UCT Application Packet

Thank you for your interest in the UCT Medicare Supplement plan!

This application packet provides you with access to a printable copy of the Enrollment Form and the Outline of Coverage in addition to a link to the Choosing a Medigap Policy Guide.

Should you decide to apply by secure upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to UCT. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) Download Policy Outline (.pdf) Download Application (.pdf)

Our website: http://www.medicare-texas.net

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

The Order of United Commercial Travelers of America • A Fraternal Benefit Society
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, OH 43215
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 800.948.1039 • www.uct.org

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

Requested Effective Date of Policy:

Last Name: **First Name:** **MI:**

WRITE THE PLAN OPTION YOU PREFER:

Plan: ________________

If approved, Please: ☒ **Mail Policy to Insured** ☐ **Mail Policy to Agent**

RESIDENCE ADDRESS

Street: ______________________________

City: ______________________________

State: ____________ **Zip Code:** ______________

E-mail: ______________________________

TELEPHONE: (________) ________-______________

SOCIAL SECURITY NUMBER:	AGE:	DATE OF BIRTH: *Month / Day / Year*	SEX: ☐ Female ☐ Male	HEIGHT:	WEIGHT:

MEDICARE INFORMATION

1. Did you turn age 65 in the last 6 months? .. ☐ Yes ☐ No
2. Did you enroll in Medicare Part B in the last 6 months? .... ☐ Yes ☐ No
   If yes, what is the effective date? ________________
3. To the best of your knowledge, what is the date you first enrolled in Medicare Part B? ____________

Medicare Claim Number: ________________________

If Medicare Parts A and B are to be effective at a future date, provide the date both Medicare Parts A and B will be effective:

Part A: ___________________ Part B: ________________

NOTE: Medicare effective date is always the 1st day of the month. Applicant must have both Medicare Parts A & B on the effective date of the policy. If not, coverage cannot be issued.

UNDERWRITING RISK CLASSIFICATION QUESTION

Have you used any form of tobacco in the past two years? .... ☐ Yes ☐ No

Are you a member of The Order of United Commercial Travelers of America? . ☐ Yes ☐ No

If yes, Council Name: ______________________________

Council City & State: ______________________________

SELECT THE METHOD OF PAYMENT YOU WANT:

☐ Annual ☐ Semi Annual ☐ Quarterly
☐ Monthly EFT ☐ Direct Monthly

MODAL PREMIUM: .... $__________

MODAL FRATERNAL DUES: .... $__________

TOTAL MODAL PAYMENT: .... $__________

PART I – HEALTH QUESTIONS

YOU ARE *NOT REQUIRED* TO ANSWER HEALTH QUESTIONS 1-9 IF YOU ARE IN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD. PLEASE SEE PAGE 6 FOR AN EXPLANATION OF OPEN ENROLLMENT/ GUARANTEED ISSUE PERIOD INFORMATION.

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS 1-8, YOU ARE NOT ELIGIBLE FOR COVERAGE.

1. Are you currently confined in a hospital or skilled nursing facility or extended care facility, or receiving the services of a home health agency? .... ☐ Yes ☐ No
2. Do you require or receive any assistance with any of your activities of daily living such as bathing, transferring, toileting, eating, dressing, or continence? .... ☐ Yes ☐ No
3. Are you currently bedridden or do you use the assistance of a wheelchair, walker, or motorized mobility aid? .... ☐ Yes ☐ No
4. Within the past two (2) years have you:
   a. Been hospitalized more than 2 times or received home health care services more than 3 times? .... ☐ Yes ☐ No
   b. Been confined to a nursing facility for more than 30 days? .... ☐ Yes ☐ No
   c. Been diagnosed with, treated for, or taken medication for Angina; Arrhythmia including chronic or recurrent Atrial Fibrillation; Heart Attack; Heart or Heart Valve Surgery; Implantation of Cardiac Pacemaker; Cardiomyopathy; Myocarditis; Heart Failure; Cardiac or Vascular Angioplasty; Stent Placement; Bypass; unrepaired Aneurysm; or Endarterectomy? .... ☐ Yes ☐ No
   d. Had a Stroke or Transient Ischemic Attack (TIA)? .... ☐ Yes ☐ No

5. Do you have now, or in the last two (2) years have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for the following conditions:
   a. Hepatitis (other than A), Cirrhosis of the Liver or Other Liver Disease? .... ☐ Yes ☐ No
   b. Major Depression, Bi-Polar Disorder, Schizophrenia, Paranoid or Psychotic Disorder? .... ☐ Yes ☐ No
   c. Diabetes on Insulin; Diabetic Neuropathy; Retinopathy, Peripheral Vascular Disease; Addison's Disease or Salt Losing Syndrome; Chronic Kidney Disease; Renal Insufficiency; Renal Failure; or any Kidney Disease requiring dialysis? .... ☐ Yes ☐ No
   d. Crohn's Disease, Ulcerative Colitis, Colostomy (Ostomy), Pancreas Disease, or Disorder of Prostate with elevated PSA level under observation? .... ☐ Yes ☐ No
   e. Cancer, Leukemia, Hemophilia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma? .... ☐ Yes ☐ No
   f. Alcohol or Drug Abuse? .... ☐ Yes ☐ No
   g. Paralysis, Post-Polio Syndrome, Spinal Stenosis, or Osteoporosis with fractures? .... ☐ Yes ☐ No
   h. Paget's Disease, Rheumatoid or Inflammatory Arthritis, Lupus or other Connective tissue disorder? ..... ☐ Yes ☐ No
6. Do you have now, or at any time have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for the following conditions:
   a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Dementia, Senility, Alzheimer's Disease, or Organic Brain Disorder? .... ☐ Yes ☐ No
   b. Emphysema, Chronic Pulmonary Disease requiring the use of oxygen and/or steroids, or Chronic Obstructive Lung Disease (COLD) excluding Asthma? .... ☐ Yes ☐ No
   c. Sleep Apnea requiring oxygen and/or positive airway pressure, or sleep apnea diagnosed but not under treatment? .... ☐ Yes ☐ No
   d. Cardiac condition requiring an internal Defibrillator? .... ☐ Yes ☐ No
   e. Amputation caused by disease or organ transplant other than corneas? .... ☐ Yes ☐ No
7. Have you ever been diagnosed as having or told by a medical doctor that you have AIDS, HIV. Or ARC disorders?.......... ☐ Yes ☐ No
8. Have you been advised that you will need to be admitted to a hospital, skilled nursing facility or extended care facility or has surgery been advised but not performed, or any surgery anticipated, including cataract surgery? .... ☐ Yes ☐ No
9. Have medical tests, treatment, or therapy been advised but not performed? .... ☐ Yes ☐ No
10. Are you currently taking any medications? If so, please list the following: .... ☐ Yes ☐ No

Medication	**mg/Dosage**	**Frequency**	**Reason for Prescription (Condition)**	**Length of Time Taken**

Phone interviews will be completed on the non-open enrollee/Guarantee Issue applicants.

Daytime Phone No.: (________)_________-______________Best Time to Call:_________________________

PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

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 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 our application. PLEASE ANSWER ALL QUESTIONS.

Please mark Yes or No with an "X."

1. To the best of your knowledge,
   a. Do you have another Medicare Supplement policy in force? .... ☐ Yes ☐ No
   b. If so, with what company and what plan do you have?
   ____
   c. If so, do you intend to replace your current Medicare Supplement policy with this policy? .... ☐ Yes ☐ No

2. Are you covered for medical assistance through the state Medicaid program? .... ☐ Yes ☐ No
   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,
   a. Will Medicaid pay your premiums for this Medicare Supplement policy? .... ☐ Yes ☐ No
   b. Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? .... ☐ Yes ☐ No

3. a. If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. If you are still covered under this plan, leave "END" blank. .... START: ______________
   END: ______________
   b. 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
   c. Was this your first time in this type of Medicare plan? .... ☐ Yes ☐ No
   d. Did you drop a Medicare Supplement plan to enroll in the Medicare plan? .... ☐ 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)? .... ☐ Yes ☐ No
   a. If so, with what company and what kind of policy?
   ____
   ____
   ____
   b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank. .... START: ______________
   END: ______________

IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

1. You do not need more than one Medicare Supplement Insurance Policy.
2. 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.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Policy.
4. 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. 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 the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance Policy 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).

I hereby apply to The Order of United Commercial Travelers of America for a policy to be issued entirely in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy. I agree the policy shall not be effective until it has actually been issued. I have received an outline of coverage for the policy applied for and a *Guide To Health Insurance for People With Medicare*.

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

Pre-existing conditions are covered immediately upon effective date under a policy issued by The Order of United Commercial Travelers of America. You are not required to satisfy any waiting period.

If not a current member of The Order of United Commercial Travelers of America, I apply to become a member as indicated by my signature below. I understand UCT is a fraternal benefit society and agree to abide by the Society's Constitution and Bylaws.

Applicant's Signature: ____________________ **Dated: (m/d/y)** ____________

AGENT(S) CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

____

____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

____

____

I (we) certify that:
1. I (we) have accurately recorded the information supplied by the Applicant; and
2. I (we) have given an outline of coverage for the policy applied for and a *Guide To Health Insurance for People With Medicare* to the Applicant.

Agent's Printed Name: Tiffany Jackson
Agent No.: 9586429 **% Amount:** 100
Agent's Signature: ____________
Date: ____________
E-mail Address: client.services@cda-insurance.com

Agent's Printed Name: ____________
Agent No.: ____________ **% Amount:** ____________
Agent's Signature: ____________
Date: ____________
E-mail Address: ____________

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-9 on Page 1 and 2 of this application if you (a) are within 6 months of turning (about to turn or have already turned 65); (b) are within 6 months of purchasing Part B coverage for the first time; or (c) were previously covered under Medicare (due to a disability, for example) and are within 6 months of turning age 65.

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997:

The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

a. Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; or

b. Enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

c. Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material certificate/policy provision, or a material misrepresentation was made to the individual; or

d. Enrolled in a Medicare Supplement certificate/policy and coverage discontinues due to insolvency, substantial violation of a material certificate/policy provision, or material misrepresentation; or

e. Enrolled under a UCT Medicare Supplement certificate/policy, terminates and enrolls for the first time in a Medicare+Choice or Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or

f. Upon *first* becoming eligible for benefits under Part B at age 65 or older, enrolled in a Medicare+Choice or a Medicare Advantage or PACE provider and you disenroll within 12 months.

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

IF YOU ARE APPLYING DURING AN OPEN ENROLLMENT PERIOD OR A GUARANTEED ISSUE PERIOD, THE AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION TO THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA DOES NOT NEED TO BE COMPLETED OR SIGNED.

AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION TO THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health or prescription drug usage to give The Order of United Commercial Travelers of America, or its reinsurers, any such information. I understand that this authorization is voluntary. I understand that I am authorizing The Order of United Commercial Travelers of America to receive my health information or prescription drug usage history. I understand that when my medical records are disclosed pursuant to this Authorization, my records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. The released information received by The Order of United Commercial Travelers of America will remain protected by federal and/or state regulations as long as it is maintained by the health plan.

Reason for Disclosure is to evaluate and underwrite my application to determine eligibility for insurance

I understand that the information requested is necessary for evaluation of my application and underwriting to determine eligibility for the Insurance Policy for which I have applied. I understand that failure to provide the authorization to The Order of United Commercial Travelers of America *will* result in the rejection of the Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying The Order of United Commercial Travelers of America in writing at their Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619. I understand that such revocation will not have any effect on actions The Order of United Commercial Travelers of America took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative may request to receive a copy of this authorization.

Applicant Name:______________________________

Social Security Number:______________________ **Date of Birth:**______________

Signature of Applicant:______________________ **Date:**______________

AUTHORITY TO HONOR PREMIUM CHECKS

AUTHORIZATION

IN FAVOR OF: **The Order of United Commercial Travelers of America**
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619

Name of Bank Customer: ________________________ **Type of Account:** ☐ **Checking**

Insured's Name: ________________________ ☐ **Savings**

Routing Number: ______________ **Account Number:** ______________

To (Name of Bank): ________________________

Address of Bank: ________________________

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Date:	**Signature of Bank Customer:**

AUTHORIZATION

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

To: Bank above: In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

ATTACH VOIDED CHECK HERE – Deposit Slips NOT Accepted

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NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

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

According to (your application) (information you have furnished), you intend to terminate existing Medicare supplement or Medicare Advantage coverage and replace it with a policy to be issued by The Order of United Commercial Travelers of America. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY ISSUER, (OR OTHER REPRESENTATIVE):
I have reviewed your current medical or health coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reasons:

________ Additional benefits,
________ Same benefits but lower premiums,
________ Fewer benefits and lower premiums,
________ My plan has outpatient prescription drug coverage and I am enrolling in Part D,
________ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
____
________ Other (specify) ____

I call to your attention the following items for your consideration:

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

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

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

(4) 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 Other Representative | Applicant's Signature | Date

Tiffany Jackson - PO Box 26540, Eugene, OR 97402
Typed Name and Address of Issuer or Agent

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You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

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____
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________________________ ________________________ ____________
Signature of Agent Other Representative | Applicant's Signature | Date

Tiffany Jackson - PO Box 26540, Eugene, OR 97402
Typed Name and Address of Issuer or Agent

FOR AGENT USE ONLY

Medicare Supplement Application Submission Checklist:

- ☐ Complete Application
- ☐ Collect premium amount (Please remember to include membership dues – a minimum of $18 annually, $9 semi-annually, $4.50 quarterly, or $1.50 monthly)
- ☐ Provide client with *Buyer's Guide*
- ☐ Provide client with Outline of Coverage
- ☐ Provide client with Premium Receipt
- ☐ Complete Replacement Notice and leave copy with the applicant if necessary

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PREMIUM RECEIPT

Make check payable to UCT.

Received from ____, the sum of $____________________

for _______________ months' premium for (check one):

☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan F ☐ Plan G ☐ Plan N

If, for any reason, the policy is not issued, payment will be refunded in full in a timely manner. Insurance is not effective until the application is approved, the premium has been paid and the policy is issued. The effective date of the Insurance will not be prior to the date indicated on your identification card.

Date: ______________________ Licensed Resident Agent: ____

1801 Watermark Drive, Suite 100
Columbus, OH 43215

Tel: 614.487.9680
Toll-free: 800.848.0123
Fax: 800.948.1039

The Order of United Commercial Travelers of America
www.uct.org

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