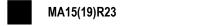
## PART I: APPLICANT INFORMATION

Plan Code  (Refer to Rate Card)  *Medicare first eligil  Select Plan Applying for  Applicant's First Name  Last Name	ole before	before 2020 only			O F* O N			y) DF*	Mode of Premium				m	Method of Payment  O Send Premium Notices  O Automatic Payment Plan  M.I					;	Draft Date  Day (01-28) of the Month to Draft Bank Account				
Applicant's Mailin	Addres	ss:																						
Street or Route																								
City																						State		
Zip Code					Со	unty																		
If Applicant's Resi	dence A	ddress	is d	iffere	nt from	n Mail	ing A	Addre	ess,	shov	v be	low:			•									
Street or Route																								
City																						State		
Zip Code					Со	unty																		
Social Security Number Date of Birth (mm-dd-yyyy)			<b>-</b>						Ag Bi	je Las	' st [	eight			Sex	, –	Male Fem	(l	ght** bs.)					_
Have you used tobe  **Do not provide tobe  E-mail Address of  Proposed Insured								rollm	ent	and/c	or gu	aran	teed	issue	<b>9</b> .							- O'	Yes	O No
Verification Information	A record necessal underwri insuranc time and	ry as parting of e. The	art of your mos	the applic t conv	ation for	or O	8 AN Noo	n - 6	PM				one N	L				<b>-</b> [						











### PART II: ELIGIBILITY QUESTIONS

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.

10	THE BEST OF YOUR KNOWLEDGE:	Yes No
1.	(a) Did you turn age 65 in the last six (6) months?	_ 00
	(b) Did you enroll in Medicare Part B in the last six (6) months?	00
	(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.  If you answered "YES":	)" Yes No () ()
	(a) Will Medicaid pay your premiums for this Medicare Supplement policy?	_ 00
	(b) Do you receive any benefits from Medicaid OTHER THAN payment towards your Medicare Part B premium?	_ 00
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" by START Date (mm-dd-yyyy) - END Date (mm-dd-yyyy) - END Date (mm-dd-yyyy)	olank.
	(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	Yes No
	(c) Was this your first time in this type of Medicare plan?	_ 00
	(d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan?	_ 00
4.	(a) Do you have another Medicare Supplement policy in force?	00
	(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?	_ 00
5.	Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan	) 00
	(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)  -   -   -   -   -   -   -   -   -   -	
3.	Are you over age 65 and within 6 months of your enrollment in Medicare Part B, or otherwise qualified for guaranteed issue (including having had your employee welfare benefit plan terminated)?  (Questions 7-17 not required if the answer to question 6 is "YES.")  MA15(19)R23  (Application Continued)	Yes No

Proposed Insured \_\_\_\_

PART II: ELIGIBILITY QUESTIONS (continued)

	YOU ARE APPLYING DURING OPEN ENROLLMENT OR YOUR GUARANTEE ISSUE PERIOD, <b>DO NOT</b> ANSWER QUESTIONS 7-17.										
	ease see form BBADEF(19)R23, provided with this application, to help you determine if you are applying during a guaranteed issue or open rollment period.	V N.									
7.	Are you currently hospitalized, confined to a nursing facility or receiving Medicare approved home health care, or have you been	Yes No									
	hospitalized or received Medicare approved home health care 2 or more times in the past 12 months?  Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD), or pulmonary fibrosis within the	_00									
	last 7 years?	_ 0 0									
	Within the past 7 years, have you been bedridden or needed a wheelchair for any daily activity, or have you been diagnosed by a licensed health care provider with Gaucher's Disease or any other type of lysosomal storage disorder, or have you had any type of										
	amputation caused by disease?  Have you been advised by a licensed health care provider that surgery may be required within the payt twelve months for cataracts?	_ 0 0 _ 0 0									
	). Have you been advised by a licensed health care provider that surgery may be required within the next twelve months for cataracts?										
11.	Lateral Sclerosis, Alzheimer's disease, senile dementia, or organic brain disorder?	- 00									
	Within the past 7 years, have you been treated or diagnosed by a licensed health care provider or tested positive as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or conditions										
	derived from such infection?	_ 0 0									
	Within the past 7 years, have you had diabetes requiring more than 50 units of insulin daily?	_00									
14.	Within the past 2 years, have you been diagnosed or treated by a licensed health care provider for internal cancer, melanoma, leukemia, alcoholism or drug abuse, cirrhosis, mental or nervous disorder requiring psychiatric care, or have you been advised by a licensed health										
	care provider to have kidney dialysis?	_00									
	Within the past 2 years, have you been diagnosed or treated by a licensed health care provider for heart attack, peripheral vascular	0.0									
	disease, congestive heart failure, heart valve disorder, stroke, or transient ischemic attacks (TIA)?  Within the past 2 years, have you been diagnosed or treated by a licensed health care provider for rheumatoid arthritis or crippling	-00									
	arthritis?	_00									
	Within the past year, have you been fed intravenously or through a tube, have you been medically advised by a licensed health care provider to have surgery for joint replacement or for a heart condition, but not had such surgery, or have you been advised by a licensed										
	health care provider to have other surgery that has not been performed?	_00									
	PART III										
l.	INVOLUNTARY TERMINATION OF COVERAGE:										
If	f your previous coverage was terminated involuntarily, please provide a copy of the notice of termination of coverage and attach it to this for	m.									
V	Vhat type of coverage was terminated?										
	Pate of termination?										
II.	VOLUNTARY TERMINATION OF COVERAGE:										
	you voluntarily terminated your present coverage, please attach evidence of previous coverage to this form.										
	Vhat type of coverage was terminated?										
	Date of termination? Reason for termination?										
	(mm-dd-yyyy) L L L L L L L L L L L L L L L L L	Yes No									
1.	Was this the first time you were ever enrolled in a Medicare Advantage plan or purchased a Medicare Select policy?	-00									
	If so, did you have the Medicare Advantage plan or Medicare Select policy for less than 12 months?	-00									
2.	Did you have a Medicare Supplement policy before applying for the Medicare Advantage plan or Medicare Select policy?	_00									
	If "YES", with which Company and which Medicare Supplement plan?										
		_									
	Is that Company still offering that Medicare Supplement plan?	_ 0 0									
	* Medicare Advantage plan means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.	ans									

Initials of Proposed Insured

59971

Pg 3

#### PART IV: 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. 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. This paragraph does not apply if you are guaranteed issue as an eligible person.

I, HEREBY AUTHORIZE MIB, LLC ("MIB"), any insurance company, hospital, physician, or other practitioner that possesses any records of me or my physical or mental health and/or treatment, and any pharmacy or any pharmacy benefits manager that possesses prescription history about me, to give any and all such information to United American Insurance Company, or its reinsurers, for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case, it may not be protected under federal privacy rules. I authorize United American Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. This authorization shall be valid for two years from this date and may be revoked by sending written notice to United American Insurance Company at P.O. Box 8080 McKinney, TX 75070. I understand that I may request a copy of this authorization from United American Insurance Company or request a copy of the information in MIB's files by writing to MIB at MIB, LLC. 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or calling (866) 692-6901. I acknowledge receipt of the MIB Pre-Notice. A photographic copy of this authorization will be as valid as the original.

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 knowingly **or** willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly **or** willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Amount paid with application: \$,	App	Application Signed at City													Stat	te	On	On this Date (mm-dd-yyyy)										
for first months premiums.																						-			<b>]</b>			
Applicant's Signature	Amount paid with application: \$ ,																											
							A	pplic	ant's	Sigr	natur	e					for fi		Tota	╛		Φ.	nium				].[	

Initials of Proposed Insured

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Pg 4

### PART V: INSURANCE PRODUCER'S CERTIFICATION

MAIL POLICY TO: O Insurance Producer O Insured (The Policy will be sent to Insured unless otherwise instructed.)

MA15(19)R23





# **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	14 <sup>th</sup>								
Third Wednesday	11 <sup>th</sup> - 20 <sup>th</sup>	21st								
Fourth Wednesday	21st - 31st	28 <sup>th</sup>								

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

48030

UAI1756 **0423**