AARP Membership Benefits and Services

AARP Membership Application on Back

A Special AARP Invitation

AARP salutes a new groundbreaking generation — YOURS.

AARP is YOUR organization. Please join us and over 35 million Americans. Become an AARP member today and enjoy access to the many fine benefits and services of membership. You'll agree that it's one of the best values around.

AARP

601 E Street, N.W., Washington, DC 20049

The Many Benefits of AARP Membership — *Some Things Really Do Get Better With Time.*

In many ways, you are already redefining adult lifestyle in the 21st century. More and more, it means living life on your own terms, doing what feels right for you — whether it's working, starting a new career, not working at all, pursuing a college degree, competing in a triathlon, or any one of a thousand other pursuits.

1. ***AARP Privileges.*** Designed to let you do a lot more living for a lot less money, AARP Privileges features big savings and quality service — from hotels, motels, resorts, car rental companies, airlines, cruises, vacation packages, sightseeing — by presenting your AARP Membership Card. There are also discounts for home security and Internet service.

2. ***AARP in Action.*** AARP works on both the national and local levels to improve the economic security, employment rights, long-term care, and health care of members like you. Log on to www.AARP.org and subscribe online to receive the AARP Advocate E-letter. This informative, monthly newsletter provides you with current information about legislative topics and AARP activities.

3. ***AARP.org and Online Information.*** Visit www.AARP.org, the best place on the web for news and information that's relevant to you. There's a wealth of information to explore, along with fun diversions, such as online crossword puzzles and games. In addition, you can subscribe to many different free AARP online newsletters relating to various topics, such as books, consumer alerts, health and wellness, travel, computers, and much more.

4. ***AARP The Magazine.*** Published six times a year, this magazine reflects today's adult lifestyle, and contains information on topics ranging from health and longevity to volunteerism and travel, from work and family to food and sex.

5. ***AARP's Informational Publications.*** Free publications are available on a wide variety of subjects, including health and fitness, finances, retirement planning, and more.

6. ***AARP Bulletin.*** This informative newsletter, published 11 times a year, keeps you apprised of important legislative issues, including tax regulation, pension, and Social Security issues, as well as AARP events happening around the country.

7. ***AARP Investment Program.*** A simple, affordable, no-nonsense approach to retirement investing, specifically designed for people over 50 with medium- to long-term investment goals. In addition to streamlined investment choices, members have access to experienced and knowledgeable investment counselors as well as our online resource center featuring educational materials and helpful tools. This investment program is offered to you through AARP Financial, a registered investment adviser. For more information, go to www.aarpfunds.com. Distributed by ALPS Distributors, Inc.

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– AARP Membership Application –

(Please remember to include your AARP membership application along with a check or money order for annual AARP membership dues when you send your insurance application)

Mr./Mrs./Ms. _____
(Circle one) (Member Name) (Date of Birth)

Mr./Mrs./Ms. _____
(Circle one) (Spouse Name) (Date of Birth)

Address _____

City _____ State _____ Zip _____

Phone Number ( ) _____
(Area Code)

E-mail Address (optional) _____
(A representative may contact you)

☐ Yes, I accept membership with AARP. I understand that my AARP membership application will be accepted whether I am accepted for insurance or not.

I enclosed:
☐ $12.50 for one year ☐ $21.00 for two years
☐ $29.50 for three years

Please make check or money order payable to: "AARP." (No cash please.)

Dues are not deductible for income tax purposes. One membership includes spouse/partner. Annual dues include $3.30 for a subscription to *AARP The Magazine*, $2.09 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 1-888-OUR-AARP or e-mailing us at member@aarp.org.

PLEASE RETURN IN THE ENVELOPE PROVIDED.

AA1030 6/06 DETACH HERE V4HAA

8. *AARP Health Care Options®.* AARP Health Care Options is your trusted source for health products, health insurance plans, health services, and information for men and women age 50+. AARP Health Care Options makes available Hospital Indemnity, Hospital Advantage, Supplemental Medical, Long-Term Care, Medical Advantage, Medicare Supplement, Medicare Select, and Personal Health Insurance. Prescription discounts are available to AARP members at more than 56,000 participating retail pharmacies or through the mail order service. In addition, AARP members have access to healthy living catalogs and home delivery of Medicare-reimbursed medical supplies. Members can also save on eye care and eyewear.

9. *AARP Rewards Platinum VISA® card.* Offers a full 1% back on purchases, starting with your very first purchase. No gimmicks or spending thresholds to meet like other credit cards, and you can redeem for cash back or gift certificates to leading retailers. No Annual Fee, No Telemarketing, 100% Fraud Liability Protection.

10. *AARP Automobile and Homeowners Insurance.* The Hartford saves members who switch an average of $300 on auto insurance with a unique package of benefits and discounts not available from other companies. Besides savings, you'll enjoy a 6-Point Claim Service Guarantee, an exclusive 12-Month Rate-Lock, Lifetime Renewability, and much more. Plus, take advantage of special Homeowners protection offering you competitive rates, generous discounts, and Full-Value Replacement. Both the Auto and Home Insurance Programs offer a level of service designed exclusively for AARP members.

11. *AARP Home Business Insurance.* Members can also rely on The Hartford to protect their small/home business and commercial automobiles. You'll benefit from affordable rates and customized coverage that are designed to meet your special needs without straining your budget. Great protection, great rates — all with the first-class service AARP members have come to expect from The Hartford.

12. *AARP Life Insurance.* Term and permanent coverage provided by New York Life is available to help AARP members protect their families with a wide choice of benefit amounts and affordable premiums. It's easy to apply — there's no physical exam.

13. *AARP Mobile Home Insurance.* This unique insurance plan was developed by The Foremost Insurance Group expressly for AARP members who own or rent mobile homes.

14. *AARP Motoring Plan.* Take the trauma out of travel with this low-cost plan provided by GE, and backed by a nationwide emergency road and towing service network.

15. *AARP Legal Services Network.* Provides a free initial consultation with a network attorney. You'll receive information about your concerns as well as legal advice and options available to you. Reduced fees are available for preparation of a simple will, durable financial power of attorney, health care power of attorney, and more.

Join AARP today... and access all of the opportunities membership has to offer. You'll agree that it's one of the best values around.

Log on to **www.AARP.org/benefits** for the latest AARP benefit information and news.

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APPLICATION FORM

AARP Medicare Supplement Insurance Plans

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

AARP Membership Number (If you are already a member)

First Name MI Last Name

Address Line 1

Address Line 2

City ST Zip

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

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

- If not an AARP member, please be sure to include your AARP Membership Application and a check or money order for your $12.50 annual AARP Membership dues.
- If return envelope is lost or misplaced, please mail to: AARP Health, United HealthCare Enrollment Division, P.O. Box 105331, Atlanta, GA 30348-5331.

1 TELL US ABOUT YOURSELF

( ) –

Area Code Phone Number

Birthdate M M D D Y Y Y Y

Gender ○ M ○ F

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

MEDICARE HEALTH INSURANCE

NAME

First / Middle Initial / Last

MEDICARE CLAIM #

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

MEDICAL (PART B) EFFECTIVE DATE: M M 0 1 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.)

YOUR SPOUSE

Name

First

Middle Initial

Last

Birthdate M M D D Y Y Y Y

Gender ○ M ○ F

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

MEDICARE HEALTH INSURANCE

NAME

First / Middle Initial / Last

MEDICARE CLAIM #

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

MEDICAL (PART B) EFFECTIVE DATE: M M 0 1 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.)

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CONTINUE ON NEXT PAGE

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

I wish to apply for: ○ **AARP Medicare Supplement Plan** _____ (indicate plan code)
○ **AARP Medicare Select Plan C**

My spouse wishes to apply for: ○ **AARP Medicare Supplement Plan** _____ (indicate plan code)
○ **AARP Medicare Select Plan C**

- **You are eligible to apply if you are an AARP member, or the spouse of a member, age 65 or older, enrolled in Medicare Parts A and B and not duplicating Medicare Supplement coverage.**
- 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.)

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

My Spouse's Requested Effective Date (first of the future month) 0 1 — M M D D Y Y Y Y

3 YOUR ACCEPTANCE MAY BE GUARANTEED

You	Your Spouse	
○ Yes ○ No	○ Yes ○ No	a) Did you turn age 65 in the last 6 months?
○ Yes ○ No	○ Yes ○ No	b) Did you enroll in Medicare Part B within the last 6 months?

If you answered YES to either of the questions above, your ACCEPTANCE IS GUARANTEED and you can SKIP TO NUMBER 5.

○ Yes ○ No	○ Yes ○ No	c) 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 and **SKIP TO NUMBER 5**.

If you answered NO to a, b, and c above, 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.

Have you been diagnosed with 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?

You ○ Yes ○ No

Your Spouse ○ 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.

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5 (CONTINUED)

- 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.
- 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).

You	Your Spouse	
		Please answer all questions to the best of your knowledge.
		If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying your 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 darken the appropriate circle with Black or Blue ink.
○ Yes ○ No	○ Yes ○ No	1) Did you turn age 65 in the last 6 months?
○ Yes ○ No	○ Yes ○ No	1a) Did you enroll in Medicare Part B in the last 6 months?
○ Yes ○ No	○ Yes ○ No	1b) If yes, what is the effective date?
		You __/__/____ (M M D D Y Y Y Y) **Your Spouse** __/__/____ (M M D D Y Y Y Y)
○ Yes ○ No	○ Yes ○ No	2) 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 3a.
○ Yes ○ No	○ Yes ○ No	2a) Will Medicaid pay your premiums for this Medicare supplement policy?
○ Yes ○ No	○ Yes ○ No	2b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
○ Yes ○ No	○ Yes ○ No	3a) 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" blank.
		You
		START __/__/____ (M M D D Y Y Y Y) END __/__/____ (M M D D Y Y Y Y)
		Your Spouse
		START __/__/____ (M M D D Y Y Y Y) END __/__/____ (M M D D Y Y Y Y)
○ Yes ○ No	○ Yes ○ No	3b) 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	○ Yes ○ No	3c) Was this your first time in this type of Medicare plan?
○ Yes ○ No	○ Yes ○ No	3d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

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5 (CONTINUED)

You	Your Spouse	
○ Yes ○ No	○ Yes ○ No	4a) Do you have another Medicare supplement policy in force?
		4b) If so, with what company and what plan do you have?
		You
		Your Spouse
○ Yes ○ No	○ Yes ○ No	4c) If "yes," do you intend to replace your current Medicare supplement policy with this policy?
○ Yes ○ No	○ Yes ○ No	5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.)
		5a) If "yes," with what company and what kind of policy?
		You
		Your Spouse
		5b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)
		You START M M D D Y Y Y Y END M M D D Y Y Y Y
		Your Spouse START M M D D Y Y Y Y END M M D D Y Y Y Y
○ Yes ○ No	○ Yes ○ No	5c) Are you replacing the other health insurance indicated in question 5a?

✗ _____
YOUR SIGNATURE (REQUIRED)

✗ _____
YOUR SPOUSE'S SIGNATURE (REQUIRED)

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 declare that the answers on this application are complete and true 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 incomplete, incorrect or untrue, United HealthCare Insurance Company may have the right to rescind my coverage, adjust my premium, or reduce my benefits.

  Any person who, knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- 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:**
  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 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

CONTINUE ON NEXT PAGE ▶

6 (CONTINUED)

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, insurance company, or other organization, institution, or person 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.
- If you are enrolling in the Medicare Select Plan: I acknowledge that I have received an Outline of Coverage, Grievance Procedure, Provider Directory and a Medicare Select Disclosure Statement covering Provider Restrictions, Right to Replace Your Medicare Supplement Plan and Quality Assurance Program. I affirm that I understand the benefits, restrictions, limitations and other provisions of the Medicare Select Plan for which I am applying.

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

✗ _____
YOUR SIGNATURE (REQUIRED) TODAY'S DATE (REQUIRED) M M D D Y Y Y Y

✗ _____
YOUR SPOUSE'S SIGNATURE (REQUIRED) TODAY'S DATE (REQUIRED) M M D D Y Y Y Y

7 AGENT INFORMATION

Agent 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

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PO Box 8220
Philadelphia, PA 19101-8220

✓Save $24.00 a Year with Electronic Funds Transfer (EFT)

The Easiest Way to Pay!

Over 1.6 million AARP members nationwide are enjoying the convenience of Electronic Funds Transfer (EFT). With EFT, your monthly payment will automatically be deducted from your checking or savings account. If you use EFT, 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.

Here's How to Sign Up:

- Complete the Authorization Form below. Return it with the application. If necessary, under separate cover you may receive an additional payment coupon before your first withdrawal is made.
- 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 canceled check.

- It will take approximately two months for the service to begin. We will notify you by letter of your EFT start date.

BA9915 12/07

(Over, please)

EFT

Authorization Form

I (we) authorize United HealthCare Insurance Company (United HealthCare Insurance Company of New York for New York residents) through AARP Health 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):_____

Bank Name: _____

Bank Routing No.: _____ Bank Account No.:_____

(see reverse for diagram)

Account Type ☐ Checking ☐ Savings (statement savings only)

— The reverse side of this form must also be completed —

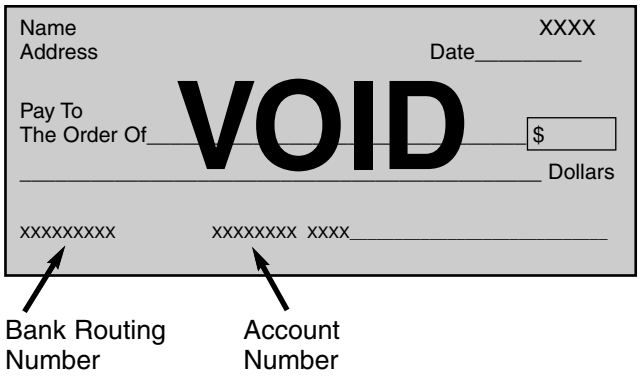
Please do not write in the space below for company use only.

EFT PAYMENT

0000008 0000431 0065 0128 UMS0612 01

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.



Should you have any questions, please call us toll-free 1-800-523-5800. Customer Service Representatives are available weekdays from 7 a.m. to 11 p.m. and Saturdays from 9 a.m. to 5 p.m., Eastern Time.

We look forward to continuing to serve you.

This authority remains in effect until United HealthCare Insurance Company (United HealthCare Insurance Company of New York for New York residents) through AARP Health and BANK receives notification from me (or either of us) of its termination in such time and manner as to give United HealthCare Insurance Company through AARP Health 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 arrears and subject to cancellation.

Name(s):_____

Membership Number: _____ Date:_____

Signature: _____

Your Spouse's Signature _____

(if joint account is maintained)

PO Box 8220, Philadelphia, PA 19101-8220

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

PO Box 8220
Philadelphia, PA 19101-8220

✓Save $24.00 a Year with Electronic Funds Transfer (EFT)

The Easiest Way to Pay!

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That's up to $24.00 a year! In addition:

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- You don't have to take time to write a check each month.
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- 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 canceled check.

- It will take approximately two months for the service to begin. We will notify you by letter of your EFT start date.

BA9915 12/07

(Over, please)

EFT

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I (we) authorize United HealthCare Insurance Company (United HealthCare Insurance Company of New York for New York residents) through AARP Health 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):_____

Bank Name: _____

Bank Routing No.: _____ Bank Account No.:_____

(see reverse for diagram)

Account Type ☐ Checking ☐ Savings (statement savings only)

— The reverse side of this form must also be completed —

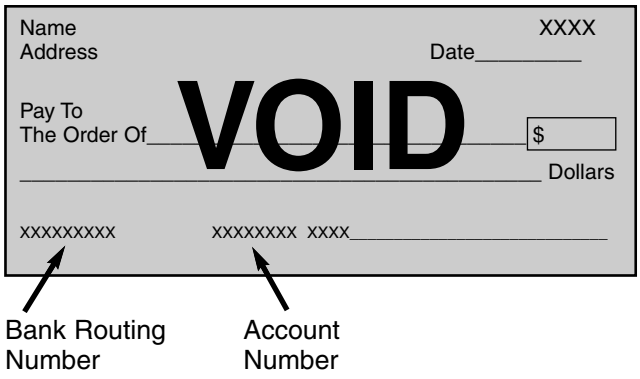
Please do not write in the space below for company use only.

EFT PAYMENT

0000008 0000432 0067 0128 UMS0612 01

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.



Should you have any questions, please call us toll-free 1-800-523-5800. Customer Service Representatives are available weekdays from 7 a.m. to 11 p.m. and Saturdays from 9 a.m. to 5 p.m., Eastern Time.

We look forward to continuing to serve you.

This authority remains in effect until United HealthCare Insurance Company (United HealthCare Insurance Company of New York for New York residents) through AARP Health and BANK receives notification from me (or either of us) of its termination in such time and manner as to give United HealthCare Insurance Company through AARP Health 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 arrears and subject to cancellation.

Name(s):_____

Membership Number: _____ Date:_____

Signature: _____

Your Spouse's Signature _____

(if joint account is maintained)

PO Box 8220, Philadelphia, PA 19101-8220

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE
UNITED HEALTHCARE INSURANCE COMPANY
Fort Washington, 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 United HealthCare 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.

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.

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)

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