

UHC SC

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

TEAR HERE

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 _____ / _____ / _____ **1D.** Gender Male Female
Month Day Year

1E. Medicare Number _____ (From your Medicare card.)

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

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

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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 65 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.

- | | |
|---------------------------------|---------------------------------|
| <input type="checkbox"/> Plan A | <input type="checkbox"/> Plan B |
| <input type="checkbox"/> Plan C | |
| <input type="checkbox"/> Plan F | <input type="checkbox"/> Plan G |
| <input type="checkbox"/> Plan K | <input type="checkbox"/> Plan L |
| | <input type="checkbox"/> Plan N |

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. Please call if you have questions.

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 your guaranteed issue rights, please see "Your Guide."

- If **YES**, skip directly to **Section 9**.
- If you answered **NO** to both questions in **Section 3**, continue to **Section 4**.

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) Yes No Not Sure
• within the past 90 days or
• 3 or more times within the past 2 years?

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

TEAR HERE

TEAR HERE

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)

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
6H. Are you awaiting any diagnostic test results?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

TEAR HERE

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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
• Diabetes, but only if you have Neuropathy, Retinopathy, any kidney problems, proteinuria, or any circulation problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
• Liver Fibrosis or Cirrhosis, Liver Failure or Chronic Kidney Disease (CKD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
• Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis (MS)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
• Alzheimer's Disease, Dementia, or Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
• Any condition that resulted in, or will require a bone marrow, stem cell, or organ transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

TEAR HERE

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

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

TEAR HERE

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First Name

Last Name

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 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 (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. 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).

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.

Yes No

If YES, you must answer Questions 9E and 9F.

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)? Yes No
If YES, you must answer Questions 9H through 9K.

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.) Yes No
If YES, please enclose a copy of the Replacement Notice.

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? Yes No
If so, what insurance company and what plan do you have?
Insurance Company: _____
Policy: _____
If YES, you must answer Question 9M.

9M. Do you intend to replace your current Medicare supplement policy with this policy? Yes No
If YES, please enclose a copy of the Replacement Notice.

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)? Yes No
If YES, you must answer Questions 9O through 9Q.

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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TEAR HERE

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

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 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 incorrect or untrue, UnitedHealthcare may have the right to rescind my coverage, adjust my premium, or reduce my benefits, subject to South Carolina's Time Limit on Certain Defenses.
- 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 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 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.

First Name

Last Name

10 Authorization and Verification of Application Information (continued)

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.

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.

TEAR HERE

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.

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.

TEAR HERE

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:

TEAR HERE

Agent Name (PLEASE PRINT)	<u>Mark</u>	<u>c</u>	<u>Sheffield</u>
	First Name	MI	Last Name
<input checked="" type="checkbox"/>	<u>Mark Sheffield</u>	<u>2082325</u>	<u>1 1</u>
	Agent Signature (required)	Agent ID (required)	Today's Date (required) Month Day Year
	<u>MRKSheff@yahoo.com</u>	<u>(910) 232-4964</u>	
	Agent Email Address	Agent Phone Number	

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TEAR HERE

AARP BENEFITS are worth far more than the cost of membership.

HEALTHCARE PRODUCTS & SERVICES

access to health and dental insurance products, as well as vision and prescription discounts

AWARD-WINNING PUBLICATIONS

including *AARP The Magazine*, the *AARP Bulletin*, and free guides on financial planning and health

FINANCIAL SERVICES access to life, auto and homeowners insurance, AARP-endorsed credit card, plus investment program options

PROTECTION OF YOUR RIGHTS

in Washington and your state government to strengthen Medicare and Social Security, confront age discrimination and protect pension benefits

TRAVEL DISCOUNTS

on hundreds of hotels, resorts, car rentals, tours, cruises and plane fares worldwide

COMMUNITY INVOLVEMENT

Local chapters with volunteer opportunities, social activities, Driver Safety Courses, and AARP Foundation Tax-Aide program



Join or renew and save 25% when you sign up for Automatic Renewal!

Save 25% off AARP standard yearly price for your first year when you select Automatic Renewal.

Visit agntu.aarpenrollment.com
Or call 1-866-331-1964

Complete the following Membership Activation Form if you don't already have an AARP membership or if it's coming up for renewal or expired.

BA25522ST



MEMBERSHIP ACTIVATION FORM

YES, I want to join AARP or renew by mail!

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

1 year/\$16 3 years/\$43 5 years/\$63

Your Name (please print) _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Date of Birth _____ / _____ / _____
Month Day Year

For FREE Spouse/Partner Membership

Spouse's/Partner's Name _____

Date of Birth _____ / _____ / _____
Month Day Year

VCGFDAUH

AA25002ST

OR

Yes, I want to join or renew with Automatic Renewal and

SAVE 25%

Visit agntu.aarpenrollment.com

Or call 1-866-331-1964

Why sign up for Automatic Renewal?

Saves time with fewer mailings. It's safe, secure and you can cancel at any time.

With AARP automatic renewal, you will be charged \$12 for your first year. For any subsequent year you remain enrolled, you will be charged the full annual rate (currently \$16) on the first day of the month in which your membership expires. You may cancel at any time by calling 1-800-516-1993.

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TEAR HERE

TEAR HERE

Here are some featured health related benefits of AARP that you'll have access to as a member:


- ✓ Supplemental Health Insurance
- ✓ Dental Coverage
- ✓ Hearing Care Program
- ✓ Vision Care Discounts
- ✓ Prescription Discounts
- ✓ AARP® Staying Sharp
- ✓ Health Tools
- ✓ Online Recipe Database
- ✓ Hearing Center
- ✓ Family Caregiving Resources
- ✓ Housing and Mobility Resources
- ✓ Local Assistance Directory




Act now and make the most of membership.

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

**SAVE
25%**

 Visit agntu.aarpenrollment.com

 Or call 1-866-331-1964



**Return this form in the
enclosed envelope.**

Please allow 3-4 weeks for delivery of your Membership Kit. Dues are not deductible for income tax purposes. One membership also includes spouse/partner. Some AARP member benefits are provided by third parties, not by AARP or its affiliates. Providers pay a royalty fee to AARP for the use of its intellectual property. These fees are used for general purposes of AARP. Some provider offers are subject to change and may have restrictions. Please contact the provider directly for details. Annual dues include \$4.03 for a subscription to *AARP The Magazine* and \$3.09 for the *AARP Bulletin*. Dues outside U.S. domestic mail limits: \$17/one year for Canada and Mexico, \$28/one year for all other countries. When you join, AARP shares your membership information with the companies we have selected to provide AARP member benefits, companies that support AARP operations, and select non-profit organizations. If you do not want us to share your information with providers of AARP member benefits or non-profit organizations, please let us know by calling 1-800-516-1993 or e-mailing us at member@aarp.org. We may steward your resources by converting your check into an electronic deposit.

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 Address

Member Address _____
City State Zip Code

Bank Name _____

Bank Routing No. _____
(9 digit number)

Account Type: Checking
 Savings (statement savings only)

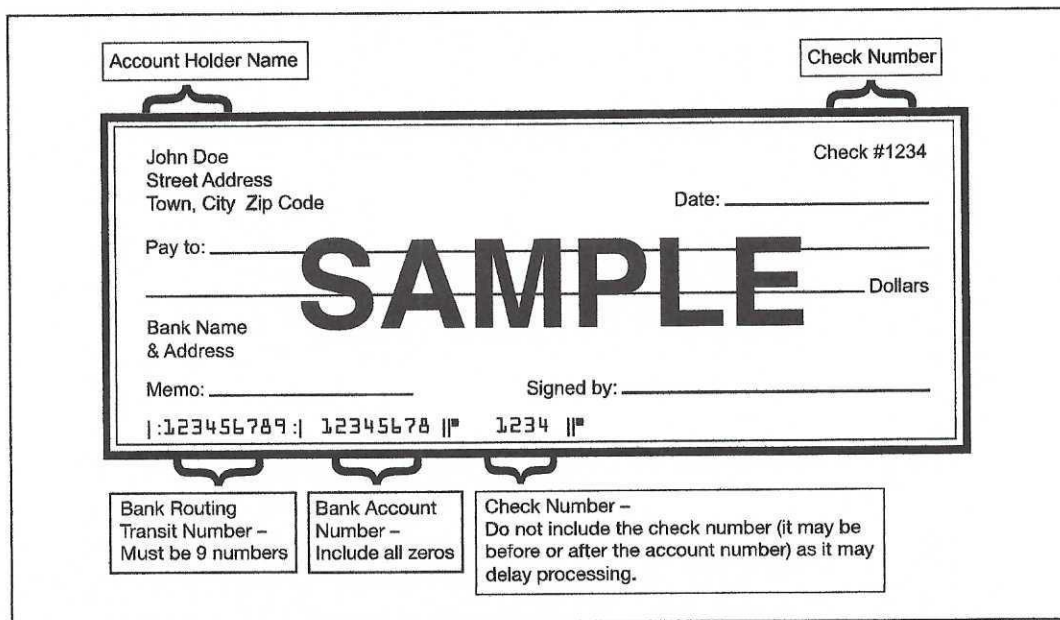
Bank Account No. _____

Bank Account Holder's Name if other than Member _____

Bank Account Holder's Signature _____

IMPORTANT

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



We look forward to continuing to serve you.

