

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

PART I: APPLICANT INFORMATION

<b>Plan Code</b> <div><div></div><div></div><div></div></div> (Refer to Rate Card) *Medicare first eligible before 2020 only	<b>Effective Date Requested (mm-dd-yyyy)</b> <div><div></div><div></div><div></div><div></div><div></div><div></div></div>	<b>Mode of Premium</b> <input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Quarterly <input type="radio"/> Monthly	<b>Method of Payment</b> <input type="radio"/> Send Premium Notices <input type="radio"/> Automatic Payment Plan	<b>Draft Date</b> Day (01-28) of the Month to Draft Bank Account <div><div></div><div></div></div>
<b>Select Plan Applying for</b> <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C* <input type="radio"/> D <input type="radio"/> F* <input type="radio"/> HDF* <input type="radio"/> G <input type="radio"/> HDG <input type="radio"/> K <input type="radio"/> L <input type="radio"/> N				

Applicant's First Name   
Last Name  M.I.

Applicant's Mailing Address:

Street or Route   
City  State   
Zip Code  County

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

Street or Route   
City  State   
Zip Code  County

Social Security Number  -  -  Height\*\*  (ft. in.) Weight\*\*  (lbs.)  
Date of Birth (mm-dd-yyyy)  -  -  Age Last Birthday  Sex ☐ Male ☐ Female

Have you used tobacco in any form in the past 12 months?\*\* ----- ☐ Yes ☐ No

\*\*Do not provide this information if you are eligible for open enrollment and/or guaranteed issue.

E-mail Address of Proposed Insured

<b>Application Verification Information</b>	A recorded interview may be necessary as part of the underwriting of your application for insurance. The most convenient time and place for the interview is:	<input type="radio"/> 8 AM - Noon <input type="radio"/> Noon - 6 PM <input type="radio"/> 6 PM - 9 PM	Home Phone No. <div><div></div><div></div><div></div></div> - <div><div></div><div></div><div></div></div> - <div><div></div><div></div><div></div><div></div><div></div><div></div></div>
			Work Phone No. <div><div></div><div></div><div></div></div> - <div><div></div><div></div><div></div></div> - <div><div></div><div></div><div></div><div></div><div></div><div></div></div>

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.**

TO THE BEST OF YOUR KNOWLEDGE:

Yes No

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

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

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

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(d) What is your Medicare Claim Number? 

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(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":

(a) Will Medicaid pay your premiums for this Medicare Supplement policy? ----- ☐ ☐

(b) Do you receive any benefits from Medicaid OTHER THAN payment towards your Medicare Part B premium? ----- ☐ ☐

3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END Date" blank.

START Date (mm-dd-yyyy) 

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END Date (mm-dd-yyyy) 

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Yes No

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ----- ☐ ☐

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

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

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

(b) If so, with what company, and what plan do you have? \_\_\_\_\_

(c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ----- ☐ ☐

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

(a) If so, with what company and what kind of policy?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END Date" blank.)

START Date (mm-dd-yyyy) 

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END Date (mm-dd-yyyy) 

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Yes No

6. Are you applying within 6 months of your enrollment in Medicare Part B or otherwise qualified for guaranteed issue? ----- ☐ ☐  
(Questions 7-17 not required if the answer to question 6 is "YES.")



PART II: ELIGIBILITY QUESTIONS (continued)

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

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

PART III

I. INVOLUNTARY TERMINATION OF COVERAGE:

If your previous coverage was terminated involuntarily, please provide a copy of the notice of termination of coverage and attach it to this form.

What type of coverage was terminated? \_\_\_\_\_

Date of termination?   -   -     Reason for termination? \_\_\_\_\_  
(mm-dd-yyyy)

II. VOLUNTARY TERMINATION OF COVERAGE:

If you voluntarily terminated your present coverage, please attach evidence of previous coverage to this form.

What type of coverage was terminated? \_\_\_\_\_

Date of termination?   -   -     Reason for termination? \_\_\_\_\_  
(mm-dd-yyyy)

If you voluntarily terminated coverage under a Medicare Advantage plan\* or Medicare Select policy, please answer the following questions: Yes No

- |   |                       |                       |                       |                       |                       |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Was this the first time you were ever enrolled in a Medicare Advantage plan or purchased a Medicare Select policy?   | <input type="radio"/> | <input type="radio"/> |                       |                       |                       |
| If so, did you have the Medicare Advantage plan or Medicare Select policy for less than 12 months?                      |                       | <input type="radio"/> | <input type="radio"/> |                       |                       |
| 2. Did you have a Medicare Supplement policy before applying for the Medicare Advantage plan or Medicare Select policy? | <input type="radio"/> | <input type="radio"/> |                       |                       |                       |
| If "YES", with which Company and which Medicare Supplement plan?  |                       |                       |                       |                       |                       |
| _____   |                       |                       |                       |                       |                       |
| Is that Company still offering that Medicare Supplement plan?   |                       |                       |                       | <input type="radio"/> | <input type="radio"/> |

\* 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), and 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; (2) 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.



## PART IV: APPLICANT AUTHORIZATION

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

Applicant's Signature

**PART V: AGENT CERTIFICATION**

The undersigned Agent certifies that he/she has ☐ / has not ☐ personally met with the Applicant and that the Applicant has read, or had read to him/her, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

**AGENT COMPLETES** (Attach separate sheet, if necessary.)

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

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

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

Last Name

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Agent No.

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Agent's Signature

**MA15(21)R**

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

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

Proposed Insured's Social Security Number

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Requested Bank Draft Day (dd)

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[illegible]

**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.

Paula C. Holder		0001
123 Main St.		
Hometown, TX 75432		
TXDL 12345678		
Date _____		
PAY TO _____	\$ _____	
THE ORDER OF _____		
_____ Dollars		
Hometown Bank		
FDIC		
VOID		
Memo _____	_____	
123456789	1234567890	0001

Bank ABA  
Routing Number

Account  
Number

Check  
Number

Helpful Information for Social Security Recipients		
Social Security Benefits Paid On	Birth Date On	Draft Date
Second Wednesday	1 <sup>st</sup> – 10 <sup>th</sup>	14 <sup>th</sup>
Third Wednesday	11 <sup>th</sup> – 20 <sup>th</sup>	21 <sup>st</sup>
Fourth Wednesday	21 <sup>st</sup> – 31 <sup>st</sup>	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 - Business 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)**