For use with effective dates of 10/1/2020 or later
Please use the postage-paid envelope provided or mail completed application to:

UCare
P.O. Box 211522 | Eagan, MN 55121

Or fax this completed document to 1-608-327-6333

Medicare Supplement Plan Enrollment Application

Instructions

1. You may not apply more than three (3) months prior to becoming eligible for coverage. Please complete all information on this application and mail this entire form to the address above.
2. You must have Medicare Parts A and B to enroll.
3. Please sign and date the application in blue or black ink.
4. If you have other Medicare supplement insurance that you don't intend to cancel, you are not eligible for this Medicare supplement plan.
5. If you and your spouse both wish to apply, please complete separate applications.
6. For your plan selection, you are a "newly eligible" applicant if you turn 65 on or after January 1, 2020, or if you first become eligible for Medicare benefits due to age, disability, or ESRD on or after January 1, 2020.
7. Be certain that all the information asked for is answered as completely as possible. **If you are eligible for guaranteed issue, (including the six-month open-enrollment window following your Part B effective date) you will not need to provide health history information.** Please refer to **SPECIAL NOTES** section and Guaranteed Issue. Incomplete or false information may result in denial of claims or rescission of coverage.
8. If application is being completed though an agency, the agent must complete and submit the agency form (section 10 of this application).
9. Questions? Contact our sales team at 1-877-523-1518 Monday through Friday 8 a.m. to 5 p.m.
10. You will receive your member identification card after your enrollment form has been processed and approved.

Notice: This disclosure is required by Minnesota law. This policy is expected to return on average 73.2% of your premium dollar for health care. The lowest percentage permitted by state law for this policy is 65%.

1. Special Notes

Guaranteed issue – Medicare Supplement issuers must guarantee issue certain Basic Medicare Supplement policies to eligible individuals. There is an open enrollment period for Medicare supplement plans that is a six-month period during which you may buy any Medicare supplement plan offered in your state. During this time, we must sell you a policy, even if you have health problems. The open enrollment period is a six-month period that begins on the first day of the month in which you are 65 or older and enrolled in Medicare Part B.

If you have lost or are losing other health insurance coverage, you may be eligible for guaranteed issue. Your eligibility begins on the date you were notified of the termination and ends 63 calendar days after the date your coverage terminates. You must apply for coverage during this time period and include a copy of the plan's termination letter.

Multiple coverages – You do not need more than one Medicare supplement policy. If you purchase this policy, you may want to evaluate your existing coverage and decide if you need multiple coverages.

Medicaid – 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.

Disability – 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 – 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).

2. Applicant Information

Personal information

Last name _____ First _____ M.I. _____

Date of birth ___/___/_____ Gender _____ Phone number (_____)_____

Home address (P.O. Box not allowed) _____

City _____ County _____ State _____ Zip code _____

Mailing address (if different) _____

City _____ County _____ State _____ Zip code _____

Email address* (optional) _____

Medicare number _____

Medicare Part A effective ____/____/_____ Medicare Part B effective ____/____/_____

**By providing your email address, you agree that UCare may send you emails.*

Tobacco use designation

Have you used tobacco and/or smokeless tobacco* in the 24 months immediately preceding the date of this application? ☐ Yes ☐ No

**Tobacco use is defined as use of any tobacco product on average of four or more times per week within the past 24 months, excluding religious or ceremonial use.*

(Please note that your premiums may be modified if you indicate that you do not use tobacco as of the effective date of this application and evidence to the contrary is later discovered. If you are tobacco-free for a 24 consecutive-month period after your effective date, you should notify UCare in writing, so that your premium can be decreased.)

3. Plan Selection and Effective Date

Plan selection

☐ UCare Medicare Supplement Basic

Choose any of the optional riders you wish to purchase:

☐ Rider 1 – Medicare Part A Deductible ☐ Rider 3 – Medicare Part B Excess Charges

☐ Rider 2 – Medicare Part B Deductible* ☐ Rider 4 – Preventive Medical Care

☐ UCare Medicare Supplement Extended Basic with Part B Deductible coverage*

☐ UCare Medicare Supplement Extended Basic without Part B Deductible coverage

☐ UCare Medicare Supplement $20/$50 Copay (Plan N)

**Not available for "newly eligible" applicants. You are a "newly eligible" applicant if you turn 65 on or after January 1, 2020, or if you first become eligible for Medicare benefits due to age, disability, or ESRD on or after January 1, 2020.*

Requested effective date:

If UCare approves you for coverage under this Medicare supplement policy, the policy's effective date will be the latest of:

A. The first day of the calendar month in which you become enrolled in Medicare Part B; or

B. The first day of the calendar month following the date of UCare approval; or

C. Requested effective date ___/_01_/_____ (must not be more than 90 days beyond the date this application is signed)

4. Guaranteed Issue

A. Did you turn 65 or enroll in Medicare Part B within 6 months of the requested effective date? ☐ Yes ☐ No

B. Do you have Guaranteed Issue rights, as noted in the Special Notes section? If so, please include a copy of the termination form from your prior insurer or employer. ☐ Yes ☐ No

5. Other Health Insurance Coverage

A. To the best of your knowledge, please answer the following questions about Medicaid coverage.

Are you covered for medical assistance through the state Medicaid program?

☐ No. Please skip to question B.

☐ Yes. Please answer the following questions.

Which of the following programs provide coverage for you?

☐ Specified Low-Income Medicare Beneficiary (SLMB) ☐ Qualified Medicare Beneficiary (QMB)

☐ Full Medicaid Beneficiary

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

Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No

B. To the best of your knowledge, please answer the following questions about Medicare supplement coverage.

Do you have another Medicare Supplement policy in force?

☐ No. Please skip to question C.

☐ Yes. Please answer the following questions.

With which company is your policy? _____

Do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No

C. To the best of your knowledge, please answer the following questions about involuntary termination of coverage.

Are you being involuntarily terminated from a Medicare supplement, Medicare Advantage, Medicare Cost, Employer Retiree Plan, or Health Care Prepayment Plan?

☐ No. Please skip to question D.

☐ Yes. Please answer the following question. Was your coverage terminated for nonpayment of premiums or for fraud? ☐ Yes. ☐ No. You may be eligible for guaranteed issuance of a Medicare Supplement policy. (Please read the SPECIAL NOTES section.)

D. To the best of your knowledge, please answer the following questions about Medicare replacement coverage.

Have you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, Medicare HMO or PPO)?

☐ No. Please skip to question E.

☐ Yes. Please answer the following questions. You may be eligible for guaranteed issuance of Medicare Supplement policy. (Please read the SPECIAL NOTES section.)

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

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

Did you terminate a Medicare supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No

E. To the best of your knowledge, please answer the following questions about other health insurance.

Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?

☐ No. Please skip to Section 6. ☐ Yes. You may be eligible for guaranteed issuance of a Medicare Supplement policy. (Please read the SPECIAL NOTES section.)

Please provide the following information if you answered Yes to questions C, D, and/or E.

Company (carrier) name: _____

Company phone number: _____ Type of policy: _____

Policy number: _____ Policy effective Date: ____/____/_____

Policy termination Date: ____/____/_____

6. Health Questions

You do not need to complete this section if you are eligible for guarantee issue (including the six (6)-month open-enrollment period following your Part B effective date). See SPECIAL NOTES section.

1. Are you currently in a nursing facility, hospitalized, enrolled in a hospice program, confined to a bed, or confined to a wheelchair? ☐ Yes ☐ No
2. In the last two years, have you been hospitalized (more than 24 hours) three times or more, or been recommended to have inpatient surgery that hasn't yet been performed? ☐ Yes ☐ No
3. In the last two years, have you been hospitalized for the treatment of mental or nervous disorders, including alcohol or drug abuse? ☐ Yes ☐ No
4. Within the past two years, did a licensed medical professional diagnose, provide advice, recommend treatment, treat, or prescribe medication/refills for any of the conditions listed on page 7, part 6, A? ☐ Yes ☐ No
5. Within the past five years, did a licensed medical professional diagnose, provide advice, recommend treatment, treat, or prescribe medication/refills for any of the conditions listed on page 7, part 6, B? ☐ Yes ☐ No

7. Acceptance/Agreement

By my signature below, I acknowledge that I have read and understand the additional language listed on pages 7 and 8, section 7.

Applicant's signature: _____ Date: ___/___/_____

8. If you are replacing coverage, read and sign this section

STATEMENT TO APPLICANT BY ISSUER, AGENT, BROKER OR OTHER REPRESENTATIVE:

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 policy because you intend to terminate the existing Medicare supplement policy. The replacement policy is being purchased for the following reason (check one):

☐ Additional Benefits
☐ No change in benefits, but lower premiums
☐ Fewer benefits and lower premiums
☐ Other (please specify) _____

By my signature below, I acknowledge that I have read and understand the additional language listed on page 8, section 8.

_____
Signature of agent, broker, or other representative (Signature not required for direct response sales)

_____ _____
Printed name and address of issuer, agent, or broker | Agency number

_____ _____
Applicant's signature | Date

9. Premium Payment Options

Requested frequency

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Please check ONE of the two options.

☐ **Automatic Bank Withdrawal:** We electronically transfer your premium directly from your bank account at the frequency you request.

A. Account information (or attach a voided check to the bottom of this page)

Bank name _____

9-digit routing number _____ Account number _____

Type of account: ☐ Checking ☐ Savings

B. Account holder information:

Name _____

Address _____

City _____ County _____ State _____ Zip code _____

C. Timing of Payments:

On the 1st of the coverage month

Authorization and signature: By my signature below, I authorize UCare Health, Inc (UCare) or their authorized designee to instruct my financial institution to deduct my premium payments from the account designated above. I authorize my financial institution to debit the amount of my premium from my designated account. This authorization will remain in effect until I notify UCare in writing of its termination. My notification must afford UCare and my financial institution reasonable opportunity to act on it. UCare is not responsible for any loss, incorrect deliver, destruction, delay, or interception of this application and its contents by others.

Account holder's Signature _____ Date: ____/____/_____

☐ **Direct Bill:** We send a premium notice directly to your home at the frequency you request. You return payment to UCare by the premium due date.

10. Agency Form

If application is being completed though an agent, he or she must complete the following section.

Please list any other insurance policies you have personally sold to the applicant that are still in force. (If none, please write none.) Also, list any policies you sold the applicant in the past five (5) years that are no longer in force.

Policy description	In Force
_____	☐ Yes ☐ No
_____	☐ Yes ☐ No
_____	☐ Yes ☐ No

Signed at _____ Date ___/___/_____

Writing agent (print name) _____ Signature of writing agent _____

Agency name _____ Tax ID number _____

Neither UCare Health, Inc. nor its agents are connected with the federal Medicare program. Our products are not connected with or endorsed by the United States government or the federal Medicare program. UCare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, disability, or sex.

6. Health Questions

A - conditions for question 4

- Aneurysm
- Broken bones due to Osteoporosis
- Carotid Artery Disease
- Congestive Heart Failure
- Coronary Artery Disease
- Diabetes requiring insulin
- End-Stage Renal Disease (ESRD) or require dialysis
- Enlarged Heart
- Heart Attack
- Heart Valve Disorder
- Heart Rhythm Disorder
- Kidney Disease
- Liver Disease
- Peripheral Vascular Disease
- Stroke

B - conditions for question 5

- Alzheimer's Disease
- Amputation caused by disease
- Bone Marrow Transplant
- Cancer (except non-melanoma skin cancer)
- Cerebral Palsy
- COPD
- Cystic Fibrosis
- Emphysema
- Hemophilia
- Hodgkin's Disease
- Leukemia
- Melanoma
- Muscular Dystrophy
- Myasthenia gravis
- Organ transplant (except for the cornea)
- Parkinson's Disease
- Rheumatoid Arthritis
- Systemic Lupus

7. Acceptance/Agreement

By my signature below, I understand and agree that all statements and answers I've given are complete and true to the best of my knowledge, and that the policy for which I'm applying will be effective only after UCare Health, Inc. approves this application.

I authorize UCare, its legal representative, reinsurers, authorized agents or designees, to obtain from any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me any and all information in any form (excluding psychotherapy notes) about me concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal traits, and mode of living, including, but not limited to, all medical and health care records. The information authorized for release shall not include the release of information about the results of tests performed to determine the presence of blood borne pathogens which include, but are not limited to, the Hepatitis B virus (HBV), the Hepatitis C virus (HCV) and the Human Immunodeficiency virus (HIV). This information will be used to determine eligibility for coverage under this Medicare supplement policy, claims processing, conduct utilization review, and health care operations, and that my failure to authorize the release of said information might result in a refusal to issue or provide coverage. I agree that UCare may release said information to UCare's reinsuring companies, representative(s) or other person(s) performing business or legal services as may be permitted or required by law, or as I may further authorize from time to time. I understand that I may revoke this authorization by providing advance written notice of termination to UCare Customer Support P.O. Box 211522 Eagan, MN 55121, and that any information released in reliance upon this authorization and prior to such revocation cannot be retrieved. I understand that I should retain a copy of this completed authorization for my own records, and that a photographic copy shall be as valid as the original.

I understand that the insurer fully complies with the regulations and orders regarding doing business with foreign countries or foreign nationals listed on the Office of Foreign Assets Control's Specially Designated Nationals and Blocked Persons (SDN) list. Therefore, the insurer may rescind and void any coverage if it determines that I am either listed on the SDN list or associated with an entity listed on the SDN list.

I understand and acknowledge that any person who, with intent to defraud or knowledge that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false and deceptive statement is committing a fraudulent act, which is a crime, and may be subject to criminal and civil penalties.

I acknowledge that I have received the Medicare supplement outline of coverage and the booklet entitled "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" before applying for this policy.

This application is not complete unless signed and dated. IMPORTANT: Please read and sign section 8 if you are replacing a current Medicare supplement or Medicare Advantage policy/certificate with this policy.

This policy has a pre-existing condition limitation and if a physician has diagnosed or provided treatment for any injury or illness within the 90-day period prior to issuance of the policy for which I am applying, no coverage will be provided for that illness or injury or other condition until 6 months after the policy has been issued. This limitation does not apply to you during your open enrollment period (when you turn 65 and enroll in Medicare Part B, or when you are first eligible for Medicare due to disability or end-stage kidney disease) or if you enroll during a qualified period in which the policy is guaranteed to be issued without underwriting.

8. If you are replacing coverage, read and sign this section

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE
UCare Health, Inc | 500 Stinson Blvd | Minneapolis, MN 55413

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

According to your application or information you have furnished, you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by UCare Health, Inc.. Your new policy will provide 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 policy. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Health conditions which you may presently have (preexisting 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 or certificate.

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

If you still wish to terminate your present policy or certificate 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 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 information has been properly recorded. This section does not apply if you are eligible for guaranteed issue, including the six-month open-enrollment window following your Part B effective date.

Do not cancel your present policy or certificate until you have received your new policy and you are sure that you want to keep it.