Please print out the form below and mail your completed form to:

AARP Medicare Enrollment Services

Attention: Rick Plata
23331 Via Sausalito
Moreno Valley, CA 92557

Or

Fax to: (888) 391- 0562

Enrollment questions, please call Rick Plata at (888) 235-8060

Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

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. Written comments in other areas of the form will slow down processing of the application.
- Be sure to sign and date the application in all the places indicated. The agent must also sign and date the application and include his or her agent identification number.

✔ **AARP Membership Form**

AARP membership is required to enroll in an AARP Medicare Supplement Plan. If you are not currently an AARP member, simply complete the membership form and submit with the plan application, along with a separate check for $16.00 payable to AARP.

✔ **Automatic Payments Authorization Form**

Automatic payments are available by submitting the completed form (signed and dated) and a voided check. If requesting automatic payments, you can deduct $2 from the first month's premium check.

✔ **Notice to Applicants Regarding Replacement of Coverage**

If you are replacing 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 agent must also sign and date both copies of the form.

APPLICATION FORM

AARP Medicare Supplement Insurance Plans

Underwritten by United HealthCare Insurance Company, Fort Washington, PA 19034

AARP Membership Number (If you are already an AARP Member)

First Name MI Last Name

Address Line 1

Address Line 2

City ST Zip

Instructions

- Complete all the sections of this form.
- Please print in all **CAPITAL LETTERS**.
- Circles must be darkened with Black or Blue ***INK*****,** as shown below.

EXAMPLE:

Gender ○ M ● F

- Please include your AARP Membership Application and a check or money order for your annual Membership dues with this application.
- If return envelope is lost or misplaced, please mail to: UnitedHealthcare Insurance Company, P.O. Box 105331, Atlanta, GA 30348-5331.

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

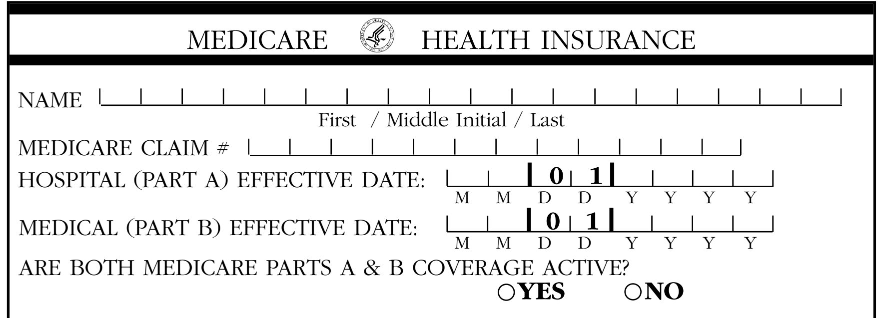
1 TELL US ABOUT YOURSELF

Please fill in the following information as found on your Medicare ID Card:

( ) –
Area Code Phone Number

Birthdate M M D D Y Y Y Y

Gender ○ M ○ F


MEDICARE HEALTH INSURANCE

NAME
First / Middle Initial / Last

MEDICARE CLAIM #

HOSPITAL (PART A) EFFECTIVE DATE: 0 1
M M D D Y Y Y Y

MEDICAL (PART B) EFFECTIVE DATE: 0 1
M M D D Y Y Y Y

ARE BOTH MEDICARE PARTS A & B COVERAGE ACTIVE?
○**YES** ○**NO**

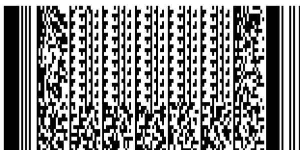
E-mail Address (Optional – may be used to communicate with you about your account and product offers.)

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

I wish to apply for Plan ________ (indicate plan code)

- **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 only eligible to apply if you do not have end-stage renal disease and can answer "No" to the "One Quick Question" shown in Section 4. You may only apply for plan A, B, C, F, H, or K. You must apply within six months of enrolling in Medicare Part B or receiving notification of your retroactive eligibility for Medicare Part B, unless you are entitled to guaranteed acceptance as shown in "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.)

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.



Requested Effective Date (first of the future month) 0 1
M M D D Y Y Y Y

2460720307

CONTINUE ON NEXT PAGE

3 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, at age 65 or older, within the last 6 months?
○ Yes ○ No c) Have you lost an employer-sponsored health plan within the last 6 months?
○ Yes ○ No d) Have you lost "Medi-Cal" within the last 6 months due to an increase in your income or assets?
○ Yes ○ No e) Are you a military retiree, or spouse of a retiree, and within the last 6 months were your health care services cancelled due to a base closure, because the base no longer offers services, or because you relocated?
○ Yes ○ No f) Was your Medicare supplement coverage cancelled within the last 6 months because your residence changed to a location not serviced by your plan?
○ Yes ○ No g) Are you enrolling during your 30-day birthday open enrollment period that begins on your birthday? If so, please note that you may be entitled to guaranteed acceptance in certain AARP Medicare Supplement Plans.
○ Yes ○ No h) 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. If you are age 65 or older and you answered YES to any of the questions above, you can SKIP TO NUMBER 5. If you answered NO to all questions above, or if you are not yet age 65, GO TO NUMBER 4.**

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**

5 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 (or, if that is no longer available, a substantially equivalent policy) will be reinstituted 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 reinstituted 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 reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of 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).
- For additional information concerning policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free telephone number, 1-800-434-0222, for a free referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

CONTINUE ON NEXT PAGE

5 (CONTINUED)

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 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.

START M M D D Y Y Y Y END M M D D Y Y Y Y

○ 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?

○ Yes ○ No 3c) If "yes," do you intend to replace your current Medicare supplement policy with this policy?

○ Yes ○ No 4) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.)

4a) If "yes," with what company and what kind of policy?

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

START M M D D Y Y Y Y END M M D D Y Y Y Y

○ Yes ○ No 4c) Are you replacing the other health insurance indicated in question 4a?

✗ ______________________________

YOUR SIGNATURE (REQUIRED)

CONTINUE ON NEXT PAGE ▶

6 IMPORTANT AUTHORIZATION AND VERIFICATION INFORMATION. PLEASE READ CAREFULLY, AND SIGN AND DATE WHERE INDICATED

- My signature below indicates that I have read and understand the contents of this application.
- I affirm that the answers on this application are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that the application becomes a part of the insurance contract and that if the answers are untrue, United HealthCare Insurance Company may have the right to rescind my coverage or adjust my premium.

  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 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 that coverage, if provided, will not take effect until issued by United HealthCare Insurance Company, 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 it's contents, underwriting, premium, or coverage.
- **Authorization for the Release of Medical Information:***

  ***Not required if you answered "yes" to any question in Section 3 YOUR ACCEPTANCE MAY BE GUARANTEED**

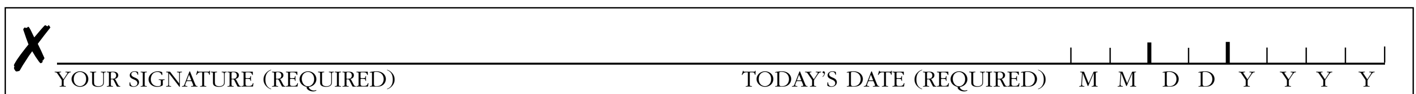
  I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager or insurance company to give United HealthCare Insurance Company and its affiliates ("The Company") any data or records 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 my eligibility for coverage. 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 only as permitted under applicable federal or state law. I understand that 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.

  This authorization is valid for 24 months from the date of my signature. I understand that I or my authorized representative may obtain a copy of this form.

  I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager or insurance company to give United HealthCare Insurance Company 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 that 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. If not revoked, this authorization is valid for the term of the coverage.

- **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.

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



CONTINUE ON NEXT PAGE

7 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) ____________________
First MI Last

AGENT PHONE NUMBER ____________________

✗ ____________________ ____________________ ____________________
AGENT SIGNATURE (REQUIRED) AGENT ID (REQUIRED) M M D D Y Y Y Y

AARP® membership offers so much for so little.

What You Get		Price
Membership	– For you (12 months)	**$16**
Membership	– For your spouse or partner (at any age)	**Included**
Discounts (nationwide)	- Vision: exams, frames, lenses - Pharmacy: prescriptions and over-the-counter items - Fitness: gym membership and personal trainers - Travel: vacation packages, hotels, car rentals, airlines, cruises - Plus: legal services from Allstate®*, home security, books & comfortable shoes	**Included**
Trusted Information	- *AARP The Magazine*: the largest magazine circulation in the world - *AARP Bulletin* Newspaper (10 issues per year)	**Included**
Access to Health Products	- AARP-endorsed health insurance for you and your dependents - AARP-endorsed dental and long-term care insurance	**Included**
Advocacy	- Representation of your interests in Washington and your state - Confronting age discrimination by employers - Strengthening Social Security - Protecting pension and retirement benefits - Fighting predatory home loan lending	**Included**
Access to Financial Programs	- AARP-endorsed auto, homeowners, life, mobile home, motorcycle insurance - AARP-endorsed cash-back credit card	**Included**
Local Opportunities	- Safe driving courses (also available online) - Over 2,200 local AARP chapters - Social activities, volunteer opportunities, classes & workshops	**Included**

*Legal Services Network reduced-fee benefits are not available in HI, NV and OH.

BA9999 (12/09)

Yes, I'd like to join AARP today!

Please return this form in the envelope provided.

My Name (please print: First, Middle Initial, Last)

Address Apt.

City State Zip

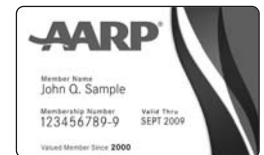
Date of Birth: Month / Day / Year

Spouse's/Partner's Name (for **FREE** membership – at any age)

Daytime Phone Number (in case we need to contact you)

☐ **1 year/$16**
☐ **3 years/$43**
☐ **5 years/$63**

I agree to pay for the term I select.



☐ Check or money order enclosed, payable to AARP. **Do not send cash.**

☐ Please keep in touch with me by e-mail about AARP activities, events and member benefits.

E-mail Address

F6TAA 1

Dues are not deductible for income tax purposes. One membership includes spouse/partner. Annual dues include $4.03 for a subscription to *AARP The Magazine,* $3.09 for the *AARP Bulletin.* Dues outside U.S. domestic mail limits: Canada and Mexico–1 year/$17, all other countries –1 year/$28. Please allow up to six weeks for delivery of Membership Kit. When you join, AARP shares your membership information with the companies we have selected to provide AARP member benefits and support AARP operations. If you do not want us to share your information with providers of AARP member benefits, please let us know by calling 1-800-516-1993 or e-mailing us at member@aarp.org.

AA1035 (12/09)

As a member, you have access to:

Travel Discounts

Using AARP's exclusive travel savings just once could pay for your membership several times over!

- Savings on hotels, motels and resorts worldwide
- Discounted rates on airfares, cruises and auto rentals
- Special pricing on vacation packages

Health-Related Benefits

With today's high health care costs, AARP membership is more valuable than ever.

- Supplemental and custom-designed health plans for AARP members and their dependents
- Vision and prescription discounts nationwide
- Dental and long-term care insurance

Local Opportunities

AARP offers many ways to get active in your community.

- Over 2,200 local AARP chapters
- Social activities
- Volunteer opportunities
- Safe driving courses
- Classes and workshops

Protection of Your Rights

Your job. Your health. Your future. AARP will stand up for you by ...

- Representing your interests in Washington and your state
- Confronting age discrimination by employers
- Strengthening Social Security
- Protecting pension and retirement benefits
- Fighting predatory home loan lending

Dependable Financial Programs

Designed specifically for AARP members. With the high level of service you expect.

- Low-interest, no-fee credit card
- Investment programs
- Auto, homeowners, and life insurance

Valuable Information

Accurate and authoritative, direct from your reliable source – AARP.

- *AARP The Magazine*
- The *AARP Bulletin*
- FREE financial and health guides
- Our web site, www.aarp.org

Specially Priced Products & Services

AARP helps you save in ways and places you never imagined.

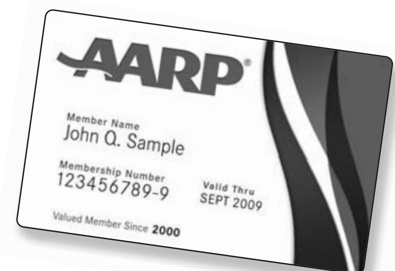
- Discounts on home security, internet access, gifts and other products
- Reduced-fee legal services from Allstate*
- Roadside assistance and emergency towing

NOTE: The benefits listed are only a partial list. Your Membership Kit will supply you with a full list of approved service providers that offer exclusive services and discounts to AARP members only.

* Legal Services Network reduced-fee benefits are not available in HI, NV and OH.

Value our members appreciate.

Members often tell us their AARP membership paid for itself with the first service they use. They're surprised at how many ways and places their membership proves valuable. And it's an even better value because **your spouse/partner is included free (at any age)!**



To become an AARP member, please return the form on the front in the envelope provided.

AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

Automatic Payments

Save $24 a year with Automatic Payments

The easiest way to pay.

Almost 1.8 million AARP Medicare Supplement members nationwide enjoy the convenience of the Automatic Payments option. With automatic payments, your monthly payment will automatically be deducted from your checking or savings account. If you use automatic payments, 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.

Sign Up in Two Easy Steps

1. Complete both sides of the Authorization Form below. Return it with the application **and be sure to keep a copy for your records.**
2. 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 cancelled check.

Your Automatic Payments Effective Date

If you are submitting this Electronic Funds Transfer (EFT) form with your enrollment application, your automatic payments 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, automatic 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 Automatic Payments Authorization Form form and will include the amount of your withdrawal.

BA9957 9/09

AUTOMATIC PAYMENT AUTHORIZATION FORM

☑ I (we) authorize UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York, for New York residents) 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.

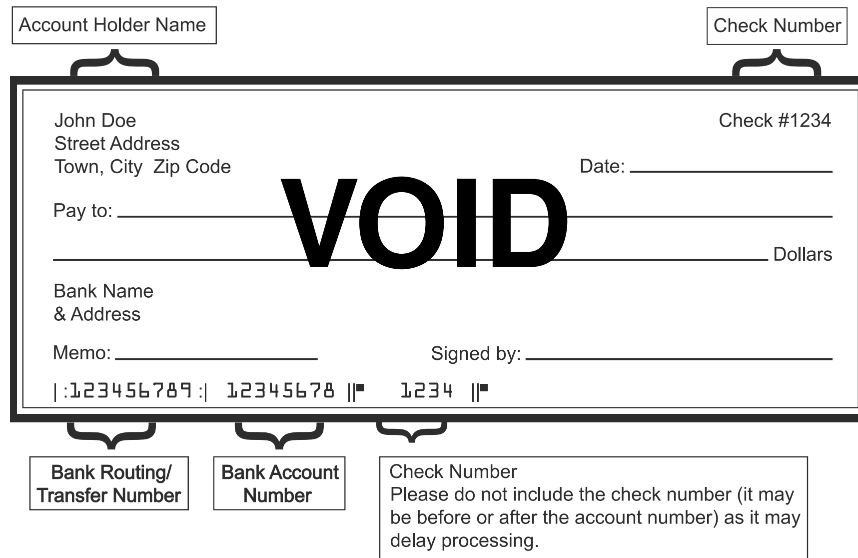
Name(s) ____________________
Address ____________________
City ____________________
State ____________ Zip Code ______
Bank Name ____________________
Bank Routing No. ____________________
Bank Account No. ____________________
Account Type: ☐ Checking
☐ Savings (statement savings only)

Please complete the reverse of this form to enroll in automatic payments. ▶

0000002 0000064 0063 0070 UAM0107A 01 L

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.



We look forward to continuing to serve you.

This authority remains in effect until UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York, for New York residents) and BANK receive notification from me (or either of us) of its termination in such time and manner as to give UnitedHealthcare Insurance Company 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 late status and subject to cancellation.

Name(s) ______________________ Member # __________

Signature ______________________ Date __________

Spouse's Signature ______________________ Date __________

(if joint account is maintained)

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

____

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT OR MEDICARE ADVANTAGE COVERAGE
UNITEDHEALTHCARE INSURANCE COMPANY
Horsham, Pennsylvania

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

If you intend to cancel or terminate existing Medicare supplement or Medicare Advantage coverage and replace it with coverage issued by UnitedHealthcare Insurance Company, please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

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 not duplicate coverage. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

___________ Additional benefits that are: ____

___________ No change in benefits, but lower premiums.

___________ Fewer benefits and lower premiums.

___________ Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D.

___________ Disenrollment from a Medicare Advantage Plan. Please explain reason for Disenrollment.

____

____

___________ Other (Please specify): ____

____

____

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)	(Applicant's Printed Name & Address)