MEDICARE SUPPLEMENT

Insurance Application

UTA

United Teacher Associates

Insurance Company

Notice to Agent regarding completion of Application Package.

- The inside pages of this application (two-page centerfold), which are printed "black & white" are to be completed and returned to the company.
- The remaining pages (outer shell), which have been printed in color, are to be completed and left with the applicant.

UNITED TEACHER ASSOCIATES INSURANCE COMPANY
5508 Parkcrest Drive
P.O. Box 26580
Austin, TX 78755-0580

MEDICARE SUPPLEMENT SUPPLEMENTARY APPLICATION

Definitions of Eligible Person for Guaranteed Issue And Creditable Coverage

The following are definitions of the categories of the individuals who are eligible for Guaranteed Issue:

(a) Enrolled under an employee welfare benefit plan that either: (a) supplements Medicare, and the plan terminates, or the plan ceases to provide all such benefits; or (b) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; or

(b) Enrolled in a Medicare+Choice plan or 65 years of age or older and enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provided under Section 1894 of the Social Security Act and the organization's certification or plan is terminated or the individual has been notified of an impending termination of certification or the organization has terminated or otherwise discontinued providing the plan in the are in which the individual resides or the individual is no longer eligible to elect the plan because of change in circumstances, but not including termination of enrollment where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior, or the plan is terminated for all individuals within a residence area; or the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select Plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material representation was made to the individual; or

(d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, bankruptcy or other involuntary termination of coverage, substantial violation of a material policy provision, or material misrepresentation, or

(e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare+Choice, a risk or choice contract, or a Medicare Select plan, and then the insured person terminates coverage within 12 months of enrollment; or

(f) Upon first becoming eligible for benefits under Part B at age 65 or older, enrolled in a Medicare+Choice or in a PACE program and disenrolls within 12 months.

If any of the definitions apply to you, please complete an Application for Medicare Supplement Insurance and submit evidence of the date of termination or disenrollment. Application must be made for coverage no later than 63 days of termination or disenrollment.

The following is a definition of Creditable Coverage:

Creditable Coverage means (a) a group health plan; (b) health insurance coverage; (c) Part A or Part B of Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) Chapter 55 of Title 10 (CHAMPUS); (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under Chapter 89 of Title 5 (Federal Employees Health Benefits Program); (i) a public health plan (as defined in federal regulation); (j) a health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)); or (k) short-term limited duration insurance.

I acknowledge receipt of this Supplementary Application.

_____ _____

Signature of Applicant Date

UNITED TEACHER ASSOCIATES INSURANCE COMPANY

P.O. Box 26580 • Austin, Texas 78755-0580

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

Part I: APPLICANT INFORMATION

Proposed Insured	**Spouse****
Name:	Name:
Social Security Number:	Social Security Number:
Medicare Number:	Medicare Number:
Date of Birth: / /	Date of Birth: / /
Height: Weight: Sex:	Height: Weight: Sex:
Have you used tobacco within the last 12 months?	Have you used tobacco within the last 12 months?
Beneficiary:	Beneficiary:
Relationship:	Relationship:
Proposed Insured's Address:	
City: State: Zip: Phone Number:	
Name & Address of Family Doctor – Proposed Insured:	
Name & Address of Family Doctor – Spouse:	

Part II: MEDICAL & GENERAL (A telephone interview with the applicant may be conducted to verify application).

Basic Questions

To the best of your knowledge:

A. Do you have another (or pending applications for) Medicare Supplement policy or certificate in force?..... ☐ Yes ☐ No

1. If so, list all companies (attach separate sheet if necessary)
   Company Policy
2. If so, do you intend to replace your current Medicare supplement policy with this policy? ..... ☐ Yes ☐ No

If so, complete a Replacement of Insurance Form. Termination Date of replaced policy:

B. Do you have any other health insurance that provides benefits similar to this Medicare Supplement Policy? ☐ Yes ☐ No
If so, with which company? What kind of policy?

C. Are you covered for medical assistance through the state Medicaid program:

1. As a Specified Low Income Medicare Beneficiary..... ☐ Yes ☐ No
2. As a Qualified Medicare Beneficiary (QMB)?..... ☐ Yes ☐ No
3. For other Medicaid medical benefits? ..... ☐ Yes ☐ No

D. Are you covered or will you be covered under:
Medicare Part A (Hospitalization)? ……. ☐ Yes ☐ No
Insured Effective Date Spouse Effective Date
Medicare Part B (Medical Expenses)? …… ☐ Yes ☐ No
Insured Effective Date Spouse Effective Date

If the answer to either question in section D above is "No", then the applicant is not eligible for coverage and this application should not be submitted.

Please give details to "Yes" answers of Questions A-C.

E. Is the Insured eligible for guarantee issue or applying during open enrollment ……..…….. ☐ Yes ☐ No
Is the Spouse eligible for guarantee issue or applying during open enrollment?……..…….. ☐ Yes ☐ No

If yes, please provide proof of eligibility and check the "Yes" box above. <u>DO NOT</u> answer the Health questions that follow this section. Please see form MS02-UTA-SA.APP-TX for definitions.

Health Questions

IF THE ANSWER TO ANY OF QUESTIONS 1-6 IS "YES", THEN THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE AND THIS APPLICATION SHOULD NOT BE SUBMITTED. IF YOU ARE AN ELIGIBLE PERSON FOR GUARANTEED ISSUE OR IN OPEN ENROLLMENT, THESE QUESTIONS DO NOT APPLY.

1. Within the past two years have you had a diagnosis of, or had treatment for:
   a. Congestive Heart Failure or any other type of Heart Failure, Cardiomyopathy; Heart Attack; Angina; Stroke; Transient Ischemic Attack (TIA or mini-stroke); Heart surgery; Coronary By-pass surgery or Angioplasty in any artery?..... …….. ☐ Yes ☐ No
   b. Cirrhosis; Hemophilia; Multiple Sclerosis; Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease); Leukemia; Amputations due to Disease or any disease or disorder requiring an Organ Transplant other than Corneal Transplant? .....…….. ☐ Yes ☐ No
   c. Renal or Kidney Dialysis; X-Ray Therapy; Radium or Chemotherapy; Crippling Arthritis; Internal Cancer, elevated PSA levels; undiagnosed lumps in any part of the body; Emphysema; Hodgkin's Disease; Disease or Disorder of Lungs or Respiratory System for which you use a mechanical breathing device or Oxygen? .....…….. ☐ Yes ☐ No

d.	Parkinson's Disease; Alzheimer's Disease, Dementia; Organic Brain Disease or other Senility Disorders, Alcohol or Drug Abuse?	☐ Yes ☐ No
2.	Are you an Insulin Dependent Diabetic taking more than 50 Units per Day?	☐ Yes ☐ No
3.	Within the past two years, have you been confined to a nursing home or a wheelchair, or has such care been medically advised?	☐ Yes ☐ No
4.	Are you currently hospitalized or receiving Medicare approved home health care, or have you been hospitalized or received Medicare approved home health care three or more times in the past two years?	☐ Yes ☐ No
5.	Within the past year have you been advised to have surgery (including cataract surgery) but not had such surgery?	☐ Yes ☐ No
6.	Have you tested positive for exposure to HIV infection or been diagnosed as having ARC (AIDS Related Complex) or AIDS caused by HIV infection or other sickness or condition derived from such condition?	☐ Yes ☐ No

Part III: COVERAGE APPLIED FOR

Insured

MEDICARE SUPPLEMENT PLAN: ☐ A ☐ B ☐ C ☐ D ☐ F ☐ G Enrollment Fee: _____

PAYMENT MODE: ☐ Annual Direct ☐ Semi-Annual Direct ☐ Monthly Bank Draft Amount Enclosed: _____

Spouse

MEDICARE SUPPLEMENT PLAN: ☐ A ☐ B ☐ C ☐ D ☐ F ☐ G Enrollment Fee: _____

PAYMENT MODE: ☐ Annual Direct ☐ Semi-Annual Direct ☐ Monthly Bank Draft Amount Enclosed: _____

Part IV: CREDITABLE COVERAGE DETERMINATION (Include proof of creditable coverage with application.)

Within the last 63 days, were you covered under creditable coverage*? ☐ Yes ☐ No

If "Yes", what type of coverage? _____.

If "Yes", with what company? _____. Policy No. _____.

* "Creditable Coverage" means (a) a group health plan; (b) health insurance coverage; (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare); (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928; (e) Chapter 55 of Title 10 (CHAMPUS); (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under chapter 89 of Title 5 (Federal Employees Health Benefits Program); (i) a public health plan (as defined in federal regulation); or (j) a health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)). Creditable coverage does not include hospital indemnity, specified disease or illness, accident or disability income plans.

Part V: INSURED CERTIFICATION

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 more than one type of coverage in addition to your Medicare benefits.

You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

The benefits and premiums under your Medicare Supplement policy can be suspended for 24 months, if requested, during your entitlement to benefits under Medicaid. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

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 certify that I have received a copy of the Outline of Coverage and Guide to Health Insurance for People with Medicare. To the best of my knowledge and belief, the answers to the above statements are true and correct. I request that the issue date and the effective date of this policy be (month) _____, (day) _____ (year) _____.

I agree the policy shall not be effective unless it has actually been issued. I further understand that the policy for which I am applying has a pre-existing condition limitation. If a physician has provided medical advice or treatment for any condition within the six month period before the effective date of the policy for which I am applying, no coverage will be provided for that condition until six months after the effective date. **All other conditions are covered from the date the policy is issued.** I understand and agree that oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. I hereby authorize any Bureau or other organization, institution, or person, that has any record or knowledge of me or my health, to give to United Teacher Associates Insurance Company or its authorized agent any such information. A photocopy hereof will be as valid as the original. This authorization shall remain in effect for twenty four (24) months. **I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.**

Signed at _____, this _____ day of _____, _____.
(City and state)

_____ _____
(Applicant's signature) (Spouse's signature if applying for coverage)

Part VI: AGENT CERTIFICATION AGENT COMPLETES (attach separate sheet if necessary)

1. List all policies sold to the applicant that are still in force. _____
2. List all policies sold to the applicant in the last five (5) years that are no longer in force.
3. To the best of your knowledge, is insurance replacement involved in this transaction? ☐ Yes ☐ No
   If "Yes", did applicant receive and sign the Notice to Applicant Regarding Replacement? ☐ Yes ☐ No
4. I certify that I have accurately recorded the information supplied by the Applicant, I have given an outline of coverage for the policy applied for and a Guide to Health Insurance for People with Medicare to the Applicant.

Licensed Agent's Signature	Agent's Code	Print Agent's Name	Agent's State Identification
	3B00120000	Jerry Hill	

Part VII: BANK DRAFT AUTHORIZATION

Name of Bank: _____ Routing Number: _____

As a convenience to me, I hereby request and authorize you to initiate debit entries, whether by electronic or paper means, with said debits drawn on my account by and payable to the order of the UNITED TEACHER ASSOCIATES INSURANCE COMPANY, Austin, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn on my account and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring such debit. I further agree that if any such debit is not paid by me for any reason, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such non-payment results in the forfeiture of insurance.

_____ **(√)** _____

Date (Your signature EXACTLY as it appears on Bank Records) (Account Number)

IMPORTANT: FOR BANK ACCOUNT IDENTIFICATION, ENCLOSE A VOIDED BLANK PERSONAL CHECK.

** **Please note that if a Proposed Insured and Spouse both apply for coverage on this application, separate policies will be issued to the Proposed Insured and Spouse.**

UNITED TEACHER ASSOCIATES INSURANCE COMPANY

An Old Line Legal Reserve Company
5508 Parkcrest Drive • P.O. Box 26580 • Austin, Texas • 78755-0580
(512) 451-2224

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

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

According to your application, you intend to terminate existing Medicare supplement coverage and replace it with a policy to be issued by United Teacher Associates Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration and acceptance by the replacing insurer, you find that purchase of this Medicare supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY 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 coverage, because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason(s) (check one):

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

_____

_____

I call to your attention the following items for your consideration:

(1) Health conditions which you may presently have 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 to the extent such time was spent 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 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, read and review it carefully to be certain that all information has been properly recorded.

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

_____ _____
Signature of Agent, Broker or other Representative Applicant's Signature Date

Jerry Hill , 11811 East Freeway STE 545, Houston, Texas 77029 _____
Typed Name and Address of Agent or Broker 3B00120000 Spouse's Signature Date

ACKNOWLEDGEMENT OF NONDUPLICATION

PLEASE READ CAREFULLY BEFORE SIGNING

I, Jerry Hill certify that I have
(Agent's Name)
done the following:

1. Informed the undersigned applicant of the right to have all existing health insurance policies presently in force reviewed by me to determine whether duplicate coverage will occur with the issuance of the policy.

2. Reviewed the policies listed below and have found that duplication WILL or WILL NOT (circle one) occur with the issuance of the applied for policy.

_____
(Form Number)

Company	Policy Number	Type of Policy

Check One:

_____ a. Duplication will not occur because the above listed policy(ies) # _____ will be replaced by the applied for policy _____ (form number). Justification for the replacement is (explain benefit to consumer).

_____

_____

_____

_____ b. No health coverage in force at this time.

_____ c. Applicant has elected not to have the policy(ies) reviewed.

_____
Date Agent/Company Representative

NOTICE TO CONSUMERS
Age 65 and Older

This Notice is required by the State Board of Insurance because of its concern that some consumers may buy unnecessary coverage or may replace their coverage needlessly. Buying too much coverage or replacing a policy may be a waste of your money.

1. PURCHASING MORE THAN ONE POLICY OF EACH OF THE FOLLOWING TYPES MAY BE UNNECESSARY AND COSTLY:
- ! SPECIFIED DISEASE (CANCER, STROKE, ETC.)
- ! HOSPITAL INDEMNITY
- ! BASIC HOSPITAL EXPENSE OR BASIC MEDICAL EXPENSE (THESE POLICIES ARE TYPIFIED BY A SCHEDULED BENEFIT PER ILLNESS)
- ! LONG TERM CARE

THE TEXAS STATE BOARD OF INSURANCE CANNOT SAY WHETHER YOU SHOULD OR SHOULD NOT PURCHASE ANY OR ALL OF THESE POLICY TYPES. THE DECISION IS YOURS ALONE AND SHOULD BE DETERMINED BY YOUR NEEDS AND CIRCUMSTANCES.

2. IF YOU HAVE MORE THAN ONE POLICY IN ANY OF THE ABOVE CATEGORIES, THE STATE BOARD OF INSURANCE SUGGESTS THAT YOU GET A SECOND OPINION FROM SOMEONE YOU TRUST AS TO WHETHER YOU NEED MORE THAN ONE OF THESE POLICIES.

3. IF YOU REPLACE EXISTING HEALTH INSURANCE POLICIES, YOU MAY LOSE COVERAGE DURING A PERIOD OF TIME THAT NEW EXCLUSIONS, REDUCTIONS, LIMITATIONS, OR WAITING PERIODS MUST BE SERVED.

4. THE STATE BOARD OF INSURANCE STRONGLY URGES YOU TO ALLOW YOUR INSURANCE AGENT OR COMPANY TO REVIEW ALL YOUR CURRENT HEALTH POLICIES PRIOR TO REPLACING EXISTING HEALTH COVERAGE OR PURCHASING ADDITIONAL HEALTH COVERAGE.

I certify that my right to have all of my existing health policies examined has been explained to me by the agent named above.

_____ I have been informed that the policy for which I am applying WILL or WILL NOT (circle one) result in duplicate coverage.

_____ I have chosen to waive my right to have my policies reviewed to determine if they unnecessarily duplicate each other.

I have read the attached notice. Dated this _____ day of _____ , 20___ .

Applicant's Signature: _____

This Page Intentionally Left Blank

UNITED TEACHER ASSOCIATES INSURANCE COMPANY

An Old Line Legal Reserve Company
5508 Parkcrest Drive • P.O. Box 26580 • Austin, Texas • 78755-0580
(512) 451-2224

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

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

According to your application, you intend to terminate existing Medicare supplement coverage and replace it with a policy to be issued by United Teacher Associates Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration and acceptance by the replacing insurer, you find that purchase of this Medicare supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY 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 coverage, because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason(s) (check one):

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

_____

_____

I call to your attention the following items for your consideration:

(1) Health conditions which you may presently have 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 to the extent such time was spent 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 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, read and review it carefully to be certain that all information has been properly recorded.

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

_____ _____
Signature of Agent, Broker or other Representative Applicant's Signature Date

Jerry Hill , 11811 East Freeway STE 545, Houston, Texas 77029

_____ _____
Typed Name and Address of Agent or Broker 3B00120000 Spouse's Signature Date

United Teacher Associates

Insurance Company

5508 Parkcrest Drive • P.O. Box 26580
Austin, Texas 78755-0580

1-800-880-8824