United American Application Packet

Thank you for your interest in applying for the United American Medicare Supplement plan!

This packet provides you with access to the policy Outline of Coverage, printable application in addition to a link to the Choosing a Medigap Policy Guide.

Should you decide to apply by upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to United American. You may upload, 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.

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE * UNITED AMERICAN INSURANCE COMPANY
A LEGAL RESERVE STOCK COMPANY

PART I: APPLICANT INFORMATION

Plan Code
(Refer to Rate Card)

Effective Date Requested (mm-dd-yyyy)

*Medicare first eligible before 2020 only

Select Plan Applying for
○ A ○ B ○ C* ○ D ○ F* ○ HDF*
○ G ○ HDG ○ K ○ L ○ N

Mode of Premium
○ Annual
○ Semi-Annual
○ Quarterly
○ Monthly

Method of Payment
○ Send Premium Notices
○ Automatic Payment Plan

Draft Date
Day (01-28) of the Month to Draft Bank Account

Applicant's First Name

M.I.

Last Name

Applicant's Mailing Address:

Street or Route

City

State

Zip Code

County

If Applicant's Residence Address is different from Mailing Address, show below:

Street or Route

City

State

Zip Code

County

Social Security Number - -

Height (ft. in.)

Weight (lbs.)

Date of Birth (mm-dd-yyyy) - -

Age Last Birthday

Sex ○ Male ○ Female

Have you used tobacco in any form in the past 12 months? ○ **Yes** ○ **No**

E-mail Address of Proposed Insured

Application Verification Information

A recorded interview may be necessary as part of the underwriting of your application for insurance. The most convenient time and place for the interview is:
○ 8 AM - Noon
○ Noon - 6 PM
○ 6 PM - 9 PM

Home Phone No. - -

Work Phone No. - -

PART II: ELIGIBILITY QUESTIONS

Are you an eligible person for guaranteed issue who is applying for this policy after terminating enrollment in a Medicare supplement policy with prescription drugs and not later than 63 days after enrolling in Part D of Medicare, or after the date of termination or disenrollment in an Employee Welfare Benefits Plan, a Medicare Advantage Plan, a Medicare Select Plan, Medicare Risk or Cost Plan, a Medicare HMO Plan, a Pace Program, a Medicare Supplement Policy or Medicaid and have evidence of the date of termination or disenrollment in one of these Plans? ○ ○
If "YES", submit your evidence of termination or disenrollment with this application. **Yes No**

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. **PLEASE ANSWER ALL QUESTIONS**.

TO THE BEST OF YOUR KNOWLEDGE: **Yes No**

1. (a) Did you turn age 65 in the last six (6) months? ---------- ○ ○

   (b) Did you enroll in Medicare Part B in the last six (6) months? ---------- ○ ○

   (c) If "YES", what is the effective date? (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐

   (d) What is your Medicare Claim Number? ☐☐☐☐☐☐☐☐☐☐☐
   (as shown on your Medicare card omitting dashes)

2. Are you covered for medical assistance through the state Medicaid 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. ---------- **Yes No** ○ ○
   If you answered "YES":
   (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ---------- ○ ○
   (b) Do you receive any benefits from Medicaid OTHER THAN payment towards your Medicare Part B premium? ---------- ○ ○

3. (a) If you had coverage from any Medicare plan other than original 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 Date" blank.
   START Date (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐ END Date (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐

   Yes No
   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ---------- ○ ○

   (c) Was this your first time in this type of Medicare plan? ---------- ○ ○

   (d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ---------- ○ ○

4. (a) Do you have another Medicare Supplement policy in force? ---------- ○ ○

   (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? ---------- ○ ○

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ○ ○

   (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 Date" blank.)

   START Date (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐ END Date (mm-dd-yyyy) ☐☐ - ☐☐ - ☐☐☐☐

PART II: ELIGIBILITY QUESTIONS (continued)

	Yes	No
6. Are you within 6 months of your enrollment in Medicare Part B or are you an Eligible Person for Guaranteed Issue (as defined in the attached Application Supplement form)? (Questions 7-17 not required if the answer to question 6 is "YES".)	○	○

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES," THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE:

	Yes	No
7. Are you currently hospitalized, confined to a nursing facility or receiving Medicare approved home health care, or have you been hospitalized or received Medicare approved home health care 2 or more times in the past 12 months?	○	○
8. Do you have emphysema, Chronic Obstructive Pulmonary Disease (COPD), or pulmonary fibrosis?	○	○
9. Are you bedridden or do you use a wheelchair for any daily activity, or have you been diagnosed with Gaucher's Disease or any other type of lysosomal storage disorder, or have you had any type of amputation caused by disease?	○	○
10. Have you been advised that surgery may be required within the next twelve months for cataracts?	○	○
11. Have you been diagnosed or treated for Parkinson's disease, Multiple or Lateral Sclerosis, Alzheimer's disease, senile dementia, or organic brain disorder?	○	○
12. Have you been treated, diagnosed or tested positive as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or ever tested positive for antibodies for the AIDS (HIV) virus?	○	○
13. Do you have diabetes requiring more than 50 units of insulin daily?	○	○
14. Within the past 2 years, have you been diagnosed or treated for internal cancer, melanoma, leukemia, alcoholism or drug abuse, cirrhosis, mental or nervous disorder requiring psychiatric care, or have you been advised to have kidney dialysis?	○	○
15. Within the past 2 years, have you been diagnosed or treated for heart attack, peripheral vascular disease, congestive heart failure, heart valve disorder, stroke, or transient ischemic attacks (TIA)?	○	○
16. Within the past 2 years, have you been diagnosed or treated for rheumatoid arthritis or crippling arthritis?	○	○
17. Within the past year, have you been fed intravenously or through a tube, have you been medically advised to have surgery for joint replacement or for a heart condition, but not had such surgery, or have you been advised to have other surgery that has not been performed?	○	○

PART III: APPLICANT AUTHORIZATION

(1) You do not need more than one Medicare Supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(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 or entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). 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.

(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 suspension.

(6) 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).

I hereby apply to United American Insurance Company for a policy to be issued in reliance on my written answers to the above questions. The answers are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued. I have received an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide.

I understand that loss due to injury or sickness for which medical advice was received or treatment was recommended or given by a physician within 6 months prior to the policy effective date is not covered unless the loss is incurred more than 60 days after the policy effective date, subject to the Time Limit on Certain Defenses provision and legal proceedings.

If you have had creditable coverage within the past 63 days and you are either an open enrollee or an eligible person for guaranteed issue, the pre-existing conditions limitations provision does not apply.

I authorize the MIB, Inc., any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to United American Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that any information obtained will not be released to any person or organization except to the MIB, Inc., reinsuring companies or other persons or organizations performing business or legal services in connection with this application, with a claim or as may be otherwise lawfully required. I agree that a copy of this authorization is to be acceptable. This authorization will remain in effect for a period of 24 months from the date signed. I understand that I or an authorized representative may request a copy of this authorization. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

No agent may bind, alter, change or waive any underwriting requirements or other provisions of the application or policy. Final acceptance is made by the Underwriting Department of the Company.

Any person who, with intent to defraud or knowing that he/she 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.

Application Signed at City | **State** | **On this Date (mm-dd-yyyy)** - -

Amount paid with application: $, .

for first months premiums.

Total Premium $, .

Applicant's Signature

PART IV: AGENT CERTIFICATION

The undersigned Agent certifies that he/she has ☐ / has not ☐ personally met with the Applicant and that the Applicant has read, or had read to him/her, 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.

AGENT COMPLETES (Attach separate sheet, if necessary.)

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

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

I certify: (1) I have accurately recorded the information supplied by the Applicant, (2) I have given an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide to the Applicant.

Last Name	Agent No.
Jackson	A74032

Agent's Signature

MA15(42) MAIL POLICY TO: ○ Agent ○ Insured (The Policy will be sent to Insured unless otherwise instructed.)

United American Insurance Company
Since 1947

Bank Draft Authorization

Draft date cannot be the 29th, 30th or 31st.

Proposed Insured's Social Security Number

			-			-				

Requested Bank Draft Day (dd)

Payor's First Name

																			M.I.

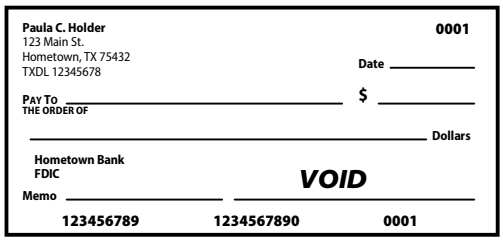
Payor's Last Name

Bank ABA Routing Number

Account Number

Bank Name

Account information fields above must be complete if voided check is not attached.
See the example check below for the location of the Bank Routing Number and Account Number.



Helpful Information for Social Security Recipients		
Social Security Benefits Paid On	Birth Date On	Draft Date
Second Wednesday	1st – 10th	14th
Third Wednesday	11th – 20th	21st
Fourth Wednesday	21st – 31st	28th

As a convenience to me, I hereby request and authorize you, United American Insurance Company, McKinney, Texas, to initiate debit entries to my bank account, as recorded above, for insurance premiums and/or non-insurance product fees, as applicable, and the bank named above to debit the same to such account. I agree that your rights and treatment of such debits shall be the same as if they were checks personally signed by me. I further agree that if any such debits are dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even if such dishonor results in the forfeiture of insurance. This authorization will remain in effect until revoked by me in writing to you, provided that you and the bank shall have a reasonable opportunity to act on such notification. All premiums and/or fees may be automatically withdrawn from my account on MONTHLY mode, unless a different mode has been selected on the application(s).

NOTE - <u>Business</u> accounts are permitted only in relation to sole proprietorships, in which case a voided check and a completed Sole Proprietor form (SP 9-01) are required.

Payor's Signature (as it appears on bank records)

FORM 1080-C

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