

ProCare® (MEDICARE SUPPLEMENT)

PRODUCT INFORMATION				APPROVED FOR	POLICY TYPE
Plan Code	See PCRC Rate Sheets			<input checked="" type="checkbox"/> Individual (Bank Draft or Direct Bill)	<input checked="" type="checkbox"/> Accident and Health
Policy Form	MSA10	MSF10	MSK06	<input type="checkbox"/> UAatWork (Payroll Deduction)	<input type="checkbox"/> Term Life
(vary by state)	MSB10	MSHDF10	MSL06	<input type="checkbox"/> UAatWork Section125 (Pretax Savings)	<input type="checkbox"/> Whole Life
	MSC10	MSG10	MSN10		
	MSD10				
Ages	65 and above (or under age 65 and eligible for Medicare due to disability)				

DESCRIPTION

Understanding Medicare

Medicare does not cover all healthcare costs. Medicare recipients are responsible for certain deductibles, copayments, and out-of-pocket expenses under both Medicare Part A and Medicare Part B.

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant). Medicare covers certain medical services and supplies in hospitals, doctors' offices, and other healthcare settings. Services are either covered under Medicare Part A (Hospital Insurance) or Medicare Part B (Medical Insurance). Medicare Part A enrollment is automatic through Social Security, and it is premium free for most people. Part A covers expenses related to hospital room and board, other costs associated with confinement, care in a skilled nursing facility, some home health, and hospice and respite care. If an individual does not meet Medicare Part A eligibility requirements – the individual or spouse having at least 40 or more quarters of Medicare-covered employment – the individual may be able to enroll in Medicare Part A hospital insurance by paying a monthly premium.

Enrollment in Medicare Part B is optional. The federal government requires a monthly premium that is subtracted from an individual's Social Security check. Medicare Part B covers doctor and surgeon fees, most lab tests and X-rays performed outside the hospital, and outpatient treatment.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COPAYS & DEDUCTIBLE AMOUNTS	
	2016 (Updated Annually)
Part A Deductible	\$1,288
Day 61-90 per day Copayments	\$322
Day 90-120 per day Copayments	\$644
Day 21-100 Skilled Nursing Confinement per day Copayments	\$161
Part B Annual Deductible	\$166
HDF Annual Deductible	\$2,180

The Centers For Medicare & Medicaid Services publishes a guide to Medicare, 'Medicare & You', also referred to as a Medicare Buyer's Guide. 'Medicare & You' is updated annually. United American has printed copies available at no cost to Agents. The Agent is required to provide every Medicare Supplement applicant a copy at the time of application. Agents should use 'Medicare & You' as a training/reference tool to understand the benefits of the Medicare Program.

Medicare Supplement Insurance

Medicare Supplement insurance policies are standardized by the federal government, meaning the coverage/benefits are the same no matter which insurance company sells them. Premiums/rates vary by company. Depending on the plan selected, coverages pay various Medicare deductibles, coinsurances, and other medical expenses not covered by Medicare. However, insurers' rates and services vary, which makes it very important for Seniors to shop carefully to get the best value for their dollars.

United American offers standardized plans A, B, C, D, F, HDF, G, K, L, and N where available. An Outline of Coverage details the benefits of the Medicare plans and the Medicare supplement policy benefits. Outlines of Coverage are updated annually and are usually state specific. Download and print Outlines from the Compliance Sheet online. The Agent is required to provide every Medicare Supplement applicant a copy of the Outline of Coverage at the time of application. Agents should use the Outline of Coverage as a training tool to understand the benefits of the Medicare Program and the benefits of the Medicare Supplement policy.

MEDICARE SUPPLEMENT PLAN BENEFITS SUMMARY

See the Outline of Coverage for details and exceptions.

PLANS / BENEFITS	A	B	C	D	F [▼]	G	K [■]	L [■]	N [●]
Basic Benefits									
Hospitalization (Part A Coinsurance)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Expenses (Part B Coinsurance)	100%	100%	100%	100%	100%	100%	50%	75%	Copay [●]
Blood	✓	✓	✓	✓	✓	✓	50%	75%	✓
Hospice	✓	✓	✓	✓	✓	✓	50%	75%	✓
Skilled Nursing Facility Coinsurance			✓	✓	✓	✓	50%	75%	✓
Part A Deductible		✓	✓	✓	✓	✓	50%	75%	✓
Part B Deductible			✓		✓				
Excess Doctor Charges					100%	100%			
Foreign Travel Emergency			✓	✓	✓	✓			✓
Out-of-pocket Annual Limit [■]							\$4,960	\$2,480	

- ▼ Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year deductible. Benefits from high deductible Plan F begin after out-of-pocket expenses exceed the calendar-year deductible (\$2,180 in 2016). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B but do not include the separate foreign travel emergency deductible in Plan F.
- Plans K and L provide for different out-of-pocket cost-sharing (50% for Plan K, 25% for Plan L). Once you reach the annual out-of-pocket limit (\$4,960 for Plan K, \$2,480 for Plan L), the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar-year. The out-of-pocket annual limit does NOT include the charges from your provider that exceed Medicare-approved amounts, called 'excess charges.' You are responsible for paying excess charges. The out-of-pocket annual limit may be increased each year for inflation.
- Plan N pays 100% of Medical Expenses (Part B Coinsurance) *except* for a copayment of up to \$20 for an office visit and up to \$50 for an emergency room visit. The emergency room copayment is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.

Premiums

The Company has the right to change the renewal premiums for this policy in accordance with a table of premium rates applicable to all policies of like form and class.

Premium rates are based on the state (ZIP code) where the applicant resides. Applications should be written in the applicant's resident state. Rates are sex distinct. And, except in community rated states, rates are also based on tobacco usage. Rates within some states vary based on the area/ZIP code. Issue-age policy rates are based on the policyholder's age at the time of policy issue. Issue age rates may increase with inflation. Attained-age policy rates are based on the policyholder's current age. Rates increase yearly (as the policyholder's age increases), usually up to age 80.

Any rate increases due to inflation are in addition to the increases due to aging. Community rated states have one rate that is the same for all ages.

ProCare Medicare Supplement policies are guaranteed renewable for life as long as premiums are paid on time.

Disability Plans B and HDF are available in some states to people under age 65 and eligible for Medicare due to disability. Some states require other Medicare Supplement plans be available to people under age 65 and eligible for Medicare due to disability. Disability plan availability is sometimes limited to certain Open Enrollment or Guaranteed Issue periods, depending on state requirements. Plan availability is shown on the rate card. Policy benefits are identical for people over or under age 65. Disability plans have different applications, rates, and Outlines of Coverage than the over age 65 plans (*may vary by state*). Applications for disability Medicare Supplement plans must also be written in the applicant's resident state.

ProCare Medicare Supplement policies have a 30 day right to examine. If the policyholder is not satisfied with their policy, it can be returned to the Company, and all payments, less any claims paid, will be returned.

ELIGIBILITY

Applicants enrolled in Medicare Parts A and B are eligible to purchase a Medicare Supplement Plan available in their state. The applicant's Medicare ID number is required on the application. This entry is vital to future claims processing.

Advanced dating is allowed for first-time applicants age 64½ with a policy effective date commensurate with the Medicare effective date. Generally, postdating 90 days (*six months for Open Enrollment / Guaranteed Issue*) is acceptable.

In addition to the applicant's health and health history questions, height and weight restrictions apply to eligibility except in Open Enrollment/Guaranteed Issue situations. The applicant is uninsurable if over the maximum weight for height.

LIMITATIONS, EXCLUSIONS, AND EXCEPTIONS (MAY VARY BY STATE)

- No benefits are payable for: any expense which the policyholder is not legally obligated to pay; or any services that are not medically necessary as determined by Medicare, or are not furnished at the direction of, and under the supervision of, a physician; or any portion of any expense for which payment is made by Medicare; or custodial or intermediate level care, or rest cures; or any type of expense not eligible for coverage under Medicare.
- With the exception of Open Enrollment/Guaranteed Issue periods**, loss due to injury or sickness for which medical advice or treatment was recommended or given by a physician within six months prior to the policy effective date is not covered unless the loss is incurred more than 60 days (*six months for under age 65 disability*) after the effective date. The waiting period is waived if replacing a Medicare Supplement policy.

HEIGHT		WEIGHT
FEET AND INCHES		POUNDS
4'	10"	251
4'	11"	257
5'	0"	260
5'	1"	262
5'	2"	268
5'	3"	272
5'	4"	281
5'	5"	287
5'	6"	295
5'	7"	301
5'	8"	311
5'	9"	321
5'	10"	324
5'	11"	333
6'	0"	337
6'	1"	348
6'	2"	353
6'	3"	364
6'	4"	385
	and above	

PART A DEDUCTIBLE WAIVER AVAILABLE WHEN A PARTICIPATING HOSPITAL PROVIDER IS SELECTED (NOT AVAILABLE IN ALL STATES)

All standardized Medicare Supplement plans, except Plan A (*the basic or core plan*), cover the Part A deductible. UA would normally pay this deductible as an eligible benefit of the Medicare Supplement policy. With the Part A Deductible Waiver, the hospital waives all or part of this deductible when the policyholder chooses to go to a participating hospital provider. After discharge from the hospital, the insured receives a credit from United American to be used to help pay their next premium payment. At this time, the credit is \$100, and this represents the policyholder’s participation in the savings.

The Part A Deductible Waiver does not apply to policyholders who purchase ProCare Plan A, since the Part A deductible is not covered on the core plan.

Where approved, policyholders receive a Part A Deductible Waiver brochure with their policy, which includes a list of participating hospitals. A list of participating hospitals is also available on UAOnline (www.unitedamerican.com/logon) and from the Home Office.

UA PARTNERS® OPTIONAL NONINSURANCE DISCOUNT MEDICAL PROGRAM INCLUDES “AUTOMATIC” CLAIMS FILING® PLUS (NOT AVAILABLE IN ALL STATES)

Review the UA Partners Marketplace Bulletin for complete details. California residents review the UA Partners with Provider Network Marketplace Bulletin.

OPTIONAL RESERVE FUND ANNUITY

Applicants, ages 65-90 with ProCare Plans A, B, D, HDF, G, K, or L, may enroll in the Reserve Fund Annuity (*Form USFMS*). It is a flexible premium deferred annuity that helps policyholders accumulate funds needed to meet their health insurance calendar-year deductible.

Funds can be deposited in a lump sum and/or through monthly deposits (*\$50 minimum*) made with their insurance premium payments. When the Company receives a healthcare provider’s claim and the calendar-year deductible amount has not been met, the Company withdraws funds from the Reserve Fund Annuity and directly pays the deductible to the healthcare provider to the extent such funds exist in the Reserve Fund Annuity.

If the account balance in the Reserve Fund Annuity is not sufficient to pay the full amount owed to the healthcare provider, the policyholder is responsible for paying any remaining balance directly to the healthcare provider.

Once the Part A and Part B calendar-year deductible and co-pay amounts have been met, the policy begins paying all eligible benefits as outlined in the policy.

A separate Reserve Fund Annuity enrollment form (*USFMS-AP*) is required. Review the UA Compliance Sheet for state approvals and required forms.

INSTRUCTIONS FOR COMPLETING THE PROCARE® MEDICARE SUPPLEMENT APPLICATION

The new MA15 application for ProCare is presented in a scannable format called PASSform. PASSform documents have specific guidelines that must be used to ensure apps are processed quickly and accurately.

Follow these guidelines for proper data entry:

- Use original applications only. Do not make photocopies to use as applications as they cannot be scanned.
- Use **Blue** or **Black** ink pen – *Do not use pencil.*
- When filling in the fields, print one character per box and stay inside the lines. Align text to the left.
- It is not necessary to enter periods (.) after abbreviations in the data fields.
(Example: **SMITH SR** or **MAIN ST**)

- When there are choices to be made with circles, or bubbles, fill in the area inside the bubble. Do not mark the bubbles with a **X** or a **✓**.
- Align numeric dollar amounts to the right; never enter a comma in an amount field.
(Example: 1000 not 1,000)
- Special symbols, such as “#” to represent apartment number, are acceptable.
- Do not mark or staple through the black boxes in the corners or the PASSform code (shown at the lower right corner on the sample).

Always leave a copy of UA’s ProCare brochure, Outline of Coverage, and CMS Medicare Buyer’s Guide with the customer at the time of sale.

PART I: APPLICANT INFORMATION

1. Enter the Plan Code – Locate the plan code on the rate card for the plan the applicant is applying for and print it in the field labeled ‘Plan Code’.

2. Select the Plan – Fill in the bubble for the plan the applicant is applying for. NOTE: The MA15 application is to be used for all available plans. Underage 65 disability plans will use the DMA15 application where required. Plans vary by state. Please check compliance sheets for current approvals.

3. Effective Date – *Advance Dating:* Allowed up to six months in advance of Medicare effective date for first-time Medicare Supplement applicants age 64½ and above that are not currently on a Medicare Supplement disability policy.

Applicants that currently have a UA Medicare Supplement disability policy in force and are applying for an overage Medicare Supplement may apply 60 days prior to their 65th birthday. Applicants currently on another company’s Medicare Supplement disability policy may be advance dated up to 90 days.

Postdating: Allowed up to six months following Medicare effective date for Open Enrollment applicants, excluding current Medicare Supplement disability policyholders. Current Medicare Supplement disability policyholders can postdate up to 90 days following Medicare effective date.

4. Method of Payment and Draft Date – Automatic payment plan is a bank draft. Complete the Account Information Fields or attach a voided check to the Bank Draft Authorization Form 1080-C. Draft date cannot be the 29th, 30th, or 31st. Never accept cash, money orders, temporary, post-dated cashier, counter checks, saving account, credit, or debit cards.

5. Residence Address – If the applicant’s residence address is different from the mailing address, fill out this section.

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

PART I: APPLICANT INFORMATION

1	Plan Code 5CN <small>(Refer to Rate Card)</small>	3	Effective Date Requested (mm-dd-yyyy) 01 01 2013	Mode of Premium <input type="radio"/> Annual <input type="radio"/> Semi-Annual <input checked="" type="radio"/> Quarterly <input type="radio"/> Monthly	Method of Payment <input type="radio"/> Send Premium Notices <input checked="" type="radio"/> Automatic Payment Plan	Draft Date Day (01-28) of the Month to Draft Bank Account 4
2	Select Plan <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D <input type="radio"/> F <input checked="" type="radio"/> HDF Applying for: <input type="radio"/> OG <input type="radio"/> OK <input type="radio"/> OL <input type="radio"/> ON					
	Applicant's First Name BEATRICE E Last Name ALLEN M.I.					
	Applicant's Mailing Address: Street or Route 1230 CLOCK DR City ANNTOWN State TX Zip Code 75121 County HOPE					
5	If Applicant's Residence Address is different from Mailing Address, show below: Street or Route City State Zip Code County					
6	Social Security Number 123-45-6789 Height (ft. in.) 5 08 Weight (lbs.) 161 Date of Birth (mm-dd-yyyy) 01-01-1948 Age Last Birthday 64 Sex <input type="radio"/> Male <input checked="" type="radio"/> Female					
7	Have you used tobacco in any form in the past 12 months? <input type="radio"/> Yes <input checked="" type="radio"/> No					
8	E-mail Address of Proposed Insured bea@medsupp.com					
	Application Verification Information A recorded interview may be necessary as part of the underwriting of your application for insurance. The most convenient time and place for the interview is:		<input checked="" type="radio"/> 8 AM - Noon <input type="radio"/> Noon - 6 PM <input type="radio"/> 6 PM - 9 PM		Home Phone No. 555-555-5555 Work Phone No.	

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6208
UAI2329 0612

6. Applicant Information – Record the applicant’s Social Security number, height (*ft., in.*), weight (*lbs.*), date of birth, and gender. Height and weight is not required in CT, NH, PA, or TN, or during open enrollment/guaranteed issue periods in FL or WI.

7. Tobacco – Applicants who answer “Yes” get standard (*or tobacco*) rates. Applicants who answer “No” qualify for preferred (*nontobacco*) rates. Not applicable in AR, CT, ME, MN, VT and WA, or during open enrollment/guaranteed issue periods in CA, HI, KY, LA, MD, NH, ND, PA, TN, VA and WI.

8. Application Verification Information – A telephone interview may be required. A phone number (*home or work*) should be written on the application.

9. Medicare Claim Number – Enter the applicant’s Medicare claim number exactly as shown on their Medicare ID card. Railroad retirees have a prefix instead of a suffix. If the applicant has a prefix, write it in the area to the left of the Medicare Claim Number. The Medicare Claim Number is never the same as the Social Security Number.

10. Medicaid – Applicants receiving full health benefits through state low-income program assistance are not eligible for coverage.

11. Replacement – If the applicant is replacing an existing Medicare Supplement policy, a Medicare Supplement Insurance Replacement Form (*REPMSM*), or its state special version, if applicable, is **mandatory**. If the applicant is replacing other health insurance (*for example, an employer, union, or individual plan*), Replacement Form (*U-1318*), or its state special version, if applicable, is **mandatory**. Use the replacement form to compare the applicant’s current Medicare Supplement policy with the new UA Med-Supp policy. This comparison will help you and the applicant determine what box to check on the replacement form.

Always be certain any comparison with other coverage is fair and accurate, and that excessive insurance is not sold. There are absolutely no exceptions to replacement forms. Applications submitted without a replacement form or with an incorrect replacement form are pended for the correct form and notice sent to the Agent.

Remember, the “Automatic” Claims Filing® Plus (*ACF® Plus*) service **is not** an insurance benefit. Therefore, if an applicant is replacing current coverage because they have opted for this plan, do not check the ‘Additional benefits’ box on the replacement form as the reason for replacement. Instead, check the box marked ‘Other’ AND specify that the applicant has selected our optional, noninsurance UA Partners discount medical plan.

Replacement forms are required by the state. Penalties are imposed for failure to report replacements. You must leave a copy of the completed replacement form with the applicant.

With respect to UA’s High Deductible Plan F (*HDF*), only replace a Medicare Supplement plan with an HDF plan if the premiums for the HDF plan are lower than those of the current plan and replacement is otherwise appropriate.

If the HDF plan is an appropriate replacement for a Plan A, B, C, or D, check both the box labeled ‘Additional benefits’ and the box labeled ‘Other’ on the replacement notice. In the space provided next to the ‘Other’ box, indicate the applicant is willing to pay a high deductible for lower premiums.

If the HDF plan is an appropriate replacement for a Plan F, check the box on the replacement form labeled ‘Other’ and, in the space provided next to that box, indicate that the applicant is willing to pay a high deductible for lower premiums.

If the HDF plan is an appropriate replacement for a Plan G, check the box on the replacement form labeled ‘Fewer benefits and lower premiums’.

If the HDF plan is an appropriate replacement for Plans K or L, check both the box labeled ‘Fewer benefits and lower premiums’ and the box labeled ‘Other’ on the replacement form. In the space provided next to the ‘Other’ box, indicate that the applicant is willing to pay an annual out-of-pocket limit for lower premiums.

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

PART II: ELIGIBILITY QUESTIONS

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

TO THE BEST OF YOUR KNOWLEDGE:

1. (a) Did you turn age 65 in the last six (6) months? Yes No

(b) Did you enroll in Medicare Part B in the last six (6) months?

(c) If “YES”, what is the effective date? (mm-dd-yyyy)

01 - 01 - 2013

(d) What is your Medicare Claim Number?

123 - 45 - 6789 - A

(exactly as shown on your Medicare card)

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

If you answered “YES”:

(a) Will Medicaid pay your premiums for this Medicare Supplement policy?

(b) Do you receive any benefits from Medicaid OTHER THAN payment towards your Medicare Part B premium?

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

START Date (mm-dd-yyyy) - - END Date (mm-dd-yyyy) - -

(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?

(d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

4. (a) Do you have another Medicare Supplement policy in force?

(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?

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

(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 Date” blank.)

START Date (mm-dd-yyyy) - - END Date (mm-dd-yyyy) - -

6. Are you within 6 months of your enrollment in Medicare Part B or otherwise qualified for open enrollment? Yes No

(Questions 7-17 not required if the answer to question 6 is “YES”.)

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12. Open Enrollment/Guaranteed Issue (may vary by state) – Applicants age 65 and above who first enroll in Medicare Part B benefits are offered Open Enrollment with no waiting period, regardless of health, provided they apply within six months from the first month they are enrolled for Part B benefits. Open Enrollment, for applicants under age 65 who enroll in Medicare due to disability, is required in some states.

Applicants involuntarily disenrolled from a Medicare Advantage (MA) plan, through no fault of their own, may qualify for Guaranteed Issue with no waiting period regardless of health, as provided in the Medicare Guide. See below for more information about Medicare Advantage Disenrollments. The Medicare Supplement insurance effective date must be later than the MA coverage expiration. Submit a copy of the applicant's Medicare Advantage ID card and a copy of the disenrollment notice from the Medicare Advantage plan.

Applicants who are disenrolled from employer group coverage that supplements Medicare coverage (*the employer pays second to or after Medicare*) may qualify for Guaranteed Issue with no waiting period.

An applicant who qualifies for Open Enrollment or Guaranteed Issue must not answer the health eligibility questions.

13. Regarding question 15 – If an applicant has had a heart attack or stroke more than two years ago and is on maintenance or preventative medicine only, #15 may be answered "No". However, if, within the past two years the applicant has been diagnosed with or is taking any type of medicine prescribed by a physician for peripheral vascular disease, congestive heart failure, heart valve disorder, stroke, or transient ischemic attacks (TIA), then the applicant is not insurable. This example is the standard MA15. State special applications and question arrangement may vary.

PART IV: APPLICANT AUTHORIZATION

14. Application Signed At – On the application, enter the city, state, and date where the application is being signed. Policies cannot be issued without the applicant's signature on the application.

Amount paid with the application includes the insurance policy premium and, where selected, the fee for the optional, noninsurance UA Partners discount medical plan.

Enrollment in Partners for Medicare Supplement Policyholders (*additional Fee of \$6.95 monthly*) includes the "Automatic" Claims Filing® Plus service.

NOTE: California Only – Agents must collect and submit no more than one month's premium with an application for a California Medicare Supplement policy. If the policyholder wishes to pay on an annual, semi-annual or quarterly premium mode, the balance of premium for the different payment mode may be collected and submitted to New Business at policy delivery, whereby the policy will be reissued, OR the policyholder may change premium mode at renewal.

15. Enter \$0.00 for the amount paid with application.

Enter the total premium amount based on the mode selected in the Total Premium boxes. Scan or fax a copy of the voided check on a separate piece of paper. Do not tape a copy of the voided check over the Automatic Payment Plan Authorization on page 5.

PART V: AGENT CERTIFICATION

16. All Med-Supp applications (*except disability applications*) can be taken in person or over the phone.

17. You are required to list any health insurance policy you have sold to this applicant. These policies are not limited to policies issued by United American Insurance Company. The Agent's signature and Agent number are required.

18. Enter the first five letters of your last name and your UA Agent number.

AUTOMATIC PAYMENT PLAN AUTHORIZATION

19. The Bank Draft Authorization Form (1080-C) can be completed by filling in the Payor's bank information section or by attaching a voided check (use tape; no staples). The applicant's Social Security number and signature are required with either method.

13. Within the past 2 years, have you been diagnosed or treated for heart attack, peripheral vascular disease, congestive heart failure, heart valve disorder, stroke, or transient ischemic attacks (TIA)?

14. Application Signed at City: McKINNEY State: TX On this Date (mm-dd-yyyy): 12-13-2012

Amount paid with application: \$ 00.00 for first 03 months premiums.

15. Total Premium \$ 102.00

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PART V: AGENT CERTIFICATION

16. The undersigned Agent certifies that he/she has / has not personally met with the Applicant and that the Applicant has read, or had read to him/her, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

17. AGENT COMPLETES (Attach separate sheet, if necessary.)

1. List any other health insurance policy you have sold to the Applicant which is still in force:
not applicable

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years which is no longer in force:
not applicable

I certify: (1) I have accurately recorded the information supplied by the Applicant, (2) I have given an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide to the Applicant.

18. Last Name: SLIGNA Agent No.: 123456

Agent's Signature: Beatrice Allen

MA15 MAIL POLICY TO: Agent Insured (The Policy will be sent to Insured unless otherwise instructed.)

United American Insurance Company Bank Draft Authorization

Draft date cannot be the 29th, 30th or 31st.

Proposed Insured's Social Security Number: 123-45-6789 Requested Bank Draft Day (dd):

Payor's First Name: BEATRICE M.I.: E

Payor's Last Name: ALLEN

Bank ABA Routing Number: 061000227 Account Number: 987654321

Bank Name: BANK OF AMERICA

Account information fields above must be complete if voided check is not attached. See the example check below for the location of the Bank Routing Number and Account Number.

Bank ABA Routing Number: 061000227 Account Number: 987654321 Check Number:

As a convenience to me, I hereby request and authorize you, United American Insurance Company, McKinney, Texas, to initiate debit entries to my bank account, as recorded above, for insurance premiums and/or non-insurance product fees, as applicable, and the bank named above to debit the same to such account. I agree that your rights and treatment of such debits shall be the same as if they were checks personally signed by me. I further agree that if any such debits are dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even if such dishonor results in the forfeiture of insurance. This authorization will remain in effect until revoked by me in writing to you, provided that you and the bank shall have a reasonable opportunity to act on such notification. All premiums and/or fees may be automatically withdrawn from my account on MONTHLY mode, unless a different mode has been selected on the application(s).

NOTE - Business accounts are permitted only in relation to sole proprietorships, in which case a voided check and a completed Sole Proprietor form (SP 9-01) are required.

Payor's Signature (as it appears on bank records): Beatrice Allen

FORM 1080-C 48656 08/17/05 0512

AGENT GUIDELINES

Medicare Supplement Phone Sales

Phone sales are not permitted in Washington

1. WHEN you sell a United American ProCare Medicare Supplement plan over the phone, please confirm compliance with the following guidelines:

- You are licensed and appointed in the state in which the applicant resides and quote the correct premium rate for that state.
- You comply with all state laws/regulations applicable to Medicare Supplement sales.
- Check the Compliance Sheet for the state in which you are making the sale and use the correct Medicare Supplement application, Replacement Form, etc.
- Download the most current application from the Compliance Sheet or order from Supply. Make sure to check the 'has not personally met' check box in Section V of the application.
- You are confident the applicant qualifies for the plan. That is, the plan is a suitable fit in terms of the applicant's health, lifestyle, risk tolerance, and financial situation.
- Review 'General Underwriting Guidelines' on the General Agency website under 'Sales Training' for the correct way to complete the application.
- Determine whether the applicant has existing coverage that is being replaced and, if so, make sure you conduct a fair and accurate comparison of the applicant's existing coverage to the policy being applied for.
- Do not include any unapproved or non-UA material in the packet to the applicant. Submit any unapproved advertising materials pertaining to UA or its products to the Home Office for approval prior to use.
- Only communicate with the applicant regarding UA products in person, over the phone, or via postal mail. E-mail or faxes must not be used for this purpose.
- Tell the applicant to send you a copy of his/her Medicare Advantage Disenrollment letter if replacing a Medicare Advantage Plan.
- Tell the applicant you will include a letter with instructions when you send him/her the application and other required materials.
- Encourage the applicant to return his/her material to you promptly. The sooner you receive the signed forms, the sooner the policy can be issued.
- Confirm the correct mailing address with the applicant.
- Tell the applicant to expect a call from the Home Office to confirm the information he/she provides for the application. Stress that the application cannot be considered until the Home Office call is completed.

2. BEFORE you send the completed Medicare Supplement application and required forms to the applicant for his/her signatures, check the Compliance Sheet on the General Agency website for the submission forms required in the state in which you sell and please confirm compliance with the following guidelines:

- You are confident the Medicare Supplement application is complete and all required questions have

been answered. (Call the applicant back if any information is missing or unclear.)

- Check all the applicable boxes on the Applicant Letter as appropriate prior to mailing.
- Highlight where the applicant should sign with a yellow highlighter or colored, stick-on tabs.
- Put all material in a large envelope with your return address in upper left corner. Include a return, stamped/metered/prepaid, self-addressed envelope (65 cents postage required for #10 envelopes) for the applicant to mail material back to you.
- Send the following materials, if applicable, to the applicant. Form numbers shown are standard. Use state specials as needed:
 - *Introductory Applicant Letter (UAI2319)*
 - *Medicare Supplement Application (MA15) # specific to the state*
 - *ProCare Medicare Supplement Brochure (F4931 R10) specific to the state*
 - *Medicare Buyers Guide (A Guide to Health Insurance for People with Medicare)*
 - *Outline of Coverage (DS-MS2010) specific to the state*
 - *Bank Draft Authorization Form (1080-C)*
 - *Sole Proprietor Form (SP 9-01 R04) if a business account*
 - *Replacement Forms (REPMSM/U-1318) if a replacement*
 - *Reserve Fund Annuity Brochure (F4546 R08)*
 - *Reserve Fund Annuity Enrollment Form (USFMS-AP)*
 - *UA Partners Enrollment Form (F6694) (optional noninsurance discount medical program)*

3. AFTER you receive the forms back from the applicant and BEFORE you mail or fax them to the Home Office New Business Department, please confirm compliance with the following guidelines:

- Applicant has signed all forms in the proper places.
- Applicant has mailed back all required material and retained the ProCare Brochure, the Medicare Buyers Guide, the Outline of Coverage, and, if applicable, the Reserve Fund Annuity Brochure, and one copy of the Replacement Forms REPMSM/U-1318.
- Applicant has enclosed a check for his/her premium payment or signed a Bank Draft Authorization (Form 1080-C) and/or attached a voided check.

Remember, once the applicant has signed the application and mailed it back to you, you cannot make any changes to the application. If you need to make changes, you must mail the application back to the applicant and have the applicant initial the change. You should initial any change. SIGN THE APPLICATION AND ANY OTHER REQUIRED MATERIALS BEFORE MAILING OR FAXING TO THE HOME OFFICE. IF THE APPLICANT GIVES YOU A PREMIUM CHECK OR VOIDED CHECK, YOU MUST POSTAL MAIL ALL MATERIAL TO THE HOME OFFICE; YOU CANNOT SCAN AND FAX.

FAX TO: 972-767-4462

OR MAIL TO:

United American Insurance Company

Attn: New Business Dept.

P. O. Box 8080

3700 Stonebridge Dr.

McKinney, TX 75070-8080

MEDICARE ADVANTAGE DISENROLLMENT RULES

Selling United American ProCare Medicare Supplements to Medicare Advantage (MA) Disenrollees During the Annual Enrollment Period or the MA Disenrollment Period

Medicare Advantage enrollees can voluntarily disenroll during the Annual Enrollment Period or the MA Disenrollment Period by calling their MA provider or by calling Medicare at 1-800-Medicare. A valid disenrollment request returns the enrollee to Original Medicare. The Medicare Rights Center strongly advises those wishing to disenroll from Medicare Advantage to do so by calling Medicare. Medicare then notifies the MA provider of the disenrollment. The MA provider must mail a disenrollment letter to the customer within 10 calendar days of receiving the request from CMS or the customer. Agents cannot call Medicare Advantage providers, or Medicare, or navigate the Internet to their websites for customers. Agents may only provide the customers with the phone number and Internet address. Agents violating this rule are subject to disciplinary action up to and including termination.

Applicants who drop Medicare Advantage voluntarily after one year of MA enrollment are generally not eligible for Guaranteed Issue and the standard pre-existing waiting period will apply.

United American requires applicants who are disenrolling from an MA plan during the Annual Enrollment Period or MA Disenrollment Period, and applying for Medicare Supplement coverage, to submit ONE of the following documents with their completed application:

A copy of the applicant's MA plan disenrollment notice* -OR-

A copy of the signed letter the applicant sent to their MA plan requesting disenrollment -OR-

A signed statement by the applicant that he/she has requested to be disenrolled from his/her MA plan, indicating how the request was made, whether by contacting the MA organization by phone or over the Internet, or by calling 1-800-MEDICARE

The above document(s) should be dated and must include the name of the MA company from which they disenrolled, and the MA termination date.

* The applicant's MA Plan disenrollment or termination notice is required if the applicant is applying for a guaranteed issue Medicare Supplement policy (see below).

Selling Medicare Supplement Outside the Annual Enrollment Period or the MA Disenrollment Period (may vary by state)

Medicare Supplement may be sold to MA enrollees who return to Original Medicare due to the following situations:

Scenario 1

Applicant is disenrolled from an MA Plan because the Plan is leaving Medicare, stops giving care in his/her area, or the applicant moves out of the plan's service area.

Applicants in this scenario are guaranteed issue to Medicare Supplement Plan A, B, C, F, HDF, K, or L sold in their state by any insurance company.

Applicants can apply for a Medicare Supplement as early as the day they receive notice that their MA coverage will end, but no later than 63 days after the MA coverage ends.

Scenario 2

Applicant joined an MA plan when he/she was first eligible for Medicare Part A at age 65 and within the first year of joining, decides to return to Original Medicare.

Applicants in this scenario are guaranteed issue to any Medicare Supplement sold in their state from any insurance company.

Applicants can apply for a Medicare Supplement as early as 60 days before the date their MA coverage will end, but no later than 63 days after the MA coverage ends.

Scenario 3

Applicant dropped his/her Medicare Supplement to join Medicare Advantage for the first time, has been with the MA plan for less than a year, and wants to return to Original Medicare.

Applicants in this scenario are guaranteed issue to the Medicare Supplement Plan he/she had before joining MA if the same insurance company he/she had before still sells it. If the former Medicare Supplement Plan isn't available, he/she can buy a Medicare Supplement Plan A, B, C, F, HDF, K, or L sold in their state by any insurance company.

Applicants can apply for a Medicare Supplement as early as 60 days before the date their MA coverage will end, but no later than 63 days after the MA coverage ends.

Scenario 4

Medicare has made a determination that a Medicare Advantage organization materially misrepresented plan provisions or violated its agreement with the enrollee. Applicants in this scenario who disenroll from the MA plan and return to Original Medicare are guaranteed issue to Medicare Supplement Plan A, B, C, F, HDF, K, and L sold in their state by any insurance company.

It has been our experience that MA enrollees have a difficult time disenrolling for the reason above as Medicare investigates each of these claims. No definitive timeline can be provided as to how soon a disenrollment will be approved.

In an effort to protect applicants who may not qualify for Guaranteed Issue as described in the scenarios above, Agents should advise applicants not to disenroll from Medicare Advantage plans until his/her United American Medicare Supplement application has been approved by the Home Office. The applicant has up to 60 days to provide proof of disenrollment from Medicare Advantage to the Home Office (*see timeline below*). No Medicare Supplement policy will be issued without proof of Medicare Advantage disenrollment.

Health questions must not be answered if the applicant is eligible for Guaranteed Issue.

Home Office Pending Business Timeline

- Day 1 Initial request sent to Agent requesting information needed to issue policy.
- Day 7 Home Office calls applicant directly, requesting information and sends a letter as a follow-up to conversation.
- Day 15 Second request letter is sent to applicant and Agent.
- Day 30 Call is made to applicant to find out status of requested information. Third request letter is sent to applicant and Agent.
- Day 45 Final request letter is sent to the applicant and Agent.
- Day 60 Application is declined if information is not received.

Commissions will continue to be paid on submit of business (except for HDF without the Reserve Fund Annuity). However, commissions will be charged back in the event the disenrollment letter is not provided within 60 days.

PROPER COMPLETION OF THE APPLICATION FOR MA DISENROLLMENTS

The Medicare Supplement application must be fully completed, and a copy of the Medicare card must be included. Please remember that:

1. The MA plan start date must be provided in response to PART II, Question 3(a)
2. The MA plan date of termination must be provided in PART III:
 - a. MA members being involuntarily disenrolled from their MA plan must complete PART III, Section I by providing the name of the MA Company, the date of termination and the reason for termination.
 - b. MA Members disenrolling voluntarily must complete PART III, Section II by providing the name of the MA Company, the date of termination and the reason for termination. Additionally, Questions 1 and 2 must be answered.

Also, replacement form REPMSM must be completed by marking "Disenrollment from a Medicare Advantage Plan," and giving a brief explanation of the reason for disenrolling.

SUBMITTING APPLICATIONS

MAIL PAPER APPLICATIONS

United American Insurance Company
Attn: New Business
P.O. Box 8080
McKinney, TX 75070

FAX APPLICATIONS

- All applications must be written using **BLACK INK**.
- Each individual application, and all required supplemental forms, must be faxed as one complete document set.
- If applicant submits a premium check or voided check, you must postal mail all material to the Home Office; you cannot scan and fax.
- Only send one application per fax.
- Each fax should include a fax cover sheet indicating the number of pages being faxed.
- Faxes should be sent to 972-767-4462.

iGo e-App® SUBMISSION

- Send electronically from iPad, laptop, or PC.
- Certification required to use.
- Accessed through UAOnline.
- Details on General Agency Office Website "e-App" tab.
- Do not take a check for initial premium or deposit.

SUPPLIES AND TOOLS (ALWAYS PROVIDE THE APPLICANT AN OUTLINE OF COVERAGE AND A MEDICARE BUYER'S GUIDE)

FOR THE HOME OFFICE	FOR THE CONSUMER	AGENT TRAINING
<input checked="" type="checkbox"/> Application <input checked="" type="checkbox"/> Replacement Notice REPMSM <i>(if replacing a Medicare Supplement)</i> <input checked="" type="checkbox"/> Replacement Notice U-1318 <i>(if replacing another health policy)</i> <input type="checkbox"/> HIV Consent Form <input type="checkbox"/> Bank Draft Authorization 1080-C <input type="checkbox"/> HIPAA Authorization F3978 <input checked="" type="checkbox"/> UA Partners Enrollment F6694 <input checked="" type="checkbox"/> RFA Enrollment Form USFMS-AP	<input checked="" type="checkbox"/> Advertising Brochure <input type="checkbox"/> Laptop Sales Presentation <input type="checkbox"/> eApp <input type="checkbox"/> Proposal System <input checked="" type="checkbox"/> Product Brochure <i>(contains the</i> <i>Conditional Receipt)</i> F4931 <input checked="" type="checkbox"/> Outline of Coverage <input checked="" type="checkbox"/> A Guide To Health Insurance For People With Medicare <input checked="" type="checkbox"/> Reserve Fund Annuity Brochure	<input checked="" type="checkbox"/> Brainshark <input checked="" type="checkbox"/> Marketplace Bulletin <input checked="" type="checkbox"/> Reserve Fund Annuity Marketplace Bulletin <input checked="" type="checkbox"/> UA Partners Marketplace Bulletin <input checked="" type="checkbox"/> Sample Policy <input checked="" type="checkbox"/> Compliance Sheet <input checked="" type="checkbox"/> Rate Card(s) <input checked="" type="checkbox"/> Medicare A/B Chart <input checked="" type="checkbox"/> Side by Side Guide

STATE APPROVAL & REQUIRED FORMS CHART

PROCARE MEDICARE SUPPLEMENT

	Application	Outline of Coverage	Brochure	Replacement Notice	Disability Application	Disability Outline of Coverage	State Specific Policy Exceptions
Alabama	MA15(01)	DS-MS2010	F4931 R10	REPMSM	DMA15(01)	DS-DMS2010	
Alaska	MA15	DS-MS2010	F4931 R10	REPMSM	DMA15	DS-DMS2010	
Arizona	MA15(02)	DS-MS2010(02)	F4931 R10	REPMSM	—	—	
Arkansas	MA15(03)	DS-MS2010(03)	F4931 R10	REPMSM	DMA15(03)	DS-DMS2010(03)	
California	MA15(04)	DS-MS2010(04)	F4931 R10	REPMSM	DMA15(04)	DS-DMS2010(04)	
Colorado	MA15(05)R	DS-MS2010(05)	F4931 R10	REPMSM	—	—	
Connecticut	MA15(06)	DS-MS2010(06)	F4931(06) R10	REPMSM	—	—	
Delaware	MA15(07)	DS-MS2010(07)	F4931 R10	REPMSM	DMA15(07)R	DS-DMS2010(07)	
District of Columbia	MA15(08)	DS-MS2010	F4931 R10	REPMSM	DMA15(08)	DS-DMS2010	
Florida	MA15(09)	DS-MS2010(09)	F4931(09) R10	REPMSM	DMA15(09)	DS-DMS2010(09)	
Georgia	MA15(10)	DS-MS2010(10)	F4931 R10	REPMSM	—	—	
Hawaii	MA15	DS-MS2010(51)	F4931 R10	REPMSM	—	—	Only approved for plans A, B, F
Idaho	MA15	DS-MS2010(11)	F4931(11) R10	REPMSM(11)	DMA15	DS-DMS2010	
Illinois	MA15(12)	DS-MS2010(12)	F4931 R10	REPMSM	DMA15(12)	DS-DMS2010(12)	
Indiana	MA15	DS-MS2010(13)	F4931 R10	REPMSM	—	—	
Iowa	MA15	DS-MS2010(14)	F4931 R10	REPMSM	DMA15(14)	DS-DMS2010(14)	
Kansas	MA15(15)	DS-MS2010(15)	F4931 R10	REPMSM	—	—	
Kentucky	MA15(16)R	DS-MS2010(16)	F4931 R10	REPMSM	DMA15(16)R	DS-DMS2010(16)R	
Louisiana	MA15(17)	DS-MS2010(17)	F4931 R10	REPMSM(17)	DMA15(17)	DS-DMS2010(17)	
Maine	MA15(18)	DS-MS2010(18)	F4931(18) R10	REPMSM	—	—	
Maryland	MA15(19)R	DS-MS2010(19)	F4931(19) R10	REPMSM	DMA15(19)R	DS-DMS2010(19)	
Massachusetts							
Michigan	MA15(21)	DS-MS2010(21)	F4931 R10	REPMSM	DMA15(21)	DS-DMS2010(21)	
Minnesota							
Mississippi	MA15	DS-MS2010(23)	F4931 R10	REPMSM	DMA15	DS-DMS2010(23)	
Missouri	MA15(24)	DS-MS2010(24)	F4931 R10	REPMSM	DMA15(24)	DS-DMS2010(24)	
Montana	MA15(25)	DS-MS2010(25)	F4931(25) R10	REPMSM	DMA15(25)	DS-DMS2010(25)	
Nebraska	MA15(26)	DS-MS2010	F4931 R10	REPMSM	DMA15(26)	DS-DMS2010(26)	
Nevada	MA15	DS-MS2010	F4931 R10	REPMSM	—	—	
New Hampshire	MA15(28)	DS-MS2010(28)	F4931(28) R10	REPMSM(28)	DMA15(28)	DS-DMS2010(28)	
New Jersey	MA15(29)	DS-MS2010(29)	F4931(29)	REPMSM	—	—	
New Mexico	MA15(30)	DS-MS2010	F4931 R10	REPMSM	DMA15(30)	DS-DMS2010	
New York							
North Carolina	MA15(32)	DS-MS2010(32)	F4931(32) R10	REPMSM(32)	DMA15(32)	DS-DMS2010(32)	
North Dakota	MA15(33)	DS-MS2010	F4931 R10	REPMSM	DMA15(33)	DS-DMS2010	
Ohio	MA15(34)	DS-MS2010(34)	F4931 R10	REPMSM	—	—	
Oklahoma	MA15(35)	DS-MS2010(35)	F4931 R10	REPMSM	DMA15(35)	DS-DMS2010(35)	
Oregon	MA15	DS-MS2010(36)	F4931 R10	REPMSM	—	—	
Pennsylvania	MA15(37)	DS-MS2010(37)R	F4931 R10	REPMSM	—	DS-MS2010(37)R	
Rhode Island	MA15(38)R	DS-MS2010	F4931 R10	REPMSM	DMA15(38)R	DS-DMS2010	
South Carolina	MA15	DS-MS2010	F4931 R10	REPMSM	DMA15(14)	DS-DMS2010(26)	
South Dakota	MA15(40)	DS-MS2010(40)	F4931(40) R10	REPMSM	—	—	
Tennessee	MA15(41)	DS-MS2010(41)	F4931 R10	REPMSM	—	—	
Texas	MA15(42)	DS-MS2010(42)	F4931(42) REV3/12	REPMSM(42)	DMA15(42)	DS-DMS2010(42)	
Utah	MA15	DS-MS2010	F4931 R10	REPMSM	DMA15	DS-DMS2010	
Vermont	MA15(44)	DS-MS2010(44)R13	F4931(44) R10	REPMSM	—	—	
Virginia	MA15(45)	DS-MS2010(45)	F4931(45) R10	REPMSM	—	—	
Washington	MA15(46)	DS-MS2010(46)R	F4931(46) R10	REPMSM(46)	DMA15(46)	DS-DMS2010(46)	Only face-to-face sales are allowed
West Virginia	MA15	DS-MS2010	F4931 R10	REPMSM	DMA15	DS-DMS2010	
Wisconsin	MA15(48)	DS-MC4810 DS-MC4810HD	F4931(WI) R10 F4931HD(WI) R15	REPMSM(48)			
Wyoming	MA15(49)	DS-MS2010	F4931(49) R10	REPMSM	DMA15(49)	DS-DMS2010	