabetic Conditions:
- Diabetes
- Hyperglycemia
- Elevated Blood Sugar

F Nervous System Conditions:
- Parkinson’s Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Amyotrophic Lateral Sclerosis (ALS)
- Alzheimer’s Disease
- Dementia

G Mental/Psychiatric Conditions:
- Psychological Disorder
- Mental Disorder

H Liver Conditions:
- Cirrhosis of the Liver
- Hepatitis B or C

CONTINUE ON NEXT PAGE
5 (CONTINUED)
If you darkened a circle for any item in questions A through H, please provide the following information for each condition:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Year Diagnosed</th>
<th>Date Last Treated</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Treatment
(List dates and details of treatment received, such as physician visits, hospitalization, type of surgery, etc. Include all medications prescribed.)

<table>
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Treatment
(List dates and details of treatment received, such as physician visits, hospitalization, type of surgery, etc. Include all medications prescribed.)

Note: Please attach an additional sheet of paper if necessary.

6 FOR YOUR PROTECTION YOU ARE REQUIRED TO ANSWER ALL THE FOLLOWING QUESTIONS AND SIGN WHERE INDICATED

- 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 coverage.
- 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 will be reinstated 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 reinstated 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 will be reinstated 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 reinstated 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).

Please answer all questions to the best of your knowledge.

☐ Yes ☐ No 1) Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run healthcare 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,” please answer NO to this question.] If “yes,” continue. If “no,” go to question number 2.

☐ Yes ☐ No 1a) Will Medicaid pay your premiums for this Medicare supplement policy?

☐ Yes ☐ No 1b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
2a) 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.

<table>
<thead>
<tr>
<th>START</th>
<th>END</th>
</tr>
</thead>
<tbody>
<tr>
<td>M M D D Y Y Y Y</td>
<td>M M D D Y Y Y Y</td>
</tr>
</tbody>
</table>

- Yes ☐ No ☐

2b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

- Yes ☐ No ☐

2c) Was this your first time in this type of Medicare plan?

- Yes ☐ No ☐

2d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

- Yes ☐ No ☐

3a) Do you have another Medicare supplement policy in force?

- Yes ☐ No ☐

3b) If so, with what company and what plan do you have?


3c) If “yes,” do you intend to replace your current Medicare supplement policy with this policy?

- Yes ☐ No ☐

4a) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.)

- Yes ☐ No ☐

4b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave “END” blank.)

<table>
<thead>
<tr>
<th>START</th>
<th>END</th>
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<tbody>
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<td>M M D D Y Y Y Y</td>
</tr>
</tbody>
</table>

- Yes ☐ No ☐

4c) Are you replacing the other health insurance indicated in question 4a?

- Yes ☐ No ☐
7 (CONTINUED)

- Please see “Your Guide” to determine if the following pre-existing condition waiting period applies to you.
  I understand that 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 acknowledge receipt of the Guide to Health Insurance for People with Medicare and the Outline of Coverage.
- I understand that the person discussing plan options with me is either employed by or contracted with United HealthCare Insurance Company. This person may be compensated based on my enrollment in a plan.
- If you are enrolling in the 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.

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

8 AGENT INFORMATION

If application is being made through an agent, he or she must complete the following; and if appropriate, the notice of replacement coverage included with this application. All information must be completed or the application will be returned.

1. List any other medical or health insurance policies sold to the applicant:

2. List any policies that are still in force:

3. List policies sold in the past five years that are no longer in force:

AGENT NAME (PLEASE PRINT)  A Y M A N  S  H A W H
  First  MI  Last

AGENT PHONE NUMBER  8 0 7 3 9 4 0 0

AGENT SIGNATURE (REQUIRED)  5 3 0 4 2 5
  AGENT ID (REQUIRED)  M M D D Y Y Y Y
Almost 1.8 million AARP Medicare Supplement members nationwide enjoy the convenience of Electronic Funds Transfer (EFT). With EFT, your monthly payment will automatically be deducted from your checking or savings account. If you use EFT, you’ll save $2.00 off the total monthly rate for your household.

**That’s up to $24.00 a year! In addition:**
- 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.

**Here’s How to Sign Up:**
- Complete the Authorization Form below. Return it with the application and be sure to keep a copy for your records.
- Be sure to include a voided check from the account you want your payments withdrawn from. The information on your check is necessary for us to process your Authorization Form.
- Do not send a deposit slip or canceled check.
- Your EFT start date will be equal to your plan effective date. Please note that if your coverage is effective in the future or your account is paid in advance, EFT withdrawals will begin for the next payment due. If your account is effective in the past or is in arrears, a letter will be sent under separate cover that provides the specific information necessary to remit the payment due to bring your account up to date. A letter will be sent confirming that we processed your EFT form and will include the amount of your withdrawal.

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**EFT Authorization Form**

I (we) authorize United HealthCare Insurance Company (United HealthCare Insurance Company of New York for New York residents) through AARP Health to initiate monthly withdrawals, in the amount of the then-current monthly rate, from the account named on this form and authorize the named banking facility (BANK) to charge such withdrawals to my (our) account.

Name(s): __________________________________________________________

Bank Name: _______________________________________________________

Bank Routing No.: __________________ Bank Account No.:______________

(see reverse for diagram)

Account Type  □ Checking  □ Savings (statement savings only)

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**The reverse side of this form must also be completed**

*Please do not write in the space below for company use only.*
IMPORTANT

• Please refer to the diagram below to obtain your bank routing information.
• Be sure to attach a voided check from the checking account you wish to use.

Should you have any questions, please call us toll-free 1-800-523-5800. Customer Service Representatives are available weekdays from 7 a.m. to 11 p.m. and Saturdays from 9 a.m. to 5 p.m., Eastern Time.

We look forward to continuing to serve you.

This authority remains in effect until United HealthCare Insurance Company (United HealthCare Insurance Company of New York for New York residents) through AARP Health and BANK receives notification from me (or either of us) of its termination in such time and manner as to give United HealthCare Insurance Company through AARP Health and BANK a reasonable opportunity to act on it. I (we) have the right to stop payment of a withdrawal by notification to BANK in such time as to give BANK a reasonable opportunity to act upon it, with the understanding that such action may put my (our) health care contract in arrears and subject to cancellation.

Name(s):__________________________________________________________________
Membership Number:_________________________________Date:___________________
Signature:_________________________________________________________________
Your Spouse’s Signature_____________________________________________________

(If joint account is maintained)

PO Box 8220, Philadelphia, PA 19101-8220
Please do not write in the space below for company use only.