AARP | Medicare Supplement
from UnitedHealthcare

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.
- ❑ Be sure to sign and date the application in all the places indicated.

AARP Membership Form

AARP membership is required to enroll in an AARP Medicare Supplement Plan, insured by UnitedHealthcare Insurance Company. If you are not currently an AARP member or are unsure, you may enroll, renew or verify in one of three ways:

- ❑ Log on to aarp.org/ActToday;
- ❑ Call toll-free 1-866-331-1964; or
- ❑ Complete the membership form and submit it with the plan application, along with a separate check for $16.00 payable to AARP.
  - Note: One membership covers both the member and another individual living in the same household. Therefore, only one membership application is required if two individuals of a household are applying for AARP membership.

Electronic Funds Transfer (EFT) Authorization Form

Automatic payments are available; if requesting, you may deduct $2 from the first month's premium check.

- ❑ Submit the completed form (signed and dated).

Notice to Applicants Regarding Replacement of Coverage

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

If Reply Envelope Is Missing

Please mail completed application to: UnitedHealthcare Insurance Company
P.O. Box 105331
Atlanta, GA 30348-5331

(Over Please)

AARP endorses the AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers. AARP does not employ or endorse agents, brokers or producers.

Insured by UnitedHealthcare Insurance Company, 185 Asylum Street, Hartford, CT 06103. Policy form No. GRP 79171 GPS-1 (G-36000-4).

In some states plans may be available to persons under age 65 who are eligible for Medicare by reason of disability or End-Stage Renal Disease.

Not connected with or endorsed by the U.S. Government or the federal Medicare program.

This is a solicitation of insurance. A licensed insurance agent/producer may contact you.

See the following materials for complete information including benefits, costs, eligibility requirements, exclusions and limitations.

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

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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

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 ____ / ____ / ____ (Month / Day / Year) **1D.** Gender ☐ Male ☐ Female

1E. Medicare Number_____ (From your Medicare card.)

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

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

2460720307 _AGT

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 50 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,
- if you are age 50-64 and eligible for Medicare by reason of disability or End-Stage Renal Disease (ESRD):

You are eligible for Guaranteed Acceptance in Plan C if your Medicare Part B effective date is prior to 1/1/2020 and you apply:

- within six months of enrollment in Medicare Part B; or
- within six months beginning with the month in which a retroactive determination of eligibility for Medicare is made.

(Unless you are entitled to guaranteed issue of a Medicare supplement plan as shown under the "Guaranteed Acceptance" section in the "Your Guide.")

You are eligible for Guaranteed Acceptance in Plan D if your Medicare Part B effective date is:

- prior to 1/1/2020 and you apply within six months of enrollment in Medicare Part B and you are not covered by any other Medicare Supplement Plan; or
- on or after 1/1/2020 and you apply within 12 months of enrollment in Medicare Part B.

(Unless you are entitled to guaranteed issue of a Medicare supplement plan as shown under the "Guaranteed Acceptance" section in the "Your Guide.")

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. If you are age 50-64 and eligible for Medicare by reason of disability or End-Stage Renal Disease, please see the Plan information shown above. Please call if you have questions.

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

TEAR HERE

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

TEAR HERE

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 **or** the beginning of the month that a retroactive determination of eligibility for Medicare is made (12 months for Applicants age 50-64 eligible for Medicare by reason of disability or End-Stage Renal Disease who are enrolling in Plan D and who first enrolled in Medicare Part B on or after 1/1/2020)?

☐ 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**.

First Name Last Name

3 Is your acceptance guaranteed? (continued)

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 guaranteed issue rights, please see "Your Guide."

- If **YES**, skip directly to **Section 9**.
- If you answered **NO** to both questions in **Section 3** and you are:
  - **age 65 or over,** continue to **Section 4**.
  - **age 50-64 and eligible for Medicare by reason of disability or ESRD, you are NOT eligible to apply**.

TEAR HERE

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

TEAR HERE

First Name Last Name

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.

TEAR HERE

6A. Were you hospitalized as an inpatient (not including overnight Outpatient observation) • within the past 90 days or • 3 or more times within the past 2 years?	☐Yes ☐No ☐Not Sure
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
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?	☐Yes ☐No ☐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?	☐Yes ☐No ☐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)?	☐Yes ☐No ☐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?	☐Yes ☐No ☐Not Sure
6H. Are you awaiting any diagnostic test results?	☐Yes ☐No ☐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.

TEAR HERE

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

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

TEAR HERE

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? ☐Yes ☐No ☐Not Sure
  - Asthma
  - Autoimmune disorders
  - Blood disorders
  - Cognitive impairment
  - Connective tissue disorders
  - Eye disorders
  - Genetic or Hereditary disorders
  - Migraine headaches
  - Osteoarthritis

First Name Last Name

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

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 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).

TEAR HERE

PLEASE ANSWER ALL QUESTIONS.
To the best of your knowledge,

Questions about Medicaid	
9A. 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. **If YES, you must answer Questions 9B and 9C.**	☐Yes ☐No
9B. Will Medicaid pay your premiums for this Medicare supplement policy?	☐Yes ☐No
9C. 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)	
9D. 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)? **If YES, you must answer Questions 9E through 9H.**	☐Yes ☐No

First Name Last Name

9 Your past and current coverage (continued)

9E. 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
9F. 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.) **If YES, please enclose a copy of the Replacement Notice.**	☐Yes ☐No
9G. Was this your first time in this type of Medicare plan?	☐Yes ☐No
9H. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐Yes ☐No
Questions about Medicare supplement plans	
9I. Do you have another Medicare supplement policy in force? If so, what insurance company and what plan do you have? Insurance Company: _____ Policy: _____ **If YES, you must answer Question 9J.**	☐Yes ☐No
9J. Do you intend to replace your current Medicare supplement policy with this policy? **If YES, please enclose a copy of the Replacement Notice.**	☐Yes ☐No
Questions about any other type of health insurance coverage	
9K. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? **If YES, you must answer Questions 9L through 9N.**	☐Yes ☐No
9L. If so, with what insurance company and what kind of policy? **Insurance Company:**_____	**Policy:** ☐HMO/PPO ☐Major Medical ☐Employer Plan ☐Union Plan ☐Other_____
9M. 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
9N. Are you replacing this health insurance?	☐Yes ☐No

TEAR HERE

TEAR HERE

✗ _____ ____/____/____

Your Signature (required) **Today's Date** (required) Month Day Year

First Name Last Name

10 Authorization and Verification of Application Information

Read carefully, and sign and date in the signature box.

- I declare 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 this Application Form becomes a part of the insurance contract and that if the answers are incomplete, incorrect or untrue, UnitedHealthcare may have the right to rescind my coverage, adjust my premium, or reduce my benefits.
- Any person who includes any false or misleading information on an application for insurance coverage is 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.

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

TEAR HERE

First Name Last Name

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.

TEAR HERE

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:

_____

_____

Agent Name (PLEASE PRINT)_____ ___ _____
First Name MI Last Name

✗ _____ _____ _____/____/_____
Agent Signature (required) Agent ID (required) Today's Date (required)
Month Day Year

_____ (_____) _____-_____
Agent Email Address Agent Phone Number

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

HEALTH CARE PRODUCTS & DISCOUNTS
access to health and dental insurance products, as well as vision, hearing and prescription discounts

AWARD-WINNING PUBLICATIONS
including *AARP The Magazine*, *AARP Bulletin* and free guides on financial planning and health

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 car rentals, major hotels and resorts, cruises, flights and vacation packages

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

COMMUNITY INVOLVEMENT
Volunteer opportunities, social activities, safe driving courses and The 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 aarp.org/ActToday
Or call 1-866-331-1964

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

BA25584ST AGT

AARP®

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

FCSDUHCM
BA25584ST

OR

Yes, I want to join or renew with Automatic Renewal and SAVE 25%

Visit aarp.org/ActToday
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.

AGT

Here are some featured health-related benefits you'll have access to as an AARP member:

- ✔ Supplemental Health Insurance
- ✔ Dental Coverage
- ✔ Hearing Care Discounts
- ✔ Vision Care Discounts
- ✔ Prescription Discounts
- ✔ Personalized Fitness Programming
- ✔ Healthy Food Delivery Service
- ✔ AARP Hearing Center
- ✔ Family Caregiving Resources
- ✔ At-Home Physical Therapy Services

AARP®

Act today and make the most of membership.

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

SAVE 25%

Visit aarp.org/ActToday

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 emailing us at member@aarp.org. We may steward your resources by converting your check into an electronic deposit.

TEAR HERE

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Take advantage of the Electronic Funds Transfer (EFT) service!

The Easiest Way to Pay

Enjoy the convenience of the EFT option. With EFT, your monthly payment will automatically be deducted from your checking or savings account. Also, you'll save $2.00 a month – or more.*

*Additional EFT savings may be available based on your enrollment in other eligible plans.

Benefits of the EFT service:

- 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.

Signing Up is Easy

Complete the Automatic Payment Authorization Form on the reverse side. Return it with the application and be sure to keep a copy for your records. Please be sure the information is clear, as it is required for processing your request for EFT. Please do not include a check. All that is required is the EFT Authorization details noted on the back.

Your EFT Start Date

- Recurring monthly EFT withdrawals will occur on or about the fifth of each month. EFT will usually begin the same month your plan is effective. If your enrollment application is accepted at the end of the month and your plan is effective the next month, there may be a processing delay in starting your EFT. In that case, EFT will start the month after your plan is effective, and your account statement will explain how to make a payment until your EFT starts.
- If this EFT form is received and processed after your application is accepted, the start date of EFT is based on the date your EFT form is processed and whether your plan has started or is effective in the future. EFT will usually begin the month after your EFT form is processed but could start the following month. If your coverage is effective two or more months in the future, EFT will begin the same month your plan is effective. The amount and date of the first EFT withdrawal will be shown on your account statement. If any payment is due before your EFT starts, use the coupon on the account statement which will explain how to make a payment.

Complete Form on Reverse ▶

This side for your information only, return not required.

SA26150ST

AUTOMATIC PAYMENT AUTHORIZATION FORM

☐ I allow UnitedHealthcare Insurance Company or an affiliate, together known as "UnitedHealthcare," to take monthly withdrawals, for the then-current monthly rate for the named member, from the bank account shown 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 individual's payment due each month. 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

_____

City State Zip Code

Bank Name_____

Bank Routing No. _____ Account Type: ☐ Checking

(9 digit number) ☐ Savings (statement savings only)

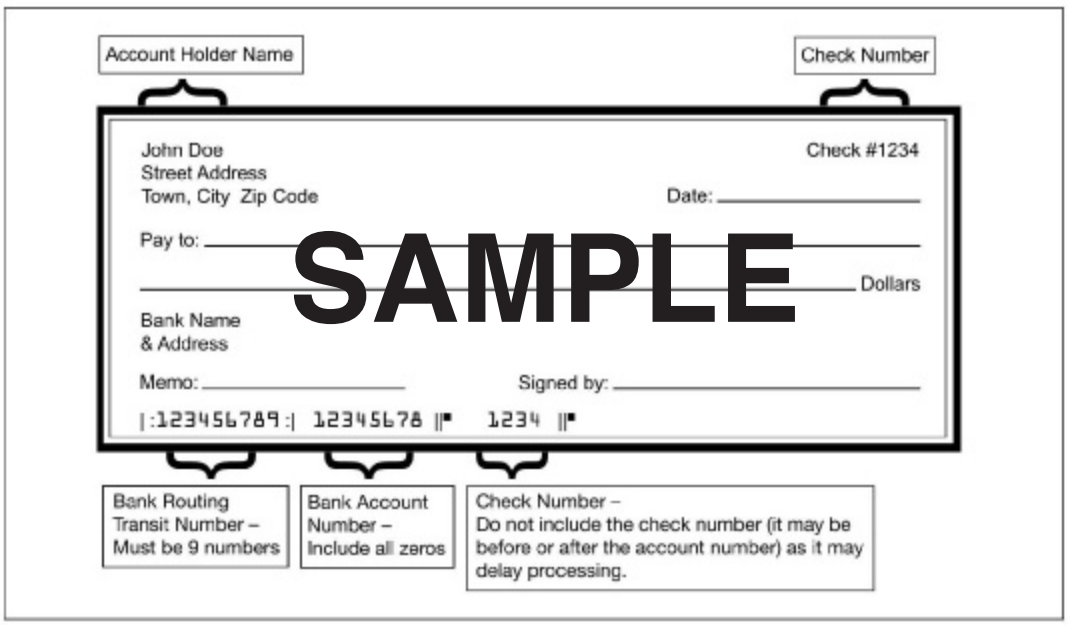
Bank Account No. _____

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.

TEAR HERE

TEAR HERE

Take advantage of the Electronic Funds Transfer (EFT) service!

The Easiest Way to Pay

Enjoy the convenience of the EFT option. With EFT, your monthly payment will automatically be deducted from your checking or savings account. Also, you'll save $2.00 a month – or more.*

*Additional EFT savings may be available based on your enrollment in other eligible plans.

Benefits of the EFT service:

- 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.

Signing Up is Easy

Complete the Automatic Payment Authorization Form on the reverse side. Return it with the application and be sure to keep a copy for your records. Please be sure the information is clear, as it is required for processing your request for EFT. Please do not include a check. All that is required is the EFT Authorization details noted on the back.

Your EFT Start Date

- Recurring monthly EFT withdrawals will occur on or about the fifth of each month. EFT will usually begin the same month your plan is effective. If your enrollment application is accepted at the end of the month and your plan is effective the next month, there may be a processing delay in starting your EFT. In that case, EFT will start the month after your plan is effective, and your account statement will explain how to make a payment until your EFT starts.
- If this EFT form is received and processed after your application is accepted, the start date of EFT is based on the date your EFT form is processed and whether your plan has started or is effective in the future. EFT will usually begin the month after your EFT form is processed but could start the following month. If your coverage is effective two or more months in the future, EFT will begin the same month your plan is effective. The amount and date of the first EFT withdrawal will be shown on your account statement. If any payment is due before your EFT starts, use the coupon on the account statement which will explain how to make a payment.

Complete Form on Reverse ▶

This side for your information only, return not required.

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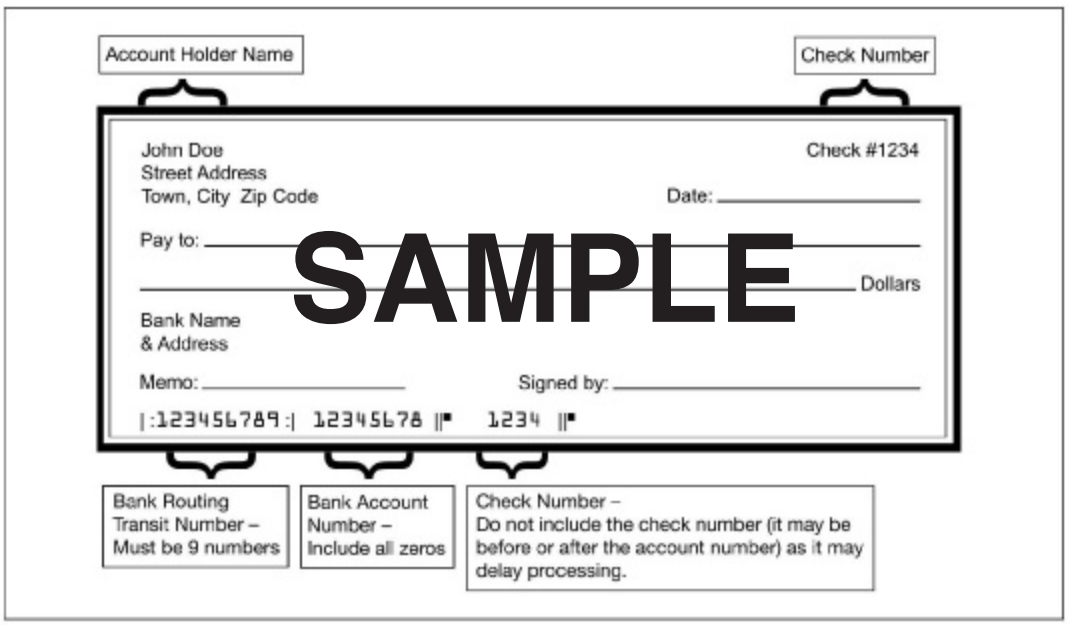

We look forward to continuing to serve you.

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

Horsham, Pennsylvania

Save this notice! It may be important to you in the future

According to the information you furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by UnitedHealthcare Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

TEAR HERE

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, 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 policy or leave your Medicare Advantage plan. The replacement policy is being purchased for one of the following reasons (check one):

_____ Additional benefits.

_____ No change in 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 (Please Specify) _____

_____

_____

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 waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits 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 company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

TEAR HERE

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) (Date)

_____

(Applicant's Signature) (Date)

_____

(Applicant's Printed Name & Address)

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_____

(Signature of Agent, Broker or Other Representative) (Date)

_____

(Applicant's Signature) (Date)

_____

(Applicant's Printed Name & Address)

Thank You for Applying for an AARP® Medicare Supplement Insurance Plan Insured by UnitedHealthcare Insurance Company

For Your Records:

You selected Plan _____ with a requested effective date (1st day of a future month) of _____ / _____ / _____.

Based on the information you provided, your monthly premium for the plan you selected may be $_____. **Please note that your final monthly premium will be determined once your application is approved.**

You will be notified when review of your application has been completed.

What's Next:

Once your application is approved, you may expect your insured Member Identification (ID) Card to arrive. Using the information on the Member ID Card, you may register for a secure online account at **www.myaarpmedicare.com** to gain access to tools and resources to help you manage both your plan and your health.

In addition to your insured Member ID Card and website access, you'll also receive:

Welcome Kit.

The Welcome Kit will include your Certificate of Insurance, coverage details, and helpful resources.

Educational Materials.

UnitedHealthcare's educational materials can help you make the most of your plan benefits.

Dedicated Customer Service.

You'll receive a friendly call from one of our courteous and caring UnitedHealthcare Customer Service Advocates, who will review your new member materials, and help answer questions you may have.

Exclusive AARP Member Benefits.

A full listing of the benefits you receive with your AARP membership — including healthcare-related discounts, access to financial programs, driver safety courses, social activities, and much more — can be found when you log into **www.myaarpmedicare.com/extras**

AARP® | Medicare Supplement from UnitedHealthcare®

Let's stay connected.

As your licensed insurance agent contracted with UnitedHealthcare Insurance Company, I am here to help.

Name _____

Email _____

Phone _____

AARP® | Medicare Supplement from UnitedHealthcare®

AARP endorses the AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers. AARP does not employ or endorse agents, brokers or producers.

You must be an AARP member to enroll in an AARP Medicare Supplement Insurance Plan.

Insured by UnitedHealthcare Insurance Company, 185 Asylum Street, Hartford, CT 06103. Policy form No. GRP 79171 GPS-1 (G-36000-4).

In some states, plans may be available to persons under age 65 who are eligible for Medicare by reason of disability or End-Stage Renal Disease.

Not connected with or endorsed by the U.S. Government or the federal Medicare program.

This is a solicitation of insurance. A licensed insurance agent/producer may contact you.

See enclosed materials for complete information including benefits, costs, eligibility requirements, exclusions and limitations.

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