Application Form

AARP® Medicare Supplement Insurance Plans

Insured by
UnitedHealthcare Insurance Company (UnitedHealthcare),
Hartford, CT 06103

Instructions

1. Fill in all requested information on this Application Form and sign in all places a signature is needed.

2. Print clearly, using CAPITAL letters AND black or blue ink - not pencil. *Example:* ☒ Yes ☐ No ☐ Not Sure

3. Initial any changes or corrections you make while completing this Application Form.

Note: Plans and rates are only good for residents of the state of California. The information you provide on this Application Form will be used to determine your acceptance and rate.

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AARP Membership Number (If you are already a member) _____

Applicant First Name MI Last Name

Permanent Home Address Line 1 (P.O. Box/PMB is not allowed)

Permanent Home Address Line 2 City State Zip

Mailing Address Line 1 (if different from permanent address)

Mailing Address Line 2 City State Zip

1 Provide additional information about yourself and your Medicare Insurance.

( ) -

1A. Phone Number **1B.** Email address (optional). Include periods (.) and symbols (@).

By providing your address, phone number and/or email address, you are agreeing to receive information and be contacted by UnitedHealthcare.

1C. Birthdate ____ / ____ / ____ (Month / Day / Year) **1D.** Gender ☐ Male ☐ Female

1E. Medicare Number_____ (From your Medicare card.)

1F. Medicare Start: Hospital (Part A) ____ / 01 / ____ (Month / Year) Medical (Part B) ____ / 01 / ____ (Month / Year)

1G. Will your Medicare Part A and Part B be active on your AARP Medicare Supplement Plan start date? ☐ Yes ☐ No

2460720307 _AGT

First Name Last Name

2 Choose your Plan and start date.

Plan Choice

2A. You are eligible to apply if all of these are true:

- you are an AARP member,
- you are age 50 or older,
- you are enrolled in Medicare Parts A and B,
- you are not enrolled in more than one Medicare supplement plan at the same time,

NOTE: If you are age 50-64 and eligible for Medicare by reason of disability and do not have End-Stage Renal Disease and are not in your Birthday Open Enrollment Period and replacing a Medicare supplement plan, you must apply within 6 months after enrolling in Medicare Part B or receiving notification of retroactive eligibility for Medicare Part B, unless you are entitled to guaranteed issue of a Medicare supplement plan as shown under the "Guaranteed Issue" section in "Your Guide." If you were **enrolled in Medicare Part A before 1/1/2020**, you may only apply for Plan A, B, C, F or K. If you were **enrolled in Medicare Part A on or after 1/1/2020**, you may only apply for Plan A, B, G or K.

Please choose 1 Plan for which you are eligible to apply from the right-hand column. Important: Plans C and F are only available to eligible Applicants who turned 65 or enrolled in Medicare Part A prior to 1/1/2020. If you are age 50-64 and eligible for Medicare by reason of disability, please see the Plan information shown above. Please call if you have questions.

☐ Plan A ☐ Plan B
☐ Plan C
☐ Plan F ☐ Plan G
☐ Plan K ☐ Plan L
☐ Plan N

Plan Start Date

2B. Your Plan will start on the first day of the month following receipt and approval of this Application Form and receipt of your first month's payment. If you would like your Plan to start on a later date (the first day of a future month), please indicate the date:

/ 01 /
Month Day Year

3 Answer these questions to determine if your acceptance is guaranteed.

3A. Are you enrolling during your annual 60-day Birthday Enrollment Period that begins on your birthday **AND** are you replacing a Medicare supplement plan with a Medicare Supplement plan that has equal or lesser benefits? See "Your Guide" for more information. ☐ Yes ☐ No

- If **YES**, your acceptance is guaranteed. Go directly to **Section 8**. You do not have to answer the questions in **Sections 4, 5, 6 and 7**.
- If **NO**, and you are:
  - **age 65 or over,** skip **Question 3B** and go directly to **Question 3C**.
  - **age 50-64**, you must answer **Question 3B**.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

3B. During the past two years, were you diagnosed or treated for end-stage renal (kidney) disease? ☐ Yes ☐ No ☐ Not Sure

- If **YES**, you are **NOT** eligible for these plans at this time.
- If **NO**, you must answer **Question 3C**.
- If you're **NOT SURE**, you must answer **Question 3C**. We may also contact you for further information to determine your acceptance.

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First Name Last Name

3 Answer these questions to determine if your acceptance is guaranteed. (continued)

3C. Will your AARP Medicare Supplement Plan start date be within 6 months after you turn age 65 **or** enroll in Medicare Part B? ☐Yes ☐No

- If **YES**, your acceptance is guaranteed. Skip to **Section 8**.
- If **NO**, continue to **Question 3D**.

3D. Is your acceptance guaranteed as described below? ☐Yes ☐No

Your acceptance is guaranteed if **any one** of the following applies to you:

- you lost an employer-sponsored health plan within the last 6 months,
- you have lost Medi-Cal within the last 6 months due to an increase in your income or assets,
- you are a military retiree, or spouse of a retiree, and your health care services were cancelled within the last 6 months due to a base closure, because the base no longer offers services or because you relocated,
- your Medicare supplement (including Medicare Select) coverage cancelled within the last 6 months because your residence changed to a location not serviced by your plan.

- If **YES**, your acceptance is guaranteed. Skip to **Section 8**.
- If **NO**, continue to **Question 3E**.

3E. Have you lost or are losing health insurance coverage or do you have a Medicare Advantage Plan "trial right" and, if so, have you received a notice from your employer or prior insurer saying that you are eligible for guaranteed issue of a Medicare supplement plan? ☐Yes ☐No

If you have a guaranteed issue right, you must provide a copy of the notice, disenrollment letter or other documentation you received AND your Application Form must be received no more than 63 days (123 days for the loss of a Medicare Advantage Plan) after the termination date of your prior coverage. The documentation should include the type of coverage being lost, the termination reason, the termination date and the name of the person(s) who lost or is losing coverage.

- If **YES**, skip directly to **Section 8**.
- If you answered **NO** to all of the applicable questions in **Section 3** and you are:
  - **age 65 or over,** continue to **Section 4**.
  - **age 50-64 and eligible for Medicare by reason of disability, you are NOT eligible to apply**.

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First Name Last Name

Answer the health questions in Sections 4-6 ONLY if your acceptance is not guaranteed as defined in Section 3.

4 Tell us about your medical providers. Do not provide this information if you are in your Open Enrollment or entitled to guaranteed issue.

Provide the following information for all physicians that you have seen within the past 2 years. We may follow up with your physicians for additional information and verification of your health history. If needed, please use an additional sheet of paper and check this box to indicate you are attaching it. ☐

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Primary Physician ( ) - Phone #

Specialist Name Specialty ( ) - Phone #

Diagnosis/Condition

Specialist Name Specialty ( ) - Phone #

Diagnosis/Condition

5 Answer this health question. Do not answer this question if you are in your Open Enrollment or entitled to guaranteed issue. If you answer YES or NOT SURE, we may follow up for additional information.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

5A. Within the past 2 years, did a medical professional provide treatment or advice to you for any problems with your kidneys other than kidney stones? ☐Yes ☐No ☐Not Sure

6 Answer these health questions. Do not answer these questions if you are in your Open Enrollment or entitled to guaranteed issue. If you answer YES to any question, you are not eligible for coverage. If you answer NOT SURE, we may follow up for additional information.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

6A. Were you hospitalized as an inpatient (not including overnight Outpatient observation)
- within the past 90 days or
- 3 or more times within the past 2 years?

☐Yes ☐No ☐Not Sure

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First Name Last Name

6 **Answer these health questions. Do not answer these questions if you are in your Open Enrollment or entitled to guaranteed issue.** If you answer YES to any question, you are not eligible for coverage. If you answer NOT SURE, we may follow up for additional information. (continued)

6B. Are you confined to a bed, receiving home health care, or currently being treated or living in any type of nursing facility other than an assisted living facility?	☐Yes ☐No ☐Not Sure
6C. Within the past 2 years, did you receive IV infusions or injections for Primary Immunodeficiency Syndrome?	☐Yes ☐No ☐Not Sure
6D. Has a medical professional ever told you that you have End-Stage Renal (Kidney) Disease (ESRD) or that you may or will require dialysis?	☐Yes ☐No ☐Not Sure
6E. Within the past 5 years, were you diagnosed with, treated, given medical advice, or prescribed medications by a medical professional for: • Leukemia, Lymphoma or Multiple Myeloma?	☐Yes ☐No ☐Not Sure
6F. Within the past 3 years, were you diagnosed with, treated, given medical advice, or prescribed medications by a medical professional for: • Cancer (other than Leukemia, Lymphoma, or Multiple Myeloma) • Melanoma or Metastatic Merkel Cell (but not other skin cancers)?	☐Yes ☐No ☐Not Sure
6G. Within the past year, did a medical professional tell you that you may need any of the following that **has NOT been completed**: • Any surgery, biopsy, further evaluation, treatment, or diagnostic testing?	☐Yes ☐No ☐Not Sure
6H. Are you awaiting any diagnostic test results?	☐Yes ☐No ☐Not Sure
6I. Within the past 5 years, did a medical professional tell you that you have or were you diagnosed with, treated, given medical advice, or prescribed medications for any of the following?	
• Pulmonary Heart Disease, Heart Failure, Ventricular Tachycardia, or a cardiac defibrillator	☐Yes ☐No ☐Not Sure
• Diabetes, but only if you have Neuropathy, Retinopathy, any kidney problems, proteinuria, or any circulation problems	☐Yes ☐No ☐Not Sure
• Liver Fibrosis or Cirrhosis, Liver Failure or Chronic Kidney Disease (CKD)	☐Yes ☐No ☐Not Sure
• Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis (MS)	☐Yes ☐No ☐Not Sure
• Alzheimer's Disease, Dementia, or Parkinson's Disease	☐Yes ☐No ☐Not Sure
• Any condition that resulted in, or will require a bone marrow, stem cell, or organ transplant	☐Yes ☐No ☐Not Sure

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First Name Last Name

6 Answer these health questions. Do not answer these questions if you are in your Open Enrollment or entitled to guaranteed issue. If you answer YES to any question, you are not eligible for coverage. If you answer NOT SURE, we may follow up for additional information. (continued)

6J. Within the past 2 years, did a medical professional tell you that you have or were you diagnosed with, treated, given medical advice, or prescribed medications for any of the following?			
• Artery blockage, or had bypass surgery, stents, or balloon angioplasty	☐Yes	☐No	☐Not Sure
• Heart Attack, Cardiomyopathy, an Enlarged Heart, or Atrial Fibrillation	☐Yes	☐No	☐Not Sure
• Carotid Artery Disease, Stroke, Transient Ischemic Attack (TIA), or Mini-Stroke	☐Yes	☐No	☐Not Sure
• Peripheral Vascular Disease (PVD) or Amputation due to disease	☐Yes	☐No	☐Not Sure
• Chronic Obstructive Pulmonary Disease (COPD), Emphysema, or Cystic Fibrosis	☐Yes	☐No	☐Not Sure
• Any lung or respiratory disorder: - requiring the use of a nebulizer or oxygen, - on 3 or more medications, or - currently using tobacco products	☐Yes	☐No	☐Not Sure
• Hemophilia, Hepatitis (other than A) or Pancreatitis	☐Yes	☐No	☐Not Sure
• Osteoporosis, but only if you received injections or have had a fracture	☐Yes	☐No	☐Not Sure
• Spinal Stenosis, Quadriplegia, Paraplegia, or Hemiplegia	☐Yes	☐No	☐Not Sure
• Psoriatic Arthritis or Rheumatoid Arthritis	☐Yes	☐No	☐Not Sure
• Systemic Lupus Erythematosus (SLE) or Myasthenia Gravis	☐Yes	☐No	☐Not Sure
• Macular Degeneration, but only if you have the Wet form	☐Yes	☐No	☐Not Sure
• Bipolar Disorder or Schizophrenia	☐Yes	☐No	☐Not Sure
• Alcoholism or Drug Abuse	☐Yes	☐No	☐Not Sure

6K. Within the past 2 years, did you receive any of the following:
- Skin grafts, or
- Blood transfusions, IV infusions or injections (not including vaccinations or B12 injections) for any of the following conditions?
  - Asthma
  - Autoimmune disorders
  - Blood disorders
  - Cognitive impairment
  - Connective tissue disorders
  - Eye disorders
  - Genetic or Hereditary disorders
  - Migraine headaches
  - Osteoarthritis

☐Yes ☐No ☐Not Sure

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7 Tell us about your tobacco usage – Do not answer this question if you are in your Open Enrollment or entitled to guaranteed issue. If you answer YES to this question, your rate will be the tobacco rate (see "Cover Page - Rates").

7A. At any time within the past 12 months, have you smoked tobacco cigarettes or used any other tobacco product? ☐Yes ☐No

First Name Last Name

8 Your past and current coverage

Review the statements.

- You do not need more than one Medicare supplement policy.
- You may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medi-Cal and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, 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 Medi-Cal 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 the suspension.
- Counseling services are available in this state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, or access the Department's Internet Web site, www.insurance.ca.gov, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

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 Form.

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PLEASE ANSWER ALL QUESTIONS.	
To the best of your knowledge, **8A.** Did you turn 65 years of age in the last 6 months??	☐Yes ☐No
8B. Did you enroll in Medicare Part B in the last 6 months?	☐Yes ☐No
8C. If YES, what is the effective date?	/01/ Month Day Year
Questions about Medi-Cal	
8D. Are you covered for medical assistance through California's Medi-Cal program? **Note to applicant:** If you have not met your share of cost under the Medi-Cal program, please answer NO to this question. **If YES, you must answer Questions 8E and 8F.** **If NO, skip to Question 8G.**	☐Yes ☐No

First Name Last Name

8 Your past and current coverage (continued)

8E. Will Medi-Cal pay your premiums for this Medicare supplement policy?	☐Yes ☐No
8F. Do you receive any benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?	☐Yes ☐No
Questions about Medicare Advantage plans (sometimes called Medicare Part C)	
8G. Have you had coverage from any Medicare plan other than original Medicare within the past 123 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)? **If YES, you must answer Questions 8H through 8K.**	☐Yes ☐No
8H. Provide the start and end dates of your Medicare plan other than original Medicare. If you are still covered under this plan, leave the end date blank.	**Start Date** ____/____/____ Month Day Year **End Date** ____/____/____ Month Day Year
8I. If you are still covered under the Medicare plan other than original Medicare, do you intend to replace your current coverage with this new Medicare supplement policy? (When you receive confirmation that this Medicare Supplement plan has been issued, you will need to cancel your Medicare Advantage Plan. Please contact your Medicare Advantage insurer for instructions on how to cancel, using the customer service number on the back of your ID card.) **If YES, please enclose a copy of the Replacement Notice.**	☐Yes ☐No
8J. Was this your first time in this type of Medicare plan?	☐Yes ☐No
8K. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐Yes ☐No
Questions about Medicare supplement plans	
8L. Do you have another Medicare supplement policy in force? If so, what insurance company and what plan do you have? Insurance Company: _____ Policy: _____ **If YES, you must answer Questions 8M and 8N.**	☐Yes ☐No
8M. Do you intend to replace your current Medicare supplement policy with this policy? **If YES, please enclose a copy of the Replacement Notice.**	☐Yes ☐No
8N. What is the plan code of your current Medicare Supplement Plan?	**Plan (A-N)** _____
Questions about any other type of health insurance coverage	
8O. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? **If YES, you must answer Questions 8P through 8R.**	☐Yes ☐No
8P. If so, with what insurance company and what kind of policy? **Insurance Company:**_____	**Policy:** ☐HMO/PPO ☐Major Medical ☐Employer Plan ☐Union Plan ☐Other_____

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First Name Last Name

8 Your past and current coverage (continued)

8Q. What are your dates of coverage under the other policy? Leave the end date blank if you are still covered under the policy.

Start Date
____ / ____ / ____
Month Day Year

End Date
____ / ____ / ____
Month Day Year

8R. Are you replacing this health insurance? ☐Yes ☐No

I have read the statements and questions in Section 8 and answered the questions to the best of my ability.

X _____ ____ / ____ / ____

Your Signature **Today's Date**
Month Day Year

Note: If you are signing as the legal representative (e.g., POA, Guardian, Conservator, etc.) for the applicant, please send a complete copy of the appropriate legal documentation and check this box. ☐

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9 IMPORTANT INFORMATION

READ CAREFULLY, AND SIGN AND DATE WHERE INDICATED.

- I affirm that the answers on this Application Form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that the Application Form becomes a part of the insurance contract and that if the answers are untrue, UnitedHealthcare may have the right to rescind my coverage or adjust my premium.
- For your protection California law requires the following to appear on this Form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- I understand coverage, if provided, will not take effect until issued by UnitedHealthcare, the actual premium is not determined until coverage is issued and that this Application Form and payment of the initial premium does not guarantee coverage will be provided.
- I acknowledge receipt of the Guide to Health Insurance for People with Medicare and the Outline of Coverage.
- A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet Web site (www.insurance.ca.gov).

If the Application Form is being completed through an Agent or Broker:

- I understand an agent or broker discussing Plan options with me is appointed by UnitedHealthcare, and may be compensated based on my enrollment in a Plan.
- I understand that an agent or broker cannot change or waive any terms or requirements related to this Application Form and its contents, underwriting, premium or coverage and cannot grant approval.

Please note: The pre-existing condition exclusion does not apply to you if you are in your Open Enrollment or entitled to guaranteed issue.

First Name Last Name

9 IMPORTANT INFORMATION (continued)

I understand the plan will not pay benefits for stays beginning or medical expenses incurred during the first 3 months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within 3 months prior to the insurance effective date.

My signature indicates I have read and understand all contents of this Application Form and have answered all questions to the best of my ability.

X _____ / /

Your Signature **Today's Date**
Month Day Year

Note: If you are signing as the legal representative (e.g., POA, Guardian, Conservator, etc.) for the applicant, please send a complete copy of the appropriate legal documentation and check this box. ☐

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Authorization for the Release of Medical Information

Not required if you answered "Yes" to Question 3A, 3C, 3D or 3E. I authorize UnitedHealthcare and its affiliates ("The Company") to obtain from any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or The Company's own information, any data or records about me or my mental or physical health. This may include information about medical advice, diagnosis, treatment and prescribed medications related to mental illness, alcoholism and drug abuse. I understand the purpose of this disclosure and use of my information is to allow The Company to determine my eligibility for coverage. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to enroll in the health plan or to receive benefits, if permitted by law. I understand the information I authorize The Company to obtain and use may be re-disclosed to a third party only as permitted under applicable federal or state law, and once re-disclosed, the information may no longer be protected by Federal privacy laws. I understand I may end this authorization if I notify The Company, in writing, prior to the issuance of coverage. After coverage is issued, this authorization is not revocable. If not revoked, this authorization is valid for 24 months from the date of my signature. I understand that I or my authorized representative may obtain a copy of this form.

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Do not sign if you are in your Open Enrollment or entitled to guaranteed issue. My signature indicates that I have read and understand the contents of this Authorization for the Release of Medical Information to the best of my ability.

X _____ / /

Your Signature **Today's Date**
Month Day Year

Note: If you are signing as the legal representative (e.g., POA, Guardian, Conservator, etc.) for the applicant, please send a complete copy of the appropriate legal documentation and check this box. ☐

First Name Last Name

9 IMPORTANT INFORMATION (continued)

READ CAREFULLY, AND SIGN AND DATE WHERE INDICATED.

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, or insurance company to give UnitedHealthcare and its affiliates ("The Company") any data or records about me or my mental or physical health. This may include information about medical advice, diagnosis, treatment and prescribed medications related to mental illness, alcoholism and drug abuse. I understand the purpose of this disclosure and use of my information is to allow The Company to determine the eligibility of and/or amount payable for my claims and for analytic studies. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to enroll in the health plan or to receive benefits, if permitted by law. I understand the information I authorize The Company to obtain and use may be re-disclosed to a third party only as permitted under applicable law, and once re-disclosed, the information may no longer be protected by Federal privacy laws. I understand I may end this authorization if I notify The Company, in writing, except to the extent that The Company has already acted on my authorization. If not revoked, this authorization is valid for the term of the coverage. I understand that I or my authorized representative may obtain a copy of this form..

My signature indicates that I have read and understand the contents of this Authorization to the best of my ability.

X _____ / /

Your Signature **Today's Date**

Month Day Year

Note: If you are signing as the legal representative (e.g., POA, Guardian, Conservator, etc.) for the applicant, please send a complete copy of the appropriate legal documentation and check this box. ☐

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First Name Last Name

10 For Agent/Broker Use Only

Agent/Broker must complete the following information and include the notice of replacement coverage, if appropriate, with this Application Form. All information must be complete or the Application Form will be returned.

1. List any other health insurance policies issued to the applicant:

_____

_____

2. List policies issued which are still in force:

_____

_____

3. List policies issued in the past 5 years which are no longer in force:

_____

_____

For Agents who assist the Applicant in answering the health questions on the Application Form: I attest that the information on this Application Form is complete and accurate to the best of my knowledge; and that I have explained to the Applicant in clear, easy to understand language the risk of providing inaccurate information and the Applicant understood. I understand that an Agent who wilfully attests falsely is subject to a civil penalty of up to $10,000 and may also be subject to any other penalties or remedies available under the law.

Agent Name (PLEASE PRINT)_____ ___ _____
First Name MI Last Name

✗ _____ _____ _____/_____/_____
Agent Signature (required) Agent ID (required) Today's Date (required)
Month Day Year

_____ (_____) _____-_____
Agent Email Address Agent Phone Number

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