

**APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE * UNITED AMERICAN INSURANCE COMPANY
A DELAWARE STOCK CO., WILMINGTON, DE * ADMINISTRATIVE OFFICE: MCKINNEY, TX**

PART I: APPLICANT INFORMATION

Plan Code <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <small>(Refer to Rate Card)</small>	Effective Date Requested (mm-dd-yyyy) <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/>	Mode of Premium <input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Quarterly <input type="radio"/> Monthly	Method of Payment <input type="radio"/> Send Premium Notices <input type="radio"/> Automatic Payment Plan	Draft Date Day (01-28) of the Month to Draft Bank Account <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/>
Select Plan Applying for: <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"/> K <input type="radio"/> L				

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 - -

Date of Birth (mm-dd-yyyy) - -

Age Last Birthday

Height (ft. in.)

Weight (lbs.)

Sex Male Female

E-mail Address of Proposed Insured

Application Verification Information	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. <input style="width:20px; height:25px;" type="text"/> <input style="width:20px; height:25px;" type="text"/> - <input style="width:20px; height:25px;" type="text"/> <input style="width:20px; height:25px;" type="text"/> - <input style="width:20px; height:25px;" type="text"/> <input style="width:20px; height:25px;" type="text"/> Work Phone No. <input style="width:20px; height:25px;" type="text"/> <input style="width:20px; height:25px;" type="text"/> - <input style="width:20px; height:25px;" type="text"/> <input style="width:20px; height:25px;" type="text"/> - <input style="width:20px; height:25px;" type="text"/> <input style="width:20px; height:25px;" type="text"/>
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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) - -
- (d) What is your Medicare Claim Number? - - -
(exactly as shown on your Medicare card)

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) - - END Date (mm-dd-yyyy) - -

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, list company name and policy number. _____

(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) - - END Date (mm-dd-yyyy) - -

Yes No

6. Are you within 6 months of your enrollment in Medicare Part B or otherwise qualified for open enrollment? -----
(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:

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 lipidosis, 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? -----
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 tested positive for exposure to the HIV infection or been diagnosed 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? -----
13. Do you have diabetes requiring more than 50 units of insulin daily? -----
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? -----
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)? -----
16. Within the past 2 years, have you been diagnosed or treated for rheumatoid arthritis or crippling arthritis? -----
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? -----

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? -----
If so, did you have the Medicare Advantage plan or Medicare Select policy for less than 12 months? -----
2. Did you have a Medicare Supplement policy before applying for the Medicare Advantage plan or Medicare Select policy? -----
If "YES", with which Company and which Medicare Supplement plan?

- 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 Section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, 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 V: AGENT CERTIFICATION

The undersigned Agent certifies that he/she has 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:

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:

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.

Agent's Printed Name: _____

Last Name

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Agent No.

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Agent's Florida ID No.

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Agent's Signature

MA14(09)

MAIL POLICY TO: Agent Insured

