NC UHC

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 North Carolina. 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

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 or End-Stage Renal Disease (ESRD), you are eligible only if you enrolled in Medicare Part B within the last 6 months, unless you are entitled to guaranteed issue of a Medicare supplement plan as shown under the "Guaranteed Acceptance" section in "Your Guide." If you **enrolled in Medicare Part A before 1/1/2020**, you may only apply for **Plan A or C**. If you **enrolled in Medicare Part A on or after 1/1/2020**, you may only apply for **Plan A or D**.

Please choose 1 Plan 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 or End-Stage Renal Disease, please see the Plan information shown above. Please call if you have questions.

☐ Plan A ☐ Plan B
☐ Plan C ☐ Plan D
☐ Plan F ☐ Plan G
☐ Plan K ☐ Plan L
☐ Plan N
☐ Medicare Select Plan G
☐ Medicare Select 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 Is your acceptance guaranteed?

3A. 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 9**. You do not have to answer the questions in **Sections 4, 5, 6, 7 and 8**.
- If **NO**, you must answer **Question 3B**.

3B. Have you lost or are losing health insurance coverage or do you have a Medicare Advantage Plan "trial right" and, if so, have you received a notice from your employer or prior insurer saying that you are eligible for guaranteed issue of a Medicare supplement plan? ☐ Yes ☐ No

If you have a guaranteed issue right, you must provide a copy of the notice, disenrollment letter or other documentation you received AND your Application Form must be received no more than 63 days after the termination date of your prior coverage. The documentation should include the type of coverage being lost, the termination reason, the termination date and the name of the person(s) who lost or is losing coverage.

If you have questions about guaranteed issue rights, please see "Your Guide."

- If **YES**, skip directly to **Section 9**.
- If you answered **NO** to both 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 or ESRD, you are NOT eligible to apply**.

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First Name Last Name

Answer the health questions in Sections 4-7 ONLY if your acceptance is not guaranteed as defined in Section 3.

4 Tell us about your medical providers.

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. ☐

Primary Physician ( ) - Phone #

Specialist Name Specialty ( ) - Phone #

Diagnosis/Condition

Specialist Name Specialty ( ) - Phone #

Diagnosis/Condition

5 Answer this health question. If you answer YES or NOT SURE, we may follow up for additional information.

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. 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.

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

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

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First Name Last Name

Answer the health questions in Sections 4-7 ONLY if your acceptance is not guaranteed as defined in Section 3.

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Primary Physician ( ) - Phone #

Specialist Name Specialty ( ) - Phone #

Diagnosis/Condition

Specialist Name Specialty ( ) - Phone #

Diagnosis/Condition

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First Name Last Name

6 Answer these health questions. 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)

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

7 Answer these health questions. If you answer YES to any question, your rate will be the Level 2 rate (see "Cover Page – Rates"). If you answer NOT SURE, we may follow up for additional information.

7A. 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

7 **Answer these health questions.** If you answer YES to any question, your rate will be the Level 2 rate (see "Cover Page – Rates"). If you answer NOT SURE, we may follow up for additional information. (continued)

7B. 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: - requiring the use of a nebulizer or oxygen, - on 3 or more medications, or - 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
7C. 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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First Name Last Name

8 Tell us about your tobacco usage only if your acceptance is not guaranteed as defined in Section 3. If you answer YES to this question, your rate will be the tobacco rate (see "Cover Page - Rates").

8A. At any time within the past 12 months, have you smoked tobacco cigarettes or used any other tobacco product? ☐Yes ☐No

9 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 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 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.
- 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.

PLEASE ANSWER ALL QUESTIONS.

To the best of your knowledge,	
9A. Did you turn age 65 in the last 6 months?	☐Yes ☐No
9B. Did you enroll in Medicare Part B in the last 6 months?	☐Yes ☐No
9C. If YES, what is the effective date?	/01/ (Month Day Year)
Questions about Medicaid	
9D. 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 9E and 9F.**	☐Yes ☐No

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First Name Last Name

9 Your past and current coverage (continued)

9E. Will Medicaid pay your premiums for this Medicare supplement policy?	☐Yes ☐No
9F. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?	☐Yes ☐No
Questions about Medicare Advantage plans (sometimes called Medicare Part C)	
9G. 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 9H through 9K.**	☐Yes ☐No
9H. 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
9I. 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
9J. Was this your first time in this type of Medicare plan?	☐Yes ☐No
9K. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐Yes ☐No
Questions about Medicare supplement plans	
9L. 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 Question 9M.**	☐Yes ☐No
9M. 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
Questions about any other type of health insurance coverage	
9N. 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 9O through 9Q.**	☐Yes ☐No
9O. 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

9 Your past and current coverage (continued)

9P. 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

9Q. Are you replacing this health insurance? ☐Yes ☐No

TEAR HERE

X _____ / /
Your Signature (required) **Today's Date** (required)
Month Day Year

10 Authorization and Verification of Application Information

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

- I declare 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 this Application Form becomes a part of the insurance contract and that if the answers are incomplete, incorrect or untrue, UnitedHealthcare may have the right to rescind my coverage, adjust my premium, or reduce my benefits.
- 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 when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.
- 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.
- 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.

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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.

Authorization for the Release of Medical Information

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 other organization, institution or person, 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 and rate. I understand this

First Name Last Name

10 Authorization and Verification of Application Information (continued)

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. If not revoked, 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.

TEAR HERE

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 (required) **Today's Date** (required)
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. ☐

11 Authorization for Verification of Information

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 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, at any time, 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.

TEAR HERE

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 (required) **Today's Date** (required)
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. ☐

First Name Last Name

12 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:

Agent certifies that he/she has truly and accurately recorded on the application the information supplied by the applicant.

Agent Name (PLEASE PRINT) Mark (First Name) C (MI) Sheffield (Last Name)

X Mark C Sheffield (Agent Signature (required)) 2082325 (Agent ID (required)) / / (Today's Date (required) Month Day Year)

MRKshef@yahoo.com (Agent Email Address) (910) 232-4964 (Agent Phone Number)

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AARP | Medicare Supplement
from UnitedHealthcare

Enrollment Checklist

In the following section, you will find the forms you need to complete when applying for coverage. Please be sure to complete and submit all the necessary forms to ensure your enrollment is processed quickly and accurately.

Here is an overview of the different forms and some helpful tips:

Application Form

- ❑ Be sure to review and complete each applicable section.
- ❑ Please only write comments where indicated on the application.
- ❑ Be sure to sign and date the application in all the places indicated.

AARP Membership Form

AARP membership is required to enroll in an AARP Medicare Supplement Plan, insured by UnitedHealthcare Insurance Company. If you are not currently an AARP member or are unsure, you may enroll, renew or verify in one of three ways:

- ❑ Log on to AGNTU.aarpenrollment.com;
- ❑ Call toll-free 1-866-331-1964; or
- ❑ Complete the membership form and submit it with the plan application, along with a separate check for $16.00 payable to AARP.
  - Note: One membership covers both the member and another individual living in the same household. Therefore, only one membership application is required if two individuals of a household are applying for AARP membership.

Electronic Funds Transfer (EFT) Authorization Form

Automatic payments are available; if requesting, you may deduct $2 from the first month's household premium check.

- ❑ Submit the completed form (signed and dated).

Notice to Applicants Regarding Replacement of Coverage

If you are replacing or losing current coverage as indicated on the form:

- ❑ Complete both copies of the form, submit one copy with the enrollment application, and keep the other copy for your records.
  - The licensed insurance agent must also sign and date both copies of the form.

Fax to 1-775-522-7777 for review by agent.

~~If Reply Envelope Is Missing~~

~~Please~~ mail completed application to: UnitedHealthcare Insurance Company
P.O. Box 105331
Atlanta, GA 30348-5331

(Over Please)