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

PART I: APPLICANT INFORMATION

	(Refer to Rate Card) Select Plan O A O B O C O D O F O HDF Applying for O G O N Applicant's									Mo	0	Annua	al Annua	al		Method of Payment O Send Premium Notices O Automatic Payment Plan M.I.							Draft (01-28 Draft B	B) of t	he Mo	
Last Name																										
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Street or Route																										
City																							Stat	e [
Zip Code					(Coun	ıty [
If Applicant's Resid	lence Ad	ldress	is di	ffere	nt fro	om N	/laili	ng A	ddre	ess,	shov	v bel	ow:										<u>'</u>			
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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.

T	O THE BEST OF YOUR KNOWLEDGE:	Yes 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?	
	(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.	NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO"	Yes No
	to this question. If you answered "YES": (a) Will Medicaid pay your premiums for this Medicare Supplement policy?	00
	(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.	<u>.</u>
	START Date (mm-dd-yyyy)	Vaa Na
	(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement	Yes No
	policy? (c) Was this your first time in this type of Medicare plan?	00
	(o) That the year met time it the constant 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)	00
	(a) If so, with what company and what kind of policy?	0 0
		-
		-
	(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-vvvv) -	
6.	(mm-dd-yyyy)	Yes No
6.	(mm dd ysgs) - -	

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PART II: ELIGIBILITY QUESTIONS (continued)

(IF THE ANSWER IS "NO" TO QUESTION 6a, ANSWER QUESTIONS 7 THRU 18. IF THE ANSWER IS "YES" TO QUESTIONS 7 THRU 18, THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE.)

	· · · · · · · · · · · · · · · · · · ·	es	NO
7.			_
8	hospitalized or received Medicare approved home health care 2 or more times in the past 12 months? Have you been diagnosed or had treatment by a licensed member of the medical profession for emphysema, Chronic Obstructive	0 (0
٥.	D. I (00 DD)	0 (0
9.	Are you bedridden or do you use a wheelchair for any daily activity, or have you had treatment by a licensed member of the medical profession with Gaucher's Disease or any other type of lysosomal storage disorder, or have you had any type of amputation caused by		
10		0 (0 (_
	. Have you been diagnosed or had treatment by a licensed member of the medical profession for Parkinson's disease, Multiple or	0 (
12	2. Have you tested positive for exposure to the HIV infection or been diagnosed by a licensed member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or		
13	3. Have you had or been medically treated by a licensed member of the medical profession for or been advised to have a bone	0 (
14		\circ	
	5. Within the past 2 years, have you been diagnosed or had treatment by a licensed member of the medical profession for internal cancer, melanoma, leukemia, alcoholism or drug abuse, cirrhosis, schizophrenia or bipolar disorder requiring psychiatric care, or have	0 (J
10		0	0
10	6. Within the past 2 years, have you been diagnosed or had treatment by a licensed member of the medical profession for heart attack, peripheral vascular disease, congestive heart failure, heart valve disorder, stroke, or transient ischemic attacks (TIA)?	<u> </u>	\sim
17	. Within the past 2 years, have you been diagnosed or had treatment by a licensed member of the medical profession for rheumatoid	0 (O
		0	0
18	3. Within the past year, have you been fed intravenously or through a tube, have you been medically advised to have treatment by a licensed member of the medical profession to have surgery for joint replacement or for a heart condition, but not had such surgery, or been advised to have treatment by a licensed member of the medical profession to have other surgery that has not been performed? PART III	0 (0
	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?	۱.	_
	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 ,	you voluntarily terminated coverage under a Medicare Advantage plan* or Medicare Select policy, please answer the following questions: 1. Was this the first time you were ever enrolled in a Medicare Advantage plan or purchased a Medicare Select policy?	Yes 〇	No O
	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
	If "YES", with which Company and which Medicare Supplement plan?		
	Is that Company still offering that Medicare Supplement plan?	0	0
	* 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.		Pg 3
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(Application Continued)

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PART IV: APPLICANT AUTHORIZATION

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 policy.

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.

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 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 6 months after the policy effective date.

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. 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.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Florida Residents have the right to designate a secondary addressee. Instructions will accompany all Florida policies at issue.

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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.

AGE	NT 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:
Med	tify: (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 icare Supplement Buyers Guide to the Applicant.
	nt's Printed Name:
Last	Name Agent No. Agent's Florida ID No.
	Agent's Signature
OMA ²	5(09) MAIL POLICY TO: O Agent O Insured (The Policy will be sent to Insured unless otherwise instructed.)

