United American insurance company

ProCare®

Medicare Supplement Insurance Policies

Help to reduce out-of-pocket costs that Medicare does not pay.

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IA
UAI0260 **0523**

ProCare®

Medicare Supplement Insurance Policies
Help to reduce out-of-pocket costs that Medicare does not pay.

Choosing a Medicare Supplement Plan

We offer Medicare Supplement policies for 11 of the 12 standardized plans A, B, C, D, F/HDF, G/HDG, K, L, and N *(plan availability may vary by state)*. All Medicare Standardized plans include the following Basic Benefits:

- **Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses:** Part B coinsurance *(generally 20% of Medicare approved expenses)* or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of the Part B coinsurance or copayment.
- **Blood:** First 3 pints of blood each year.
- **Hospice:** Part A coinsurance for eligible hospice/respite care expenses.

See outline of coverage for details and exceptions.

Only applicants first eligible for Medicare Part A before 2020 may purchase Plans C, F, and High Deductible Plan F.

	Plans Available to All Applicants							Medicare First Eligible Before 2020 Only	
Medicare Plans / Benefits	A	B	D	G▼	K■	L■	N●	C	F▼
Basic Benefits									
Hospitalization (Part A Coinsurance)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medical Expenses (Part B Coinsurance)	100%	100%	100%	100%	50%	75%	Copay●	100%	100%
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■					$6,940	$3,470			

▼ Plans F and G also have a high deductible option which requires first paying a plan deductible of *($2,700 in 2023)* before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High Deductible Plan G does not cover the Medicare Part B deductible. However, High Deductible Plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

■ Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit *($6,940 for Plan K, $3,470 for Plan L in 2023)*. The out-of-pocket annual limit does NOT include the charges from your provider that exceed Medicare-approved amounts, called 'excess charges'. You will be responsible for paying excess charges. The out-of-pocket annual limit may increase each year for inflation.

● Plan N pays 100% of Medicare Expenses *(Part B Coinsurance)* except for a copayment of up to $20 for some office visits and up to $50 copayment for emergency room visits that do not result in an inpatient admission. 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.

Some states require designated Medicare Supplement plans also be available to people under age 65 and eligible for Medicare due to disability *(different application forms may be required)*. Policy benefits are identical for people over or under age 65. Premiums are based on Preferred or Standard, age, sex, State/Area*.

'App Pack' Agent Instructions

ProCare Medicare Supplement applications and other commonly required forms are now conveniently packaged for your state(s) and available through Agent Supply. Please refer to the appropriate Compliance Sheet on the General Agency website for specific state requirements including possible additional forms. *(When you receive your order from Agent Supply, always verify the correct state(s) ordered are listed on the cover of the Pack.)* App Pack materials also are still available to download and print from the General Agency website.

App Pack includes:

- Color Brochure with Conditional Receipt
- Application
- HIPAA Authorization
- Replacement Form(s)
- Bank Draft Authorization
- Fax Cover Sheet

The Outline of Coverage and Medicare Buyers Guide are separate forms and not included in the App Pack.

Note: Depending on state requirements, there may be two types of replacement forms in this packet. Complete and submit *only* the form applicable to the sale. The Medicare Supplement Replacement Form (REPMSM, or state special version) is used when replacing a Medicare Supplement policy. The Health Insurance Replacement Form is used when replacing a major medical or other health insurance policy.

ALWAYS refer to the appropriate Compliance Sheet on the General Agency website for specific state requirements including possible additional forms.

Remove and send to Home Office:

1. Application
2. HIPAA Authorization
3. Replacement Form (Home Office copy)
4. Bank Draft Authorization
5. Fax Cover Sheet

Leave with Applicant:

1. Color Brochure
2. Conditional Receipt
3. HIPAA Authorization
4. Appropriate Replacement Form (Applicant copy)
5. Outline of Coverage*
6. Medicare Buyers Guide*

*Not included in App Pack.

Globe Life
General Agency Division

United American Insurance Company | Globe Life Insurance Company of New York | Globe Life And Accident Insurance Company

New Business and Underwriting Fax Cover Sheet

Please select only one company

❑ United American Insurance Company

❑ Globe Life Insurance Company of New York

❑ Globe Life And Accident Insurance Company

Fax 972-767-4462*
Secondary 972-569-3678

Date _____

Applicant's Name _____

Policy Number _____

Agent Name _____

Agent Writing Number _____

Attention to _____

Reason for Fax _____

_____

_____

_____

Number of pages (including this cover page) _____

*Do not fax applications that have been mailed. Only fax to one number.

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

PART I: APPLICANT INFORMATION

Plan Code (Refer to Rate Card)

Effective Date Requested (mm-dd-yyyy)

*Medicare first eligible before 2020 only

Select Plan Applying for ○ A ○ B ○ C* ○ D ○ F* ○ HDF* ○ G ○ HDG ○ K ○ L ○ N

Mode of Premium
- ○ Annual
- ○ Semi-Annual
- ○ Quarterly
- ○ Monthly

Method of Payment
- ○ Send Premium Notices
- ○ Automatic Payment Plan

Draft Date
Day (01-28) of the Month to Draft Bank Account

Applicant's First Name

M.I.

Last Name

Applicant's Mailing Address:

Street or Route

City

State

Zip Code

County

If Applicant's Residence Address is different from Mailing Address, show below:

Street or Route

City

State

Zip Code

County

Social Security Number - -

Height (ft. in.)

Weight (lbs.)

Date of Birth (mm-dd-yyyy) - -

Age Last Birthday

Sex ○ Male ○ Female

Have you used tobacco in any form in the past 12 months? ○ **Yes** ○ **No**

E-mail Address of Proposed Insured

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:
- ○ 8 AM - Noon
- ○ Noon - 6 PM
- ○ 6 PM - 9 PM

Home Phone No. - -

Work Phone No. - -

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: **Yes No**

1. (a) Did you turn age 65 in the last six (6) months? ○ ○

   (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) ☐☐ - ☐☐ - ☐☐☐☐

   (d) What is your Medicare Claim Number? ☐☐☐☐☐☐☐☐☐☐☐
   (as shown on your Medicare card omitting dashes)

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) ☐☐ - ☐☐ - ☐☐☐☐

   Yes No
   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ○ ○
   (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) ☐☐ - ☐☐ - ☐☐☐☐

Yes No

6. Are you within 6 months of your enrollment in Medicare Part B or otherwise qualified for open enrollment? ○ ○
   (Questions 7-17 not required if the answer to question 6 is "YES".)

PART II: ELIGIBILITY QUESTIONS (continued)

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES," THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE:

		Yes	No
7.	Are you currently hospitalized, confined to a nursing facility or receiving Medicare approved home health care, or have you been hospitalized or received Medicare approved home health care 2 or more times in the past 12 months?	○	○
8.	Do you have emphysema, Chronic Obstructive Pulmonary Disease (COPD), or pulmonary fibrosis?	○	○
9.	Are you bedridden or do you use a wheelchair for any daily activity, or have you been diagnosed with Gaucher's Disease or any other type of lysosomal storage disorder, or have you had any type of amputation caused by disease?	○	○
10.	Have you been advised that surgery may be required within the next twelve months for cataracts?	○	○
11.	Have you been diagnosed or treated for Parkinson's disease, Multiple or Lateral Sclerosis, Alzheimer's disease, senile dementia, or organic brain disorder?	○	○
12.	Have you been treated, diagnosed or tested positive as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or ever tested positive for antibodies for the AIDS (HIV) virus?	○	○
13.	Do you have diabetes requiring more than 50 units of insulin daily?	○	○
14.	Within the past 2 years, have you been diagnosed or treated for internal cancer, melanoma, leukemia, alcoholism or drug abuse, cirrhosis, mental or nervous disorder requiring psychiatric care, or have you been advised to have kidney dialysis?	○	○
15.	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)?	○	○
16.	Within the past 2 years, have you been diagnosed or treated for rheumatoid arthritis or crippling arthritis?	○	○
17.	Within the past year, have you been fed intravenously or through a tube, have you been medically advised to have surgery for joint replacement or for a heart condition, but not had such surgery, or have you been advised to have other surgery that has not been performed?	○	○

PART III

I. INVOLUNTARY TERMINATION OF COVERAGE:

If your previous coverage was terminated involuntarily, please provide a copy of the notice of termination of coverage and attach it to this form.

What type of coverage was terminated? _____

Date of termination? (mm-dd-yyyy) ☐☐ – ☐☐ – ☐☐☐☐ Reason for termination? _____

II. VOLUNTARY TERMINATION OF COVERAGE:

If you voluntarily terminated your present coverage, please attach evidence of previous coverage to this form.

What type of coverage was terminated? _____

Date of termination? (mm-dd-yyyy) ☐☐ – ☐☐ – ☐☐☐☐ Reason for termination? _____

If you voluntarily terminated coverage under a Medicare Advantage plan* or Medicare Select policy, please answer the following questions:

		Yes	No
1.	Was this the first time you were ever enrolled in a Medicare Advantage plan or purchased a Medicare Select policy?	○	○
	If so, did you have the Medicare Advantage plan or Medicare Select policy for less than 12 months?	○	○
2.	Did you have a Medicare Supplement policy before applying for the Medicare Advantage plan or Medicare Select policy?	○	○

If "YES", with which Company and which Medicare Supplement plan?

_____

Is that Company still offering that Medicare Supplement plan? ○ ○

* Medicare Advantage plan means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.

PART IV: APPLICANT AUTHORIZATION

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

(4) 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.

(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 suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I hereby apply to United American Insurance Company for a policy to be issued in reliance on my written answers to the above questions. The answers are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued. I have received an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide.

I understand that loss due to injury or sickness for which medical advice was received or treatment was recommended or given by a physician within 6 months prior to the policy effective date is not covered unless the loss is incurred more than 60 days after the policy effective date, subject to the Time Limit on Certain Defenses provision and legal proceedings.

I authorize the MIB, Inc., any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to United American Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that any information obtained will not be released to any person or organization except to the MIB, Inc., reinsuring companies or other persons or organizations performing business or legal services in connection with this application, with a claim or as may be otherwise lawfully required. I agree that a copy of this authorization is to be acceptable. This authorization will remain in effect for a period of 24 months from the date signed. I understand that I or an authorized representative may request a copy of this authorization. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

No agent may bind, alter, change or waive any underwriting requirements or other provisions of the application or policy. Final acceptance is made by the Underwriting Department of the Company.
Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Application Signed at City | **State** | **On this Date (mm-dd-yyyy)** ____ - ____ - ____

Amount paid with application: $ ____,___.__

for first ____ months premiums.

Applicant's Signature

Total Premium $ ____,___.__

PART V: AGENT CERTIFICATION

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.

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:

_____

_____

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:

_____

_____

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.

Last Name | | | | | |

Agent No. | | | | | | |

_____
Agent's Signature

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

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

Requested Bank Draft Day (dd)

[ ][ ]

Payor's First Name [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

M.I. [ ]

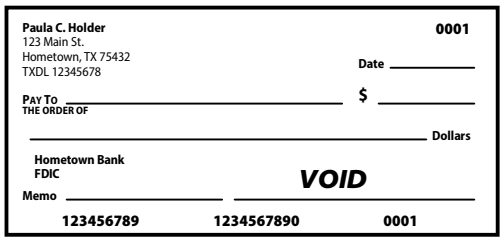
Payor's Last Name [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Bank ABA Routing Number [ ][ ][ ][ ][ ][ ][ ][ ]

Account Number [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Bank Name [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

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

Account Number

Check Number

Helpful Information for Social Security Recipients		
Social Security Benefits Paid On	Birth Date On	Draft Date
Second Wednesday	1st – 10th	14th
Third Wednesday	11th – 20th	21st
Fourth Wednesday	21st – 31st	28th

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 - <u>Business</u> 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)

FORM 1080-C

48656

UAI1756 **0423**

UNITED AMERICAN INSURANCE COMPANY

3700 S. Stonebridge Drive • McKinney, Texas 75070

Authorization for Release of Health-Related Information

This authorization is intended to comply with the HIPAA Privacy Rule

_____ _____

Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, MIB, Inc., or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the United American Insurance Company (UA) and its agents, employees, and representatives. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that UA may: 1) underwrite my application(s) for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and/or 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with UA.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to UA to the attention of the Underwriting Department at the above address. I understand that a revocation is not effective to the extent that any of My Providers have relied on this Authorization, and that, to the extent that UA has a legal right to contest a claim under an insurance policy or to contest the policy itself, such revocation may prevent UA from completing its review of policy claims. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, UA may not be able to process my application, or if coverage has been issued, may not be able to process policy claims. I acknowledge that I have received a copy of this authorization.

_____ _____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

Home Office Copy

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered YES, this form must be dated, signed by the applicant and by the Agent, and submitted with the application, AND a copy of this form must be left with the applicant.

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

UNITED AMERICAN INSURANCE COMPANY

3700 S. STONEBRIDGE DRIVE, P.O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085

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

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by United American 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 APPLICANT BY ISSUER OR 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 or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement coverage 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.
- ❑ 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 REQUESTED 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 requested 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.

_____ (Agent's Signature)

Type or print name & address of Agent or Broker:

_____

_____

_____ (Applicant's Signature)

_____ (Date)

UNITED AMERICAN INSURANCE COMPANY

A LEGAL RESERVE STOCK COMPANY • ADMINISTRATIVE OFFICES: McKINNEY, TEXAS

3700 S. STONEBRIDGE DR., P.O. BOX 8080, McKINNEY, TEXAS 75070 (972) 529-5085

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of accident and sickness insurance.

When the replacement question on the application is answered YES, this form must be dated, signed by the applicant and submitted with the application AND a copy of this form must be left with the applicant.

NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to **(your application) (the information you have furnished)**, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by United American Insurance Company. Your new policy provides a period within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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 a 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. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, 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/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, reread it carefully to be certain that all information has been properly recorded.

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

_____

(Date)

_____

(Applicant's Signature)

UNITED AMERICAN INSURANCE COMPANY

A LEGAL RESERVE STOCK COMPANY • ADMINISTRATIVE OFFICES: McKINNEY, TEXAS
3700 S. STONEBRIDGE DRIVE • P.O. BOX 8080 • McKINNEY, TEXAS 75070 • (972) 529-5085

ACKNOWLEDGEMENT OF NONDUPLICATION
(PLEASE READ CAREFULLY BEFORE SIGNING)

I. I, _____ , certify that I have done the following:
(Print Agent's Name)

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

2. Reviewed the policies listed below and have found that duplication
   - ❑ WILL
   - ❑ WILL NOT

   occur with the issuance of the following policy: _____
   (Policy Form Number)

APPLICANT'S CURRENT HEALTH INSURANCE POLICIES

Company	Policy Number	Policy Type

_____ Duplication of coverage will not occur because the above listed policy/policies will be replaced by the applied for policy.

_____ No health policies are in force at this time.

_____ Applicant has elected not to have policy/policies reviewed.

Date:_____ Agent:_____
(Signature)

II. I certify that I have been informed of my right to have all of my existing health insurance policies reviewed and:

_____ I have been informed that the policy for which I am applying
- ❑ WILL RESULT IN DUPLICATE COVERAGE.
- ❑ WILL NOT RESULT IN DUPLICATE COVERAGE.

_____ I have elected not to have my policies reviewed.

Date:_____ Applicant:_____
(Signature)

UNITED AMERICAN INSURANCE COMPANY

3700 S. Stonebridge Drive • McKinney, Texas 75070

Authorization for Release of Health-Related Information

This authorization is intended to comply with the HIPAA Privacy Rule

_____ _____

Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, MIB, Inc., or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the United American Insurance Company (UA) and its agents, employees, and representatives. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that UA may: 1) underwrite my application(s) for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and/or 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with UA.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to UA to the attention of the Underwriting Department at the above address. I understand that a revocation is not effective to the extent that any of My Providers have relied on this Authorization, and that, to the extent that UA has a legal right to contest a claim under an insurance policy or to contest the policy itself, such revocation may prevent UA from completing its review of policy claims. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, UA may not be able to process my application, or if coverage has been issued, may not be able to process policy claims. I acknowledge that I have received a copy of this authorization.

_____ _____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

Applicant Copy

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered YES, this form must be dated, signed by the applicant and by the Agent, and submitted with the application, AND a copy of this form must be left with the applicant.

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

UNITED AMERICAN INSURANCE COMPANY

3700 S. STONEBRIDGE DRIVE, P.O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085

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

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by United American 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 APPLICANT BY ISSUER OR 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 or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement coverage 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.
- ❑ 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 REQUESTED 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 requested 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.

_____ (Agent's Signature)

Type or print name & address of Agent or Broker:

_____

_____

_____ (Applicant's Signature)

_____ (Date)

UNITED AMERICAN INSURANCE COMPANY

A LEGAL RESERVE STOCK COMPANY • ADMINISTRATIVE OFFICES: McKINNEY, TEXAS

3700 S. STONEBRIDGE DR., P.O. BOX 8080, McKINNEY, TEXAS 75070 (972) 529-5085

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of accident and sickness insurance.

When the replacement question on the application is answered YES, this form must be dated, signed by the applicant and submitted with the application AND a copy of this form must be left with the applicant.

NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to **(your application) (the information you have furnished)**, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by United American Insurance Company. Your new policy provides a period within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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 a 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. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, 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/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, reread it carefully to be certain that all information has been properly recorded.

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

_____

(Date)

_____

(Applicant's Signature)

UNITED AMERICAN INSURANCE COMPANY

A LEGAL RESERVE STOCK COMPANY • ADMINISTRATIVE OFFICES: McKINNEY, TEXAS
3700 S. STONEBRIDGE DRIVE • P.O. BOX 8080 • McKINNEY, TEXAS 75070 • (972) 529-5085

ACKNOWLEDGEMENT OF NONDUPLICATION
(PLEASE READ CAREFULLY BEFORE SIGNING)

I. I, _____ , certify that I have done the following:
(Print Agent's Name)

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2. Reviewed the policies listed below and have found that duplication
   - ❑ WILL
   - ❑ WILL NOT

   occur with the issuance of the following policy: _____
   (Policy Form Number)

APPLICANT'S CURRENT HEALTH INSURANCE POLICIES

Company	Policy Number	Policy Type

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_____ No health policies are in force at this time.

_____ Applicant has elected not to have policy/policies reviewed.

Date:_____ Agent:_____
(Signature)

II. I certify that I have been informed of my right to have all of my existing health insurance policies reviewed and:

_____ I have been informed that the policy for which I am applying
- ❑ WILL RESULT IN DUPLICATE COVERAGE.
- ❑ WILL NOT RESULT IN DUPLICATE COVERAGE.

_____ I have elected not to have my policies reviewed.

Date:_____ Applicant:_____
(Signature)

ProCare®

Medicare Supplement Insurance Policies

Help to reduce out-of-pocket costs that Medicare does not pay.

United American's ProCare® plans are a smart choice …

Why Choose United American Insurance Company?

United American is a name trusted by doctors and hospitals nationwide. Medicare was signed into law in 1966, and that year United American Insurance Company developed its first Medicare Supplement program. UA has been providing Medicare Supplement insurance ever since, and we have developed an industry-wide reputation for quality Senior insurance products. Today, UA is one of the largest nationwide underwriters of individual insurance to supplement Medicare*, and we are proud of our legacy of quality products and superior service.

*NAIC Medicare Experience Report by Direct Premium Earned for Total Individual Policies, August 2022.

Freedom to Choose & Nationwide Acceptance

There is no designated physician list. There is no approval process to see a specialist. Our ProCare Medicare Supplement plans are recognized and accepted nationwide.

Strength of Tradition

A Medicare Supplement policy from United American is protection that can never be canceled *(unless there is a material misrepresentation)* as long as premiums are paid on time.

Assurance of Service

- Medicare Supplement coverage from United American features on-the-spot qualification in most cases.
- We're neighbors! We have an agent in your local area.

Financial Strength❖

For more than 45 consecutive years, UA has earned the A (Excellent) or higher Financial Strength Rating from A.M. Best Company (rating as of 8/22).❖

UA has been rated AA – (Very Strong) for Financial Strength by Standard & Poor's (rating as of 10/22).❖

❖ These ratings refer only to the financial strength of the company and are not a recommendation of the specific policy provisions, rates or practices of the insurance company.

United American Insurance Company is not connected with or endorsed by the U.S. Government or federal Medicare program. Policies and benefits may vary by state and have some limitations and exclusions. Individual Medicare Supplement policy forms MSA10, MSB10, MSC10, MSD10, MSF10, MSHDF10, MSG10, MSHDG, MSK06, MSL06, and MSN10 are available from our Company where state approved. Some states require these plans be available to persons eligible for Medicare due to disability or End Stage Renal Disease (ESRD). Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and HDF. This is a solicitation for insurance. You may be contacted by an agent representing United American Insurance Company. A licensed agent will provide additional information upon request.

ProCare®

Medicare Supplement Insurance Policies

Help to reduce out-of-pocket costs that Medicare does not pay.

30-Day review period

If after receiving your ProCare policy you want to cancel for any reason, simply return your policy and I.D. card to our Home Office within the 30-day period. Any premium, less any claims paid, is refunded.

Effective Date of Coverage

When the policy applied for has been issued.

Limitations and Exclusions

No benefits are payable for: any expense which you are 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, except as provided under the Foreign Travel Emergency benefit.

Pre-existing Conditions

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 6 months prior to policy effective date is not covered unless the loss is incurred more than 60 days *(6 months for underage 65 disability*)* after the effective date. Waiting period waived if replacing a Medicare Supplement policy.

*May vary by state

I, _____,
have applied for the following policy benefits:

I understand this brochure only highlights the available policies/ features and I should refer to my Outline of Coverage and the policy for specific benefit provisions and limitations.

Applicant Notice and Conditional Receipt

I have purchased the following Medicare Supplement Plan:

❑ A ❑ B ❑ C ❑ D ❑ F ❑ HDF

❑ G ❑ HDG ❑ K ❑ L ❑ N

My Medicare Supplement Plan is:

❑ Attained Age Rated.
Where applicable, premiums on policies with Attained Age Rates increase on each policy anniversary due to your age change, until age 81.

❑ Issue Age Rated or Community Rated.
Where applicable, premiums on policies with Issue Age Rates or Community Rates are based on age at time of issue.

All checks must be made payable to United American:
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Received of _____
Proposed Insured's Name

a bank draft authorization or check in the sum of $_____for _____ month(s) Medicare Supplement policy premium, other policy fees and noninsurance charges with application for Policy Form MSA10, MSB10, MSC10, MSD10, MSF10, MSHDF10, MSG10, MSHDG, MSK06, MSL06, or MSN10.

If for any reason the policy is not issued, payment is to be refunded in full. Insurance is not effective until the policy applied for has been issued by the Home Office.

_____ _____
Date Agent's Signature

Applicant Information:
Keep this document. It highlights the benefits of your policy. It is not a contract. Your actual policy provisions will govern your benefits.

Instructions to Agent:
Complete this section and leave with the applicant. Fill in the selected plan as chosen on the application in the spaces provided above and complete the conditional receipt.

United American insurance company

3700 S Stonebridge Dr
PO Box 8080 | McKinney, TX 75070
UnitedAmerican.com