MEDMUTUAL PROTECT™
A Medical Mutual® Company

Insurance benefits provided by:
United Insurance Company of America
Chicago, Illinois
Administrative Office: PO Box 10862
Clearwater, FL 33757-8862

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE COVERAGE

(Check one)	☒ New Business	☐ Reinstatement Policy #:	☐ Conversion Policy #:

SECTION 1. PROPOSED INSURED INFORMATION **APPLICATION#**

Applicant Name *(exactly as it appears on your Medicare Card)*

First Name	Middle Initial	Last Name
Resident Address		
City	State	Zip Code
Phone *(with area code)*	Email Address	
Age	Date of Birth *(MM/DD/YYYY)*	
Height (*Feet and inches*)	Weight (*Pounds*)	Male ☐ Female ☐
Social Security Number	Medicare Number	
Date Enrolled in Medicare Part A *(MM/DD/YYYY)*		
Date Enrolled in Medicare Part B *(MM/DD/YYYY)*		
Have you enrolled in Medicare Part B more than once?		Yes ☐ No ☐

SECTION 2. PLAN AND PREMIUM INFORMATION

Plan Applied For	Requested Policy Effective Date
Household Premium Discount Yes ☐ No ☐ *If you answered Yes, please complete the Household Questions in Section 8.*	
Modal Premium $	Premium Collected $ Policy Fee $
Payment Method:	Bank Draft ☐ Direct Bill ☐
Payment Mode: ☐ Monthly *(Bank Draft ONLY)* ☐ Annual ☐ Semi-Annual ☐ Quarterly	

SECTION 3. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS

1. Are you eligible for Medicare due to Disability or End Stage Renal Disease (ESRD)? Yes ☐ No ☐

If YES, please check the box that applies ☐ Disability ☐ End Stage Renal Disease (ESRD)

2. Are you applying during a guaranteed issue period? Yes ☐ No ☐
   (If YES you must attach proof of eligibility).

SECTION 4. HEALTH QUESTIONS

Applicants eligible for GUARANTEED ISSUE or OPEN ENROLLMENT, go to Section 7. If not PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

Within the past 12 months, have you used any tobacco products, including cigarettes, cigars, eCigarettes, chewing tobacco, or a pipe? Yes ☐ No ☐

IF THE ANSWER TO ANY PART OF QUESTIONS #1-8 IN THIS SECTION IS YES, THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE.

1. Are you bedridden, confined to a wheelchair, or do you require the assistance of a motorized mobility device, or have you had any amputation caused by disease? Yes ☐ No ☐
2. Are you currently hospitalized, in a nursing home or assisted living facility, or have you been hospitalized three or more times in the past two years? Yes ☐ No ☐
3. Are you currently receiving any occupational, speech, or physical therapy, or are you currently using the services of a home healthcare agency? Yes ☐ No ☐
4. Have you been advised by a physician to have surgery (including cataract or joint replacement surgery), medical tests, injections in a physician's office, infusions, or therapy that has not been performed? Yes ☐ No ☐
5. At any time, have you had, been medically diagnosed with, or treated for any of the following:
   a. Parkinson's disease, multiple or amyotrophic lateral sclerosis, muscular dystrophy, Alzheimer's disease, dementia, or any other cognitive disorder? Yes ☐ No ☐
   b. Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)? Yes ☐ No ☐
   c. Chronic kidney disease or insufficiency, or renal failure requiring dialysis? Yes ☐ No ☐
   d. Emphysema, chronic obstructive pulmonary disease (COPD), or any other chronic pulmonary condition, or any medical condition requiring the use of oxygen? Yes ☐ No ☐
   e. Systemic Lupus, scleroderma, or myasthenia gravis? Yes ☐ No ☐
   f. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)? Yes ☐ No ☐
   g. Chronic hepatitis or cirrhosis of the liver? Yes ☐ No ☐
   h. Cardiac defibrillator implanted? Yes ☐ No ☐
6. Within the past two (2) years, have you had any of the following:
   a. Heart attack, cardiac angioplasty, bypass surgery, or stent placement or replacement? Yes ☐ No ☐
   b. Vascular angioplasty, endarterectomy, or implantation of a pacemaker? Yes ☐ No ☐
   c. A stroke or transient ischemic attack (TIA)? Yes ☐ No ☐

SECTION 4. HEALTH QUESTIONS (Continued)

7. Within the past two (2) years have you had, been treated for, or been advised by a physician to have treatment for:

   a. Alcoholism or drug abuse? Yes ☐ No ☐

   b. Internal cancer (examples include but are not limited to breast, lung or liver cancer, etc.), leukemia, melanoma, Hodgkin's disease, or lymphoma? Yes ☐ No ☐

   c. Arthritis that restricts mobility? Yes ☐ No ☐

8. Do you have diabetes or take medication to control your blood sugar? If so, please answer each of the following questions (a-d).

   a. Have you ever required or been advised to take more than fifty (50) units of insulin daily? Yes ☐ No ☐

   b. Do you take three (3) or more medications (oral or injections) to control your blood sugar? Yes ☐ No ☐

   c. Do you take three (3) or more medications to control your high blood pressure? Yes ☐ No ☐

   d. Have you been diagnosed with or treated for any of the following conditions: peripheral vascular disease, peripheral venous thrombotic disease, peripheral artery disease, kidney disease, kidney failure, stroke, TIA, congestive heart failure, or any heart disorder? Yes ☐ No ☐

SECTION 5. CONSIDERATION HEALTH QUESTIONS

If you answer YES to any of the following health questions, your application will be submitted to underwriting for review.

Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for:

   (a) Coronary artery disease, angina, aortic or cardiac aneurysm, cardiomyopathy, congestive heart failure, heart valve disorder, atrial fibrillation, or other heart rhythm disorder? Yes ☐ No ☐

   (b) Peripheral artery disease, peripheral vascular disease, peripheral venous thrombotic disease, or carotid artery disease? Yes ☐ No ☐

   (c) Degenerative bone disease, spinal stenosis, or rheumatoid arthritis? Yes ☐ No ☐

   (d) Any mental or nervous disorder requiring treatment by a psychiatrist? Yes ☐ No ☐

YOU MUST EXPLAIN ANY YES ANSWERS ABOVE AND PROVIDE DATES AND DETAILS

SECTION 6. MEDICATION HISTORY

Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes ☐ No ☐

If YES, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	

SECTION 6. MEDICATION HISTORY (Continued)	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date Originally Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	

SECTION 7. REPLACEMENT 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:

1. (a) Did you turn age 65 in the last six (6) months? Yes ☐ No ☐
   (b) Did you enroll in Medicare Part B in the last six (6) months? Yes ☐ No ☐
   (c) If YES, indicate your effective date (*MM/DD/YYYY*) _____
2. Are you covered for medical assistance through the state Medicaid program? Yes ☐ No ☐

(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to the above question.)

SECTION 7. REPLACEMENT QUESTIONS (Continued)

If YES, answer (a) – (b) below.

(a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes ☐ No ☐

(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium. Yes ☐ No ☐

3. Have 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.) Yes ☐ No ☐

If YES, answer (a) – (g) below.

(a) Name of Company _____

Plan Type & Policy/Certificate No _____

Company Telephone Number _____

Coverage Dates (*MM/DD/YYYY*) START DATE _____

Enter date coverage will be canceling or ending. END DATE _____

(if you are still covered under this plan, leave end date blank) _____

(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 ☐

If YES, have you completed and received a copy of the replacement notice? Yes ☐ No ☐

(c) Reason for termination/disenrollment? _____

(d) Planned date of termination/disenrollment? (*MM/DD/YYYY*) _____

(e) Was this your first time in this type of Medicare plan? Yes ☐ No ☐

(f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes ☐ No ☐

(g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes ☐ No ☐

4. Do you have another Medicare Supplement or Medicare Select insurance policy in force? Yes ☐ No ☐

If YES, answer (a) – (d) below.

Name of Company _____

Plan Type & Policy/Certificate No _____

Company Telephone Number _____

Issue Date (*MM/DD/YYYY*) _____

(b) Do you intend to replace your current Medicare supplement or Medicare select policy/certificate with this policy? Yes ☐ No ☐

(c) Indicate termination date (*MM/DD/YYYY*). _____

(d) Have you completed and received a copy of the replacement notice? Yes ☐ No ☐

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.) Yes ☐ No ☐

If YES, answer (a) – (c) below.

(a) Name of Company _____

Plan Type & Policy/Certificate No _____

Company Telephone Number _____

Coverage Dates (*MM/DD/YYYY*): START DATE _____

(if you are still covered under this plan, leave end date blank) END DATE _____

(b) Reason for termination/disenrollment? _____

(c) Planned date of termination/disenrollment (*MM/DD/YYYY*)? _____

SECTION 8. HOUSEHOLD PREMIUM DISCOUNT INFORMATION

You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section (answer Question 1 or 2 below, but not both).

1. Are you applying for a United Insurance Company of America Medicare Supplement policy at the same time another Medicare eligible adult is also applying for a Medicare Supplement policy with this Company and that individual is either:

   (a) A member of your household with whom you are currently residing and have continuously resided for the last twelve (12) months (limited to three Medicare eligible adults; or Yes ☐ No ☐

   (b) Someone with whom you are currently residing and who is your spouse or whom you are in a civil union partnership? Yes ☐ No ☐

If you answered "yes" to Question 1 (a) or (b) above, please complete the following information on the other Medicare eligible adult:

Name (First/Middle/Last) _____

Street Address _____

City/State/Zip _____

Name (First/Middle/Last) _____

Street Address _____

City/State/Zip _____

Name (First/Middle/Last) _____

Street Address _____

City/State/Zip _____

Upon verification of eligibility and approval of your application, you and the individual named above will qualify for the household premium discount.

2. Is there another Medicare eligible adult who is **currently covered** under a United Insurance Company of America Medicare Supplement policy and that individual is either:

   (a) A member of your household with whom you are currently residing and have continuously resided for the last twelve (12) months (limited to three Medicare eligible adults); or Yes ☐ No ☐

   (b) Someone with whom you are currently residing and who is your spouse or whom you are in a civil union partnership? Yes ☐ No ☐

If you answered YES to Question 2 (a) or (b) above, please complete the following information on the other Medicare eligible adult(s):

Name (First/Middle/Last) _____

Policy Number _____ Company_____

Street Address _____

City/State/Zip _____

SECTION 8. HOUSEHOLD PREMIUM DISCOUNT INFORMATION (Continued)

Name (First/Middle/Last) _____

Policy Number _____ Company_____

Street Address _____

City/State/Zip _____

Name (First/Middle/Last) _____

Policy Number _____ Company_____

Street Address _____

City/State/Zip _____

Upon verification of eligibility and approval of your application, you and the individual(s) named above will qualify for the household premium discount.

SECTION 9. OTHER POLICIES SOLD BY AGENT TO APPLICANT

Agent shall list any other health insurance policies he/she has sold to the applicant.

(1) List all health insurance policies sold to the Applicant which are still in force.

Name of Company

Type of Policy

Policy/Certificate Number

Effective Date of Coverage

Name of Company

Type of Policy

Policy/Certificate Number

Effective Date of Coverage

Name of Company

Type of Policy

Policy/Certificate Number

Effective Date of Coverage

(2) List all health insurance policies sold in the last five (5) years which are no longer in force.

Name of Company

Type of Policy

Policy/Certificate Number

Effective Date of Coverage

SECTION 9. OTHER POLICIES SOLD BY AGENT TO APPLICANT (Continued)

Name of Company

Type of Policy

Policy/Certificate Number

Effective Date of Coverage

Name of Company

Type of Policy

Policy/Certificate Number

Effective Date of Coverage

SECTION 10. IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare Supplement policy.
- If you purchase this 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 Insurance Policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance 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 suspension.
- 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.
- Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy 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).

SECTION 11. ELECTRONIC AND/OR TELEPHONIC INSTRUCTIONS

Authorization is requested by the Company to act on electronic and/or telephonic instructions from the applicant. Proper identification must be provided. The Company will be held harmless for any claim, liability, loss or cost, when it has used reasonable procedures to confirm these transactions are authorized and genuine and these procedures have been followed (Check One).

☐ I authorize the Company to act on electronic and/or telephonic instructions.

☐ I DO NOT authorize the Company to act on electronic and/or telephonic instructions.

Authorization is requested by the Company for the electronic delivery of statements and other documents (Check One).

☐ I authorize the Company to electronically deliver statements and other documents. I do have access to the Internet for the purposes of accepting electronic delivery of the documents and a means by which I can provide a current Internet email address.

☐ I DO NOT authorize the Company to electronically deliver statements and other documents.

SECTION 12. AGREEMENT AND AUTHORIZATION

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete as written and are correctly recorded and I understand and agree that: (a) the insurance shall not take effect until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing.

The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

Notice: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I wish to apply for a Medicare Supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an Outline of Coverage for the policy applied for, and (b) a "*Guide to Health Insurance for People with Medicare*."

Authorization for Use and Disclosure of Protected Health Information: In connection with an application for insurance made to United Insurance Company of America (the "Company"), I, the undersigned Applicant, authorize the use and disclosure of protected health information about me as described below.

1. I understand that this authorization is necessary for the Company to determine my eligibility for insurance as part of the Company's underwriting and risk rating determinations. I understand that my application for insurance may be declined if I do not sign this authorization.

2. The following class of persons is authorized to make the disclosure: All physicians, medical practitioners, health professionals, hospitals, clinics, medical facilities, pharmacy benefit managers, pharmacy related service organizations, the Veterans Administration, reinsurers, consumer reporting agencies, insurance support organizations, or MIB, Inc.

SECTION 12. AGREEMENT AND AUTHORIZATION (Continued)

3. The Company, its agents, employees, and third-party administrators may receive my protected health information.

4. The protected health information that should be disclosed to the Company is: All my health records and information about my past, present or future physical or mental health or condition, health care I have received, and any related diagnosis, treatment or prognosis, including, but not limited to, any records that may relate to (a) psychological or psychiatric conditions (excluding psychotherapy notes), (b) drug abuse, (c) alcoholism, (d) sickle cell anemia, (e) tuberculosis or (f) communicable or venereal diseases which may include, but are not limited to, hepatitis, syphilis, gonorrhea, human immunodeficiency virus, acquired immune deficiency syndrome (AIDS) and AIDS related complex (excluding information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC).

5. I understand that the protected health information used or disclosed will not be redisclosed by the Company without my prior written authorization, unless permitted or required by federal privacy regulations or other applicable law. In the event of redisclosure of such information, it may then no longer be protected by federal privacy regulations.

6. I may revoke this authorization with respect to a recipient by notifying that recipient in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and any revocation will not affect those actions.

7. A photocopy of this authorization shall be considered as valid as the original.

8. This authorization expires 24 months after the date signed by me.

9. I understand that a copy of this authorization will be furnished to me or my authorized representative upon request.

I have paid to United Insurance Company of America the amount shown on Page 1 of this application, and I hold a receipt for that amount made up without alteration bearing the same date as this application.

Signed at:

_____	_____	_____	_____
State	Printed Name of Applicant	Signature of Applicant	Date

SECTION 13. AGENT CERTIFICATION

I certify that: (1) I have asked each question of the Applicant personally; (2) I have accurately recorded the information supplied by the Applicant; and (3) I have reviewed the current health coverage of the Applicant and have completed the information above, as applicable.

Agent Writing Number	_____ Printed Name of Agent	_____ Agent Signature
Agent Writing Number	_____ Agent Name	_____ Date
Policy Mailing Preference:	☐ Mail to Agent	☐ Mail to Applicant