APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE * UNITED AMERICAN INSURANCE COMPANY
A NEBRASKA STOCK COMPANY

PART I: APPLICANT INFORMATION

Plan Code
5HO
(Refer to Rate Card)

Effective Date Requested (mm-dd-yyyy)

*Medicare first eligible before 2020 only

Select Plan Applying for
○ A ○ B ○ C* ○ D ○ F* ○ HDF*
○ G ⊗ HDG ○ K ○ L ○ N

Mode of Premium
○ Annual
○ Semi-Annual
○ Quarterly
⊗ Monthly

Method of Payment
○ Send Premium Notices
⊗ Automatic Payment Plan

Draft Date
Day (01-28) of the Month to Draft Bank Account

Applicant's First Name: Jeff
M.I.:
Last Name: Decile

Applicant's Mailing Address:

Street or Route:
City:
State: OH
Zip Code: 45242
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): 08/01/1951
Age Last Birthday: 70
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:

Application Verification Information

A recorded interview may be necessary to verify the information provided in your application for insurance. The most convenient time and place for the interview is:
○ 8 AM - Noon
○ Noon - 6 PM
○ 6 PM - 9 PM

Home Phone No.:
Work Phone No.:

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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? _____
   (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. ---------- **Yes No** ○ ⊗
   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, 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) ____ ____ ____ END Date (mm-dd-yyyy) ____ ____ ____

Yes No

6. Are you 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?	○	○
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?	○	○
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?	○	○
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?	○	○

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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? (mm-dd-yyyy) ____ ____ ____ Reason for termination? _____

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? (mm-dd-yyyy) ____ ____ ____ Reason for termination? _____

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 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

(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, HEREBY AUTHORIZE MIB, Inc. (“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 or my authroized representative 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, Inc. 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, 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 is guilty of insurance fraud.

Application Signed at City | **State** | **On this Date (mm-dd-yyyy)**

Amount paid with application:

for first ____ months premiums.

Total Premium

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:

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.

Last Name	Agent No.
DUKE	40063

Agent's Signature

MA15(34)R MAIL POLICY TO: ○ Agent ○ Insured (The Policy will be sent to Insured unless otherwise instructed.)

Initials of Proposed Insured J D

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered YES, this form must be dated, signed by the applicant and by the Agent, and submitted with the application, AND a copy of this form must be left with the applicant.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

UNITED AMERICAN INSURANCE COMPANY

3700 S. STONEBRIDGE DRIVE, P.O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by United American Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR AGENT:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement coverage is being purchased for the following reason (check one):

- ❑ Additional benefits.
- ❑ No change in benefits, but lower premiums.
- ❑ Fewer benefits and lower premiums.
- ❑ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ❑ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____

- ❑ Other. (please specify) _____

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. FAILURE TO INCLUDE ALL REQUESTED MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY ANY FUTURE CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR POLICY HAD NEVER BEEN IN FORCE. After the application has been completed and before you sign it, review it carefully to be certain that all requested information has been properly recorded.

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

_____ _____

(Agent's Signature) (Applicant's Signature)

Type or print name & address of Agent or Broker:

_____

(Date)

_____

United American Insurance Company
Since 1947

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.

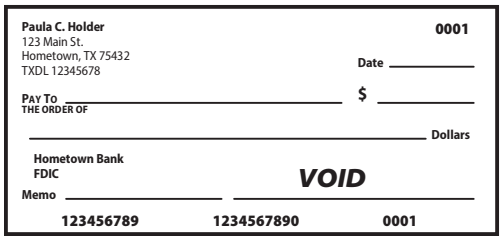
Payor's Last Name

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.



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)

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UNITED AMERICAN INSURANCE COMPANY

3700 S. Stonebridge Drive • McKinney, Texas 75070

Authorization for Release of Health-Related Information

This authorization is intended to comply with the HIPAA Privacy Rule

Jeff Decile — 08/01/1951

Name of proposed insured/patient (please print) — Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, MIB, Inc., or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the United American Insurance Company (UA) and its agents, employees, and representatives. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that UA may: 1) underwrite my application(s) for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and/or 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with UA.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to UA to the attention of the Underwriting Department at the above address. I understand that a revocation is not effective to the extent that any of My Providers have relied on this Authorization, and that, to the extent that UA has a legal right to contest a claim under an insurance policy or to contest the policy itself, such revocation may prevent UA from completing its review of policy claims. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, UA may not be able to process my application, or if coverage has been issued, may not be able to process policy claims. I acknowledge that I have received a copy of this authorization.

x

Signature of Proposed Insured/Patient or Personal Representative — Date

Self

Description of Personal Representative's Authority or Relationship to Patient

UNITED AMERICAN INSURANCE COMPANY

3700 S. Stonebridge Drive • McKinney, Texas 75070

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Signature of Proposed Insured/Patient or Personal Representative — Date

Self

Description of Personal Representative's Authority or Relationship to Patient

Applicant Copy