1112-000
Retiree

Enrollment Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

Note: Plans and rates are only good for the person at the address shown above. You may enroll using this form only if your employer has arranged to subsidize or endorse your coverage.

Please reply by
for coverage to be effective on
AARP Membership Number

Instructions

1. Fill in all requested information on this form and sign where 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 enrollment form.

Permanent Home Address (if different from above) City State Zip

Mailing Address (if different from above) City State Zip

1 Tell us about yourself

Please provide your Medicare insurance information.

NAME OF BENEFICIARY
1A. _____

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

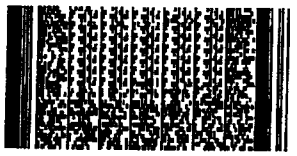
IS ENTITLED TO EFFECTIVE DATE
HOSPITAL (PART A): **1D.** /01/
MEDICAL (PART B): **1E.** /01/

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 (@).



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2 Choose your plan and start date

Plan Choice

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

You are eligible to enroll 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.

☐ 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 enrollment 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 Tell us about your tobacco usage

3A. At any time within the past 12 months, have you smoked tobacco cigarettes or used any other tobacco product? ☐Yes ☐No

If you answered YES to Question 3A, your rate will be the tobacco rate.
See the enclosed "Cover Page - Rates."

4 Tell us about your past and current coverage

Review the statements below.

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.
- 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).

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

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 enrollment form.

PLEASE ANSWER ALL QUESTIONS.

To the best of your knowledge,

4A. Did you turn age 65 in the last 6 months? ☐Yes ☐No

4B. Did you enroll in Medicare Part B in the last 6 months? ☐Yes ☐No

4C. If YES, what is the effective date? ___/___/___ (Month / Day / Year)

Answer these questions about Medicaid

4D. Are you covered for medical assistance through the state Medicaid program? ☐Yes ☐No
(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 4E and 4F.

4E. Will Medicaid pay your premiums for this Medicare supplement policy? ☐Yes ☐No

4F. 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)

4G. 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 4H through 4K.

4H. 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)

4I. 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
(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.)

4J. Was this your first time in this type of Medicare plan? ☐Yes ☐No

4K. Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐Yes ☐No

Answer these questions about Medicare supplement plans

4L. Do you have another Medicare supplement policy in force? ☐Yes ☐No
If YES, you must answer Question 4M.

4M. Do you intend to replace your current Medicare supplement policy with this policy? ☐Yes ☐No

Answer these questions about any other type of health insurance coverage

4N. 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 4O through 4Q.

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

4O. If so, with what company and what kind of policy?

Company:_____

Policy: ☐ HMO/PPO ☐ Major Medical ☐ Employer Plan ☐ Union Plan ☐ Other_____

4P. 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)

4Q. Are you replacing this health insurance? ☐Yes ☐No

5 Authorization and Verification of Enrollment Form Information

- My signature indicates I have read and understand the contents of this enrollment form.
- I declare that the answers on this enrollment form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this enrollment form becomes part of the insurance contract and that if the answers are incomplete, incorrect or untrue, UnitedHealthcare Insurance Company 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 enrollment form 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 the coverage under the plan I am enrolling in will not take effect until issued by UnitedHealthcare Insurance Company.

I have read all information 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 for the applicant, please enclose a copy of the appropriate legal documentation.

Enrollment Form Checklist

Did you remember to...

- ❑ Fill in all requested information in all sections?
- ❑ Sign in the signature box?
- ❑ Refer to the enclosed "Cover Page – Rates" for the monthly cost of the plan you have selected?
- ❑ Include the appropriate legal documentation, if you are signing as a Legal Representative?

Send no money now. You will receive billing materials once your enrollment form has been processed.

☒ 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.

Once your enrollment 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!