Application Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

AARP Membership Number (If you are already a member)

_____ – _____

First Name MI Last Name

Address Line 1

Address Line 2

City ST Zip

Note: Plans and rates described in this package are good only for residents of North Carolina

Instructions

1. Fill in all requested information on this form and be sure to sign where indicated.
2. Print clearly. Use CAPITAL letters.
3. Fill in the circles with black or blue ink. Not pencil.

Example: ○ Y ● N

☞ If you are not already an AARP Member, please include your AARP Membership Application and a check or money order for your annual Membership dues with this application.

✉ If reply envelope is missing, please mail to: UnitedHealthcare Insurance Company, P.O. Box 105331, Atlanta, GA 30348-5331.

1 Tell us about yourself

Birthdate

M M D D Y Y Y Y

Gender

○ M ○ F

Phone

Area Code and Phone Number

Please supply the following information, found on your Medicare card.

MEDICARE HEALTH INSURANCE

NAME
First / Middle Initial / Last

MEDICARE CLAIM #

HOSPITAL (PART A) EFFECTIVE DATE: M M 0 1 Y Y Y Y

MEDICAL (PART B) EFFECTIVE DATE: M M 0 1 Y Y Y Y

ARE BOTH MEDICARE PARTS A & B COVERAGE ACTIVE? ○ Y ○ N

E-mail address (optional)

By providing your email address, you are agreeing to receive important account information and product offers.
Be sure to write all necessary periods (.) and symbols (@) in their space.

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2 Choose your plan and effective date

Please indicate your plan choice below:

○ A ○ B ○ C ○ F ○ K ○ L ○ N

Select Plan C ○

Select Plan F ○

You are eligible to enroll if <u>all</u> of these are true:

- you are an AARP member,
- you are age 50 or older,
- you are enrolled in Medicare Parts A&B,
- you are not duplicating Medicare supplement coverage.

Note: If you are not yet age 65, you are eligible only if you enrolled in Medicare Part B within the last 6 months, unless you are an "eligible person" entitled to guaranteed acceptance as shown in the enclosed "Your Guide." You may only enroll in Plan A or C.

Coverage Effective Date

Your coverage will become effective on the first day of the month following receipt and approval of this application and first month's premium. You will receive a Certificate of Insurance confirming your effective date.

If you would like your coverage to begin on a later date (the 1st day of a future month), please indicate below.

Requested Effective Date

		0	1				
M	M	D	D	Y	Y	Y	Y

3 Answer these questions to determine if your acceptance is guaranteed

3A. Did you turn age 65 in the last 6 months?

○ Y ○ N **If YES,** skip to **Section 7.**

3B. Did you enroll in Medicare Part B within the last 6 months?

○ Y ○ N **If YES,** skip to **Section 7.**

3C. Will your plan effective date be within 6 months after turning age 65 and enrolling in Medicare Part B?

○ Y ○ N **If YES,** skip to **Section 7.**

- If you answered **YES to 3A, 3B, or 3C,** your acceptance is guaranteed.
- If you answered **NO to 3A, 3B, and 3C,** continue to question **3D**.

3D. Have you lost other health insurance coverage and, if so, are you an "eligible person" as defined within the termination notice you received from your prior insurer?

○ Y ○ N **If YES,** skip to **Section 7.**

- If you answered **YES to 3D,** you may be guaranteed acceptance in certain AARP Medicare Supplement Plans. **Include a copy of the termination notice with your application.**

If you answered NO to all questions in this section and:

- You are age <u>65 or over</u>: Go to **Section 4.**
- You are age <u>50 to 64</u>: You are NOT eligible to apply for these plans.

4 Tell us about your tobacco usage

If you have smoked cigarettes or used any tobacco product at any time within the past twelve months, darken this circle: ○

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5 Answer these health questions to determine if you are eligible for this coverage

5A. Do any of these apply to you?

- have end stage renal (kidney) disease
- currently receiving dialysis
- diagnosed with kidney disease that may require dialysis
- admitted to a hospital as an inpatient within the past 90 days

◯ Y ◯ N

5B. Within the past two years, has a medical professional recommended or discussed as a treatment option, any of the following that has **NOT** been completed:

- hospital admittance as an inpatient
- organ transplant
- back or spine surgery
- joint replacement
- surgery for cancer
- heart surgery
- vascular surgery

◯ Y ◯ N

STOP **If you answered YES to either question in this section, you are NOT eligible for these plans at this time.**

If your health status changes in the future, allowing you to answer NO to all of the questions in this section, please submit an application at that time.

For information regarding plans that may be available, contact your local state department on aging.

If you answered NO to <u>both</u> questions in this section, please continue to Section 6.

6 Tell us if you have any of these medical conditions to determine your rate

Complete this section <u>only</u> if you enrolled in Medicare Part B <u>three or more years ago</u>. All others go to Section 7.

Read the conditions listed below carefully. If <u>within the past two years</u>, you have been diagnosed, treated, or had any of the following conditions, darken the circle next to it. If you are unsure how to respond, please consult your physician.

6A. Heart or Vascular Conditions

- ◯ Aneurysm
- ◯ Arteriosclerosis or Atherosclerosis
- ◯ Artery or Vein Blockage
- ◯ Atrial Fibrillation or Atrial Flutter
- ◯ Cardiomyopathy
- ◯ Carotid Artery Disease
- ◯ Congestive Heart Failure (CHF)
- ◯ Coronary Artery Disease (CAD)
- ◯ Heart Attack
- ◯ Peripheral Vascular Disease or Claudication
- ◯ Stroke, Transient Ischemic Attack (TIA), or mini-stroke
- ◯ Ventricular Tachycardia

6B. Diabetes

- ◯ With any of the following complications: Circulatory problems, Kidney problems, or Retinopathy

6C. Lung/Respiratory Conditions

- ◯ Chronic Obstructive Pulmonary Disease (COPD)
- ◯ Emphysema

6D. Cancer or Tumors

- ◯ Cancer (other than skin cancer)
- ◯ Leukemia or Lymphoma
- ◯ Melanoma

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6 Tell us if you have any of these medical conditions to determine your rate – continued

Complete this section only if you enrolled in Medicare Part B three or more years ago. All others go to Section 7.

Read the conditions listed below carefully. If within the past two years, you have been diagnosed, treated, or had any of the following conditions, darken the circle next to it. If you are unsure how to respond, please consult your physician.

6E. Kidney Conditions
- ○ Chronic Renal Failure or Insufficiency
- ○ Polycystic Kidney Disease
- ○ Renal Artery Stenosis

6F. Liver
- ○ Cirrhosis of the Liver

6G. Transplants
- ○ Bone marrow or organ transplant

6H. Gastrointestinal Conditions
- ○ Chronic Pancreatitis
- ○ Esophageal Varices

6I. Musculoskeletal Conditions
- ○ Amputation due to disease
- ○ Rheumatoid Arthritis
- ○ Spinal Stenosis

6J. Substance Abuse
- ○ Alcohol Abuse or Alcoholism
- ○ Drug Abuse or use of illegal drugs

6K. Brain or Spinal Cord Conditions
- ○ Paraplegia, Quadriplegia or Hemiplegia

6L. Psychological/Mental Conditions
- ○ Bipolar or Manic Depressive
- ○ Schizophrenia

6M. Eye Condition
- ○ Macular Degeneration

6N. Nervous System Conditions
- ○ Amyotrophic Lateral Sclerosis (ALS)
- ○ Alzheimer's Disease or Dementia
- ○ Multiple Sclerosis (MS)
- ○ Parkinson's Disease
- ○ Systemic Lupus Erythematosus (SLE)

6O. Immune System Conditions
- ○ Acquired Immune Deficiency Syndrome (AIDS)
- ○ Tested positive for the Human Immunodeficiency Virus (HIV)

If you darkened a circle for any of the medical conditions in this Section (6), your rate will be the level 2 rate. Please see the enclosed "Cover Page – Rates".

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7 Tell us about your past and current coverage

Please review the statements below, then answer all questions to the best of your knowledge.

- You do not need more than one Medicare Supplement insurance policy.
- You may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability, and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services 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).

For your protection, you are required to answer all the questions below (7A through 7L) and sign in the signature box on the next page.

7A. Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the Federal Medicare 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.

◯ Y ◯ N

If NO, skip to question **7D.**
If YES, please continue to **7B** and **7C.**

7B. Will Medicaid pay your premiums for this Medicare supplement policy?

◯ Y ◯ N

7C. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?

◯ Y ◯ N

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7 Tell us about your past and current coverage – continued

7D. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)?

○ Y ○ N

If NO, skip to question **7H**.
If YES, fill in your start and end dates and continue to question **7E**. If you are still covered under this plan, leave the end date blank.

Start Date **End Date**

M M	D D	Y Y Y Y	M M	D D	Y Y Y Y
	0 1			0 1	

7E. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?

○ Y ○ N

7F. Was this your first time in this type of Medicare plan?

○ Y ○ N

7G. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

○ Y ○ N

7H. Do you have another Medicare Supplement policy in force?

○ Y ○ N

If NO, skip to question **7J**.
If YES, please continue.

7I. If YES, do you intend to replace your current Medicare Supplement policy with this policy?

○ Y ○ N

7J. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?

○ Y ○ N

If NO, please sign below, then continue to **Section 8.**
If YES, please list with what company and what type of policy in the space provided below. Then continue to question **7K**.

Company Name

Policy Type

○ HMO/PPO ○ Major Medical ○ Employer Plan
○ Union Plan ○ Other_____

7K. What are your dates of coverage under the policy you listed in **7J?** Leave the end date blank if you are still covered under the other policy.

Start Date **End Date**

M M	D D	Y Y Y Y	M M	D D	Y Y Y Y

7L. Are you replacing this health insurance?

○ Y ○ N

Your Signature – 1 (required)

X _____

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8 Authorization and Verification of Information

Please read carefully, and sign and date in the highlighted area below.

- My signature indicates I have read and understand the contents of this application form.
- I declare the answers on this application form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this application form becomes a part of the insurance contract and that if the answers are incomplete, incorrect or untrue, UnitedHealthcare Insurance Company may have the right to rescind my coverage, adjust my premium, or reduce my benefits.
- Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.
- I understand the agent or broker cannot grant approval. This application and payment of the initial premium does not guarantee coverage will be provided. I understand coverage, if provided, will not take effect until issued by UnitedHealthcare Insurance Company, and actual rates are not determined until coverage is issued.
- I understand the agent or broker may not change or waive any terms or requirements related to this application and its contents, underwriting, premium, or coverage.
- If you are enrolling in a Medicare Select Plan: I acknowledge that I have received an Outline of Coverage, Grievance Procedure, Provider Directory and a Medicare Select Disclosure Statement covering Provider Restrictions, Right to Replace Your Medicare Supplement Plan and Quality Assurance Program. I affirm that I understand the benefits, restrictions, limitations and other provisions of the Medicare Select Plan for which I am applying.
- I acknowledge receipt of the ***Guide to Health Insurance for People with Medicare*** and the Outline of Coverage.
- I understand the person discussing plan options with me is either employed by or contracted with UnitedHealthcare Insurance Company. This person may be compensated based on my enrollment in a plan.

Authorization for the Release of Medical Information
I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give UnitedHealthcare Insurance Company and its affiliates ("The Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine my eligibility for coverage and rate. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to enroll in the health plan or to receive benefits, if permitted by law. I understand the information I authorize The Company to obtain and use may be re-disclosed to a third party only as permitted under applicable law, and once re-disclosed, the information may no longer be protected by Federal privacy laws. I understand I may end this authorization if I notify The Company, in writing, prior to the issuance of coverage. After coverage is issued, this authorization is not revocable. This authorization is valid for 24 months from the date of my signature.

Please see "Your Guide" to determine if the following pre-existing condition waiting period applies to you.

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

I have read all information and have answered all questions to the best of my ability.

Your Signature – 2 (required)

X _____

Today's Date (required)

M M D D Y Y Y Y

Note: If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

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8 Authorization and Verification of Information

Please read carefully, and sign and date in the highlighted area below.

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give UnitedHealthcare Insurance Company and its affiliates ("The Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine the eligibility of and/or amount payable for my claims and for analytic studies. I understand I may end this authorization if I notify The Company, in writing, except to the extent that The Company has already acted on my authorization. If not revoked, this authorization is valid for 30 months.

Your Signature – 3

X _____

Today's Date

M M D D Y Y Y Y

Note: If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

Plan Rates

Please refer to the "Cover Page – Rates" for the monthly cost of the plan you have selected. If you answered YES to any medical conditions in Section 6, your rate will be the level 2 rate.

Once your application is processed, you'll be notified of your acceptance, rate and insurance start date.

Please submit your first month's payment with this application. Make your check or money order payable to: UnitedHealthcare Insurance Company. If you are currently insured under an AARP Medicare Supplement Plan, Send No Money Now. You will receive updated payment instructions later.

9 For Agent Use Only

If application is being made through an Agent, he or she must complete the following; and if appropriate, the notice of replacement coverage included with this application. All information must be completed or the application will be returned.

1. List any other medical or health insurance policies sold to the applicant:

2. List any policies that are still in force:

3. List policies sold in the past five years that are no longer in force:

Agent certifies that he/she has truly and accurately recorded on the application the information signed by the applicant.

Agent Name (PLEASE PRINT) PHILIP (First Name) L (MI) ROESEL (Last Name)

Agent Phone Number 910-228-8352

X _____ Agent Signature (required)

2055206 Agent ID (required)

M M D D Y Y Y Y

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HEALTH / FINANCES / CONNECTING / GIVING / ENJOYING

AARP membership offers so much for so little.

What You Get		Price
Membership	– For you (12 months)	**$16**
Membership	– For your spouse or partner (at any age)	**Included**
Discounts (nationwide)	- Vision: exams, frames, lenses - Pharmacy: prescriptions and over-the-counter items - Fitness: gym membership and personal trainers - Travel: vacation packages, hotels, car rentals, airlines, cruises - Plus: legal services,* home security, books & comfortable shoes	**Included**
Trusted Information	- *AARP The Magazine*: the largest magazine circulation in the world - *AARP Bulletin* Newspaper (10 issues per year)	**Included**
Access to Health Products	- Exclusive health insurance for you and your dependents - Dental and long-term care insurance	**Included**
Advocacy	- Representation of your interests in Washington and your state - Confronting age discrimination by employers - Strengthening Social Security - Protecting pension and retirement benefits - Fighting predatory home loan lending	**Included**
Access to Financial Programs	- Auto, homeowners, life, mobile home, motorcycle insurance - Cash-back credit card	**Included**
Local Opportunities	- Safe driving courses (also available online) - Over 2,000 local AARP chapters - Social activities, volunteer opportunities, classes & workshops	**Included**

* Legal Services Network reduced-fee benefits are not available in HI, NV and OH.

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Yes, I'd like to join AARP today!

Please return this form in the envelope provided. You can also join AARP online at **www.AGNTU.aarpenrollment.com** or by calling **1-866-331-1964**, and begin using your member benefits right away.

My Name (please print: First, Middle Initial, Last)

Address Apt.

City State Zip

Date of Birth: Month / Day / Year

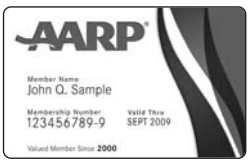
Spouse's/Partner's Name (for **FREE** membership – at any age)

☐ Please keep in touch with me by e-mail about AARP activities, events and member benefits.

E-mail Address V7FYUHG

☐ **1 year/$16**
☐ **3 years/$43**
☐ **5 years/$63**

I agree to pay for the term I select.



☐ Check or money order enclosed, payable to AARP.
Do not send cash.

Daytime Phone Number (in case we need to contact you)

Dues are not deductible for income tax purposes. One membership includes spouse/partner. Annual dues include $4.03 for a subscription to *AARP The Magazine*, $3.09 for the *AARP Bulletin*. Dues outside U.S. domestic mail limits: Canada and Mexico–1 year/$17, all other countries –1 year/$28. Please allow up to six weeks for delivery of Membership Kit. When you join, AARP shares your membership information with the companies we have selected to provide AARP member benefits and support AARP operations. If you do not want us to share your information with providers of AARP member benefits, please let us know by calling 1-800-516-1993 or e-mailing us at member@aarp.org.

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AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

Automatic Payments

Save $24 a year with Automatic Payments

The easiest way to pay.

Almost 1.8 million AARP Medicare Supplement members nationwide enjoy the convenience of the Automatic Payments option. With automatic payments, your monthly payment will automatically be deducted from your checking or savings account. If you use automatic payments, you'll save $2.00 off the total monthly rate for your household.

That's up to $24.00 a year! In addition:

- You'll save on the cost of checks and rising postal rates.
- You don't have to take time to write a check each month.
- You don't have to worry about mailing a payment if you travel or become ill, because your payment is always deducted on or about the fifth day of each month.

Sign Up in Two Easy Steps

1. Complete both sides of the Authorization Form below. Return it with the application **and be sure to keep a copy for your records.**
2. Be sure to include a voided check from the account you want your payments withdrawn from. The information on your check is necessary for us to process your Authorization Form. Do not send a deposit slip or cancelled check.

Your Automatic Payments Effective Date

If you are submitting this Electronic Funds Transfer (EFT) form with your enrollment application, your automatic payments start date will be equal to your plan effective date. Please note that if your coverage is effective in the future or your account is paid in advance, automatic withdrawals will begin for the next payment due. If your account is effective in the past or is in arrears, a letter will be sent under separate cover that provides the specific information necessary to remit the payment due to bring your account up to date. A letter will be sent confirming that we processed your Automatic Payments Authorization Form form and will include the amount of your withdrawal.

BA9957 (6-11)

Cut along the dotted line.

AUTOMATIC PAYMENT AUTHORIZATION FORM

☑ I (we) authorize UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York, for New York residents) to initiate monthly withdrawals, in the amount of the then-current monthly rate, from the account named on this form, and authorize the named banking facility BANK to charge such withdrawals to my (our) account.

Name(s) _____

Address _____

City _____

State _____ Zip Code _____

Bank Name _____

Bank Routing No. _____

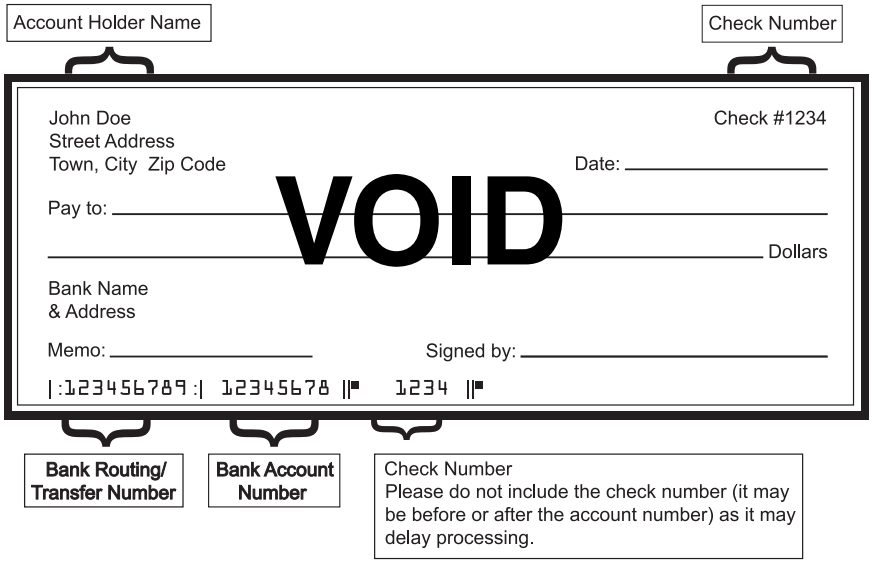
Bank Account No. _____

Account Type: ☐ Checking
☐ Savings (statement savings only)

Please complete the reverse of this form to enroll in automatic payments. ▶

IMPORTANT

- Please refer to the diagram below to obtain your bank routing information.
- Be sure to attach a voided check from the checking account you wish to use.



We look forward to continuing to serve you.

This authority remains in effect until UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York, for New York residents) and BANK receive notification from me (or either of us) of its termination in such time and manner as to give UnitedHealthcare Insurance Company and BANK a reasonable opportunity to act on it. I (we) have the right to stop payment of a withdrawal by notification to BANK in such time as to give BANK a reasonable opportunity to act upon it, with the understanding that such action may put my (our) health care contract in late status and subject to cancellation.

Name(s) _____ Member # _____

Signature _____ Date _____

Spouse's Signature _____ Date _____

(if joint account is maintained)

Please do not write in the space below for company use only.

_____

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

Horsham, Pennsylvania

Save this notice! It may be important to you in the future

According to the information you furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by UnitedHealthcare Insurance Company. 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 or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement To Appplicant By Issuer, Agent, Broker Or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement policy or leave your Medicare Advantage plan. The replacement policy is being purchased for one of the following reasons (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.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for Disenrollment.

_____ Other (Please Specify) _____

_____

_____

1. Health conditions which you may presently have (Pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
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 (or coverage) for similar benefits to the extent such time was spent (depleted) 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, review it carefully to be certain that all information has been properly recorded.

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) (Date)

_____

(Applicant's Signature) (Date)

_____

(Applicant's Printed Name & Address)