The Order of UNITED COMMERCIAL TRAVELERS OF AMERICA
Home Office: 632 N. Park St., P.O. Box 159019, Columbus, Ohio 43215-8619
(614) 228-3276, Toll-free: (800) 848-0123, Fax: (614) 228-1898 www.uct.org

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

Requested Effective Date of Policy

Last Name First Name MI

RESIDENCE ADDRESS

*Street:*_____

*City:*_____

*State:*_____ *Zip Code:*_____

*EMAIL Address:*_____

TELEPHONE: ( ) _____- _____

Check the Plan You Prefer:

- ☐ Standardized Plan A
- ☐ Standardized Plan B
- ☐ Standardized Plan C
- ☐ Standardized Plan D
- ☐ Standardized Plan E
- ☐ Standardized Plan F
- ☐ Standardized Plan G

AGE	DATE OF BIRTH	SEX	HEIGHT	WEIGHT	SOCIAL SECURITY NUMBER
	Month Day Year	☐ Male ☐ Female			

MEDICARE INFORMATION

To the best of your knowledge:
What is the date you first enrolled in Medicare Part B?
_____

Medicare Claim Number: _____

Did you turn age 65 in the last 6 months? ☐ Yes ☐ No

Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No

If yes, what is the effective date? _____

Are you a member of The Order of United Commercial Travelers of America? ☐ Yes ☐ No

Council Name:_____ Council Location (City & State) _____

UNDERWRITING RISK CLASSIFICATION QUESTION

Have you used any form of tobacco in the past two years? ☐ Yes ☐ No

(You do not have to answer this question if you are applying during open enrollment or a guaranteed issue period.)

MODAL PREMIUM:

$_____

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT ☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Monthly EFT ☐ Direct Monthly

PART I – HEALTH QUESTIONS

YOU ARE *NOT REQUIRED* TO ANSWER HEALTH QUESTIONS 1-10 IF YOU ARE IN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD. PLEASE SEE PAGE 4 FOR AN EXPLANATION OF OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION.

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS 2-9, YOU ARE NOT ELIGIBLE FOR COVERAGE.

1. Are you currently hospitalized or confined to a nursing facility; or within the past two years have you been hospitalized, confined to a nursing facility or received home health care? If yes, please provide details. ☐ Yes ☐ No

   Details to Question 1:

2. Within the past two years, have you been recommended to have surgery for joint replacement, a heart condition or other surgery but not had such surgery? ☐ Yes ☐ No
3. Are you bedridden or confined to a wheelchair? ☐ Yes ☐ No
4. Within the past two years have you had a heart attack, cardiomyopathy, congestive heart failure, heart surgery, emphysema, chronic lung disease, Transient Ischemic Attack (TIA), or stroke? ☐ Yes ☐ No
5. Within the past two years, have you had or been treated for internal cancer, leukemia, malignant melanoma, Hodgkin's Disease, disabling arthritis requiring methotrexate, cirrhosis of the liver, Alzheimer's Disease, dementia, alcohol or drug abuse? ☐ Yes ☐ No
6. Within the past two years, have you had renal failure or have been advised to have kidney dialysis? ☐ Yes ☐ No
7. Have you had or been told by your physician you have Myasthenia Gravis, Lupus, Multiple Sclerosis, paralysis, Parkinson's Disease, Paget's Disease, Lou Gehrig's Disease or need an amputation due to disease? ☐ Yes ☐ No
8. Have you been diagnosed by a member of the medical profession for AIDS, AIDS-related complex (ARC), or tested positive for the AIDS virus (HIV) or Hepatitis C? ☐ Yes ☐ No
9. Are you an insulin dependent diabetic? ☐ Yes ☐ No
10. Are you currently taking any medications? ☐ Yes ☐ No
    If yes, please list them below and indicate the condition for which the medication is used.

    Details to Question 10:

PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

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 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 our application. PLEASE ANSWER ALL QUESTIONS.

Please mark Yes or No with an "X."

To the best of your knowledge,

1. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

   (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? ☐ Yes ☐ No

2. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No
   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

   If yes,

   (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No

   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? ☐ Yes ☐ No

3. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. If you are still covered under this plan, leave "END" blank.

   START _____

   END _____

   (b) 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

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

   (d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan? ☐ Yes ☐ No

4. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? ☐ Yes ☐ No

   (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" blank

   START _____

   END _____

IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

(1) You do not need more than one Medicare Supplement Insurance 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 Insurance Policy.

(4) If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance 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 reinstated, 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 the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance Policy 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 The Order of United Commercial Travelers of America for a policy to be issued solely and entirely in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. The Order of United Commercial Travelers of America has the right to deny benefits or rescind my Policy. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy. I agree the policy shall not be effective until it has actually been issued. I have received an outline of coverage for the policy applied for and a *Guide To Health Insurance for People With Medicare*.

WARNING: Any person who, with intent to defraud or knowing that he 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.

Pre-existing conditions are covered immediately upon effective date under a policy issued by The Order of United Commercial Travelers of America. You are not required to satisfy any waiting period.

If not a current member of The Order of United Commercial Travelers of America, I apply to become a member as indicated by my signature below. I understand UCT is a fraternal benefit society and agree to abide by the Society's Constitution and Bylaws.

Signed At: _____ **Applicant's Signature:**_____

Dated: _____
(Month/Day/Year)

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-10 on Page 1 of this application if you (a) are within 6 months of turning (about to turn or have already turned 65); (b) are within 6 months of purchasing Part B coverage for the first time; or (c) were previously covered under Medicare (due to a disability, for example) and are within 6 months of turning age 65.

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997:

The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

(a) Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such benefits; or (2) 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 or a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) 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 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 certificate/policy provision, or a material misrepresentation was made to the individual; or

(d) Enrolled in a Medicare Supplement certificate/policy and coverage discontinues due to insolvency, substantial violation of a material certificate/policy provision, or material misrepresentation; or

(e) Enrolled under a Medicare Supplement certificate/policy, terminates and enrolls for the first time in a Medicare+Choice or Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, 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 a Medicare Advantage or PACE provider and you disenroll within 12 months.

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

IF YOU ARE APPLYING DURING AN OPEN ENROLLMENT PERIOD OR A GUARANTEED ISSUE PERIOD, THE AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION TO THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA DOES NOT NEED TO BE COMPLETED OR SIGNED.

AUTHORIZATION
FOR RELEASE OF HEALTH RELATED INFORMATION TO
THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health or prescription drug usage to give The Order of United Commercial Travelers of America, or its reinsurers, any such information. I understand that this authorization is voluntary. I understand that I am authorizing The Order of United Commercial Travelers of America to receive my health information or prescription drug usage history. The released information received by The Order of United Commercial Travelers of America will remain protected by federal and/or state regulations as long as it is maintained by the health plan.

Applicant Name:_____

Social Security Number: _____ **Date of Birth:** _____

Reason for Disclosure is to evaluate and underwrite my application to determine eligibility for insurance

I understand that the information requested is necessary for evaluation of my application and underwriting to determine eligibility for the Insurance Policy for which I have applied. I understand that failure to provide the authorization to The Order of United Commercial Travelers of America *will* result in the rejection of the Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying The Order of United Commercial Travelers of America in writing at their Home Office: 632 N. Park St., P.O. Box 159019, Columbus, Ohio 43215-8619. I understand that such revocation will not have any effect on actions The Order of United Commercial Travelers of America took prior to their receiving the revocation notice. I understand that this authorization will be valid for twelve (12) months from the date signed. A photocopy of this authorization will be treated in the same manner as the original.

_____ _____

Signature of Applicant **Date**

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, 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.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____
_____
_____
_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____
_____
_____
_____

I certify that:
1. I have accurately recorded the information supplied by the Applicant; and
2. 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.

Agent's Signature:_____ **Date:**_____

Agent's Printed Name:_____ **Agent Number:**_____

AUTHORITY TO HONOR PREMIUM CHECKS - ATTACH VOIDED CHECK – Deposit Slips NOT Accepted

AUTHORIZATION

IN FAVOR OF: The Order of United Commercial Travelers of America
632 N. Park St., P.O. Box 159019, Columbus, Ohio 43215-8619.

Name of Bank Customer:

Insured's Name: _____

Account Number: _____ **Routing Number:** _____

To (Name of Bank): _____

Address of Bank:

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you 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 any such check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Date	Signature of Bank Customer

AUTHORIZATION

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

To: Bank above:

In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

AUTHORIZATION FOR USES AND DISCLOSURES OF PERSONAL HEALTH INFORMATION

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS DESCRIBED BELOW FOR THE LIFE INSURANCE POLICY FOR WHICH I HAVE APPLIED. I UNDERSTAND THAT I MUST COMPLETE THE APPLICATION FOR LIFE INSURANCE AND THIS AUTHORIZATION FORM IN ORDER FOR MY APPLICATION TO BE UNDERWRITTEN.

1. I authorize United Commercial Travelers (UCT) to use the personal health information I have provided on my Medicare supplement application form to determine my eligibility to obtain coverage under the life insurance policy for which I have applied, and to determine the premium rates and terms which apply to the policy.

2. I also authorize all health care providers who have provided treatment or other health care services to me to disclose all information regarding my treatment to UCT.

3. The Underwriting Department of UCT may use my personal health information that is described above.

4. The information that is disclosed by health care providers (as described above) may be used by UCT to determine my eligibility to obtain coverage under the life insurance policy for which I have applied, and to determine the premium rates and terms that apply to the policy.

5. I understand that I may revoke this authorization in writing at any time (except to the extent that action has already been taken by UCT in reliance on this authorization) by sending a written revocation to UCT, 632 N. Park Street, Columbus, Ohio, 43215.

4. This authorization will expire when UCT has approved or denied my application for a life insurance policy.

5. I understand that the information provided under this authorization is necessary for UCT to determine my eligibility for coverage under the life insurance policy and that UCT will condition approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.

6. I understand that if the person or entity that receives my personal health information is a not a health care provider or health plan covered by the federal privacy regulations (HIPAA), the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. In the case of this authorization, however, the information described above will be received by a health plan which is covered by the federal privacy regulations, and will not be used or re-disclosed except as described above, and the information will continue to be protected under the applicable federal privacy regulations.

Member name (*please print*) _____

Personal representative name (*print name, if applicable*) _____

Personal representative's scope of authority to act on member's behalf (*if applicable, e.g. legal guardian, power of attorney, etc.*)

_____

Signature _____ Date _____

Signature of UCT representative _____ Date _____

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

The Order of United Commercial Travelers of America
A Fraternal Benefit Society
632 N. Park Street, P. O. 159019, Columbus, Ohio 43215-8619

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

According to your application, you intend to terminate existing Medicare supplement insurance or Medicare Advantage and replace it with a policy to be issued by The Order of United Commercial Travelers of America. 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 coverage 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 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 or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. 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.

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

_____ Other (please specify)_____

If, you still wish to terminate your present policy/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.

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

_____
Signature of Agent, Broker or Other Representative

_____
Typed Name and Address of Agent

The above "Notice to Applicant" was delivered to me on:

_____ _____
Applicant's Signature Date

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_____
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_____
Typed Name and Address of Agent

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_____ _____
Applicant's Signature Date

FOR AGENT USE ONLY

Medicare Supplement Application Submission Checklist:

- ☐ Complete Application
- ☐ Collect premium amount (Please remember to include membership dues – a minimum of $18 annually, $9 semi-annually, $4.50 quarterly, or $1.50 monthly)
- ☐ Provide client with *Buyer's Guide*
- ☐ Provide client with Outline of Coverage
- ☐ Provide client with Conditional Receipt
- ☐ Complete Replacement Notice and leave copy with the applicant if necessary
- ☐ HIPAA-27 Form (optional for possible issuance of final expense policy)

✂

CONDITIONAL RECEIPT

Make check payable to UCT.

Received from _____, the sum of $_____

for _____ months' premium for (check one):

☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan E ☐ Plan F ☐ Plan G

If, for any reason, the policy is not issued, payment will be refunded in full in a timely manner. Insurance is not effective until the date indicated on your identification card.

Date: _____ Licensed Resident Agent: _____

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