



MARKETPLACE BULLETIN

ProCare[®] (MEDICARE SUPPLEMENT)

PRODUCT INFORMATION				APPROVED FOR	POLICY TYPE
Plan Code	See NYPCRC Rate Sheets			<input checked="" type="checkbox"/> Individual <i>(Bank Draft or Direct Bill)</i>	<input type="checkbox"/> Accident and Health <input type="checkbox"/> Annuity <input checked="" type="checkbox"/> Medicare Supplement <input type="checkbox"/> Whole Life <input type="checkbox"/> Term Life
Policy Form	NYMSA10	NYMSF10	NYMSK06		
	NYMSB10	NYMSHDF10	NYMSL06		
	NYMSC10	NYMSG10	NYMSN10		
	NYMSD10				
Issue Ages	65 and above <i>(or under age 65 and eligible for Medicare due to disability)</i>				

MEDICARE OVERVIEW

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 automatic for most, but because individuals must pay a premium for Part B coverage, they have the option to turn it down. 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) COPAY & DEDUCTIBLE AMOUNTS	
2012 (Updated Annually)	
Part A Annual Deductible	\$1,156
Day 61-90 per day Hospital Copayments	\$289
Day 90-120 per day Hospital Copayments	\$578
Day 21-100 Skilled Nursing Facility Copayments	\$144.50
Part B Annual Deductible	\$140
F+ Annual Deductible	\$2,070

The Centers For Medicare & Medicaid Services publishes a guide to Medicare, 'Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare', also referred to as a Medicare Buyer's Guide. The guide is updated annually. First United American Life Insurance Company 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 the guide as a training tool to understand the benefits of the Medicare Program.

PRODUCT OVERVIEW

Medicare Supplement Insurance plans are standardized by the federal government, meaning the coverage and benefits are the same no matter which insurance company is the provider. Premiums and 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.

First United American offers standardized plans A, B, C, D, F, F+, G, K, L, and N. 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 of Coverage from the Compliance Sheet online at www.firstunitedamerican.com/office. 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.

ELIGIBILITY

Applicants enrolled in Medicare Part A and Part B are eligible to purchase a Medicare Supplement. The applicant's Medicare ID number is required on the application. The ID number is vital to future claims processing.

If you are age 65 or older and enrolled in Medicare Parts A and B, you are eligible for Medicare Supplement coverage. You are also eligible if you are under age 65 and qualify for Medicare due to disability. All applicants are guaranteed issue in New York.

BENEFITS OVERVIEW

See Outline of Coverage for details and exceptions.

MEDICARE PLANS / BENEFITS	A	B	C	D	F [▼]	F+ [▼]	G	K [■]	L [■]	N [●]
Basic Benefits										
Hospitalization (Part A Coinsurance)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Expenses (Part B Coinsurance)	100%	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%	100%			
Foreign Travel Emergency			✓	✓	✓	✓	✓			✓
Calendar-Year Deductible [▼]						\$2,070				
Out-of-pocket Annual Limit [■]								\$4,660	\$2,330	

- ▼ Plan F also has an option called a high deductible Plan F (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 begins after out-of-pocket expenses exceed the calendar-year deductible (\$2,070 in 2012). 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 the insured reaches the annual limit (\$4,660 for Plan K, \$2,330 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'. The insured is 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. And, in New York, premiums are Community rated, meaning there is 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.

ProCare Medicare Supplement policies have a 30-day free-look period. If the policyholder is not satisfied with the policy, it can be returned to the Company and all payments, less any claims paid, are returned.

LIMITATIONS, EXCLUSIONS, AND EXCEPTIONS

- 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
 - any type of expense not eligible for coverage under Medicare.
- 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 after the effective date. Waiting period waived if replacing an existing policy.

REPLACEMENT RULES

You must comply with applicable laws and regulations in each State in which you are appointed. Here are points to keep in mind when selling Medicare Supplement policies:

- You are required to ask all questions on the application and to leave with the applicant an Outline of Coverage, a Medicare Buyer's Guide, and our Company's Medicare Supplement brochure. If replacement is involved, you must, along with the applicant, fill out and sign the Replacement Notices. The name of the insurance company being replaced is a required field on the application. Submit the completed and signed Replacement Notices and application to the Home Office.
- Determine in each case that any policy sold is suitable to the needs of the applicant. Consider such issues as the applicant's financial situation, need for insurance, the values, benefits, deductibles, and costs in relation to any existing coverage he or she has, and whether, in the totality of the applicant's circumstances, this sale is suitable. Of course, always remind applicants they have a free look period to review their new coverage.
- If an applicant currently has or previously had coverage via a Medicare Advantage (MA) plan (*regardless of whether their healthcare services were received through an HMO, PPO, etc.*), be certain you do not create any hardships. Remember, the applicant must be disenrolled from the MA plan and enrolled in traditional Medicare prior to the effective date of their ProCare Medicare Supplement policy. You should assist in making certain correct information is obtained about disenrolling from the MA plan and enrolling in traditional Medicare. Duplicate insurance is not allowed, and enrollment in Medicare is necessary to ensure that benefits are not lost.

INSTRUCTIONS FOR COMPLETING THE PROCARE® MEDICARE SUPPLEMENT APPLICATION

The new NYMA14 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 **X** or **✓**.
- 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 First 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 NYMA14 application is to be used for all available plans. Please check compliance sheets for current plan approvals.
- 3. Effective Date** – 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 is acceptable.
- 4. Method of Payment and Draft Date** – Premiums automatically deducted from the insured's checking account are far less likely to lapse or cancel. A personalized voided check must be attached to the Bank Draft Authorization section. Draft date cannot be the 29th, 30th, or 31st.
- 5. Residence Address** – If the applicant's residence address is different from the mailing address, fill out this section.
- 6. Applicant Information** – Be sure to record the applicant's Social Security number, date of birth, and gender. This information is required for processing.
- 7. Application Verification Information** – A phone number (*home or work*) should be written on the application.

THE SALE OF A MEDICARE SUPPLEMENT POLICY IS PROHIBITED WHERE AN INDIVIDUAL HAS A MEDICARE SUPPLEMENT POLICY IN FORCE AND DOES NOT DESIRE TO REPLACE THE EXISTING POLICY OR WHERE THE MEDICARE SUPPLEMENT POLICY WOULD DUPLICATE BENEFITS TO WHICH THE INDIVIDUAL IS ENTITLED UNDER A MEDICARE ADVANTAGE PLAN.
APPLICATION FOR INSURANCE
FIRST UNITED AMERICAN LIFE INSURANCE CO. * A NEW YORK STOCK CO. * HOME OFFICE: SYRACUSE, NY

PART I: APPLICANT INFORMATION

1	Plan Code	3	Advanced Effective Date Requested
	<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>
2	Select Plan Applying for:	4	Draft Date
	<input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D <input type="radio"/> F <input type="radio"/> F+ <input type="radio"/> G <input type="radio"/> K <input type="radio"/> L <input type="radio"/> N	<input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Quarterly <input type="radio"/> Monthly (APP only) <input type="radio"/> Send Premium Notices <input type="radio"/> Automatic Payment Plan	Day (01-28) of the Month to Draft Bank Account <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
Applicant's First Name <input style="width: 100%;" type="text"/>			
Last Name <input style="width: 100%;" type="text"/> M.I. <input style="width: 20px;" type="text"/>			
Applicant's Mailing Address:			
Street or Route <input style="width: 100%;" type="text"/>			
City <input style="width: 80%;" type="text"/> State <input style="width: 10%;" type="text"/>			
Zip Code <input style="width: 20%;" type="text"/> County <input style="width: 60%;" type="text"/>			
5	If Applicant's Residence Address is different from Mailing Address, show below:		
	Street or Route <input style="width: 100%;" type="text"/>		
	City <input style="width: 80%;" type="text"/> State <input style="width: 10%;" type="text"/>		
	Zip Code <input style="width: 20%;" type="text"/> County <input style="width: 60%;" type="text"/>		
6	Social Security Number <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/>		
	Date of Birth (mm-dd-yyyy) <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/>	Age Last Birthday <input style="width: 20%;" type="text"/>	Sex <input type="radio"/> Male <input type="radio"/> Female
E-mail Address of Proposed Insured <input style="width: 100%;" type="text"/>			
7	Application Verification Information		
	<input type="radio"/> 8 AM - Noon <input type="radio"/> Noon - 6 PM <input type="radio"/> 6 PM - 9 PM Home Phone No. <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> Work Phone No. <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/>		

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(Application Continued)

8. 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 (*ID*) Number is never the same as the Social Security Number.

9. Medicaid – Applicants receiving state low-income program assistance are not eligible for coverage.

10. Replacement – If the answer to questions 3b or 4a is ‘Yes,’ two Medicare Supplement Insurance Replacement forms (*NYREPMSSM*) and (*NYU-1366 R10*), are **mandatory**. Use the replacement forms to compare the applicant’s current Medicare Supplement policy with the new First UA Med-Supp policy. This comparison helps you and the applicant determine what box to check on the replacement forms. Always be certain any comparison to other coverage is fair and accurate and excessive insurance is not sold. There are absolutely no exceptions to replacement forms. Applications submitted without replacement forms or with incorrect replacement forms are pended for the correct form and notice sent to the Agent.

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

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

If the *F+* 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 Notices; in the space provided next to the ‘Other’ box, indicate the applicant is willing to pay a high deductible for lower premiums.

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

If the *F+* is an appropriate replacement for a Plan G, check the box on the Replacement forms labeled ‘Fewer benefits and lower premiums.’

If the *F+* 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 Notices; in the space provided next to the ‘Other’ box, indicate the applicant is willing to pay an annual out-of-pocket limit for lower premiums.

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APPLICATION FOR INSURANCE
FIRST UNITED AMERICAN LIFE INSURANCE CO. * A NEW YORK STOCK CO. * HOME OFFICE: SYRACUSE, NY

PART II: ELIGIBILITY QUESTIONS

PLEASE ANSWER ALL QUESTIONS.

TO THE BEST OF YOUR KNOWLEDGE:

8 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) - -

(d) What is your Medicare Claim Number? - - -
(exactly as shown on your Medicare card)

9 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.
If 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?

10 3. (a) If you had coverage from any Medicare Advantage plan other than original Medicare within the past 63 days (for example, a Medicare HMO, PPO or PFFS), fill in your start and end dates below. If you are still covered under the Medicare Advantage plan, leave "END Date" blank. Yes No

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

(b) If you are still covered under the Medicare Advantage 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 Advantage plan?

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

4. (a) Do you have another Medicare Supplement or Medicare Select 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 or Medicare Select 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) - -

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(Application Continued)

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PART IV: APPLICANT AUTHORIZATION

11. Application Signed At – Enter the city, state, and date of the application. Obtain the applicant’s signature.

STATED VALUE OF THE GROSS FOR EACH SUCH LOCATION.

11 Application Signed at City State On this Date (mm-dd-yyyy) - -

Amount paid with application: \$, .

Applicant's Signature _____ for first months premiums.

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(Application Continued)

PART V: AGENT CERTIFICATION

12. All applications must be filled out and signed in person.
13. You are required to list any health insurance policy you have sold to this applicant. These policies are not limited to policies issued by First United American Life Insurance Company. The Agent's signature and Agent number are required.
14. Enter the first five letters of your last name and your First UA Agent number.

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FIRST UNITED AMERICAN LIFE INSURANCE CO. * A NEW YORK STOCK CO. * HOME OFFICE: SYRACUSE, NY

PART IV: AGENT CERTIFICATION

12 The undersigned Agent certifies that he/she has personally met with the Applicant and that the Applicant has read, or had read to him/her, the completed application.

13 **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, (3) I have reviewed the current health insurance coverage of the Applicant and find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.

14 Last Name: Agent No.

Agent's Signature

NYMA14 MAIL POLICY TO: Agent Insured

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APPLICATION SUBMISSIONS

Paper Applications

First United American Life Insurance Company
P.O. Box 3125
Syracuse, NY 13220-3125

Fax

972-569-3678 (Medicare Supplement Applications only)

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 NYMA14	<input checked="" type="checkbox"/> Advertising Brochure F3747NYR07	<input checked="" type="checkbox"/> Brainshark
<input checked="" type="checkbox"/> Replacement Notices NYU-1366 NYREPMSM	<input checked="" type="checkbox"/> Laptop Sales Presentation	<input checked="" type="checkbox"/> Marketplace Bulletin
<input checked="" type="checkbox"/> Bank Draft Authorization N5820	<input checked="" type="checkbox"/> eApp	<input type="checkbox"/> Sample Policy
<input checked="" type="checkbox"/> New Business Transmittal Form FUAL1080 R2	<input checked="" type="checkbox"/> Product Brochure F4931NYR10	<input checked="" type="checkbox"/> Compliance Sheet
	<input checked="" type="checkbox"/> Conditional Receipt NYMSCR10	<input checked="" type="checkbox"/> Rate Card(s)
	<input checked="" type="checkbox"/> Outline of Coverage	<input checked="" type="checkbox"/> Medicare A/B Chart
	<input checked="" type="checkbox"/> A Guide To Health Insurance For People With Medicare (NAIC)	<input checked="" type="checkbox"/> Side by Side Guide

STATE APPROVAL & REQUIRED FORMS CHART

PROCARE MEDICARE SUPPLEMENT				
	Application	Outline of Coverage	Brochure	Replacement Notices
New York	NYMA14	DS-NYMS2010	F4931NY R10	NYREPM SM NYU-1366 R10