#### PART I: APPLICANT INFORMATION

Plan Code	F	Effective Date Requested (mm-dd-yyyy)					Mode of Premium   Method of P					Date	\			D 6	. D.	4-										
					1.04		1			$\H \cap  $	O Annual				mıu	m	Method of Payment  O Send Premium Notices				Draft Date							
(Refer to Rate Card)	L											○ Semi-Annual			O Automatic Payment Plan			Day (01-28) of the Month to Draft Bank Account										
*Medicare first eligi										1	O Quarterly				Automatic Laymont Flair					Г	T							
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Applicant's First Name																												
Last Name																						M.I.						
Applicant's Mailin	g Addı	ress:																										
Street or Route																												
City																								Sta	te			
Zip Code							Cou	ınty																				
If Applicant's Resi	dence	Add	ress	is c	liffer	ent f	rom	Mai	ling A	Addr	ess,	sho	w be	low:			1	•	ı		1		· · · · ·					
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Date of Birth (mm-dd-yyyy)			_			-					Aç B	e La: irthda	st [				Sex		) Male Fem			_	•	•				
Have you used tob	Have you used tobacco in any form in the past 12 months? O Yes O No																											
E-mail Address of Proposed Insured																												
Application Verification Information	A reco neces unden insura time a	sary writin nce.	as paig of The	art o your mo:	f the appl st co	icati nven	on fo	or C	) 8 AN ) Noo ) 6 PN	n - 6	PM			e Pho						- [ - [				- [				





### 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.

TC	THE BEST OF YOUR KNOWLEDGE:	es 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" You to this question.  If you answered "YES:	res No
	(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?	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" blank.  START Date	
	(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)  (a) If so, with what company and what kind of policy?	00
	(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   -   -   END Date   -   -   -	
		Yes No
6.	Are you within 6 months of your enrollment in Medicare Part B or otherwise qualified for open enrollment?	00
	(Questions 7-17 not required if the answer to question 6 is "YES".)	

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PART II: ELIGIBILITY QUESTIONS (continued)

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

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?	Yes No								
8.	Do you have emphysema, Chronic Obstructive Pulmonary Disease (COPD), or pulmonary fibrosis?									
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?									
10	Have you been advised that surgery may be required within the next twelve months for cataracts?	- 0 0								
11	. Have you been diagnosed or treated for Parkinson's disease, Multiple or Lateral Sclerosis, Alzheimer's disease, senile dementia, or organic brain disorder?									
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?	- 00								
13	s. Do you have diabetes requiring more than 50 units of insulin daily?	0 0								
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?	- 00								
15	i. 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)?	0 0								
16	i. Within the past 2 years, have you been diagnosed or treated for rheumatoid arthritis or crippling arthritis?	-00								
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?	- 0 0								
	PART III	00								
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 that type of coverage was terminated?	n.								
	Date of termination? Reason for termination?									
II.	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?									
lf	(mm-dd-yyyy) LL LL LL LL	Yes No								
1	1. Was this the first time you were ever enrolled in a Medicare Advantage plan or purchased a Medicare Select policy?	0 0								
	If so, did you have the Medicare Advantage plan or Medicare Select policy for less than 12 months?	- 0 0								
2	2. Did you have a Medicare Supplement policy before applying for the Medicare Advantage plan or Medicare Select policy?	- 0 0								
	Is that Company still offering that Medicare Supplement plan?* 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), an 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.	d s								

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#### 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.

I authorize the MIB, Inc., any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to United American Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that any information obtained will not be released to any person or organization except to the MIB, Inc., reinsuring companies or other persons or organization performing business or legal services in connection with this application, with a claim or as may be otherwise lawfully required. I agree that a copy of this authorization is to be acceptable. This authorization will remain in effect for a period of 24 months from the date signed and I understand that I may revoke this authorization by writing the Company at United American Insurance Company, P. O. Box 8080, McKinney, TX 75070. Failure to sign this authorization statement may impair the company's ability to evaluate claims or process this application and may be a basis for denying this application or a claim for benefits. I understand that I or an authorized representative may request a copy of this authorization. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

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.

**WARNING:** Any person who, with intent to defraud or knowingly with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Application Signed at City		State On this Date (mm-dd-yyyy)	
		ount paid with application: \$,	].
Applicant's Signature		Total Premium \$ ,	
MA15(35)	Initials of Proposed Insured	(Application Continued)	2430 Pg 4

## PART V: AGENT CERTIFICATION

The undersigned Agent certifies that he/she has  $\square$  / has not  $\square$  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 und	er the policy.							
AGENT COMPL	ETES (Attach separate shee	et, if necessa	ary.)					
List any othe	r health insurance policy yo	u have sold	to the Applicar	nt which is still i	n force:			
2. List any othe	r health insurance policy yo	u have sold	to the Applicar	nt in the past fiv	re (5) years wh	ich is no longe	in force:	
	e accurately recorded the in nent Buyers Guide to the Ap		upplied by the	Applicant, (2) I I	have given an	outline of cove	rage for the p	oolicy applied for and a
Last Name	Agent No.							
	Agent's	s Signature						
MA15(35)	MAIL POLICY TO:	O Agent	O Insured	(The Policy will	be sent to Insi	ured unless oth	erwise instru	cted.)

Initials of Proposed Insured





## **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

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