

FIRST UNITED AMERICAN LIFE INSURANCE COMPANY

P.O. Box 3125 • Syracuse, New York 13220

REPLACEMENT OF MEDICARE SUPPLEMENT

Health Insurance Policy – Comparison Form

Current Policy

Proposed Policy

Name of Company: _____

Name of Company: First United American Life Insurance Company

Policy Number: _____

Application Number: _____

Premium: _____ Type: _____

Premium: _____ Type: _____

Applicant's Name: _____

- Does the current policy provide a service for an automatic filing of both assigned and unassigned Part B claims?
- If the current policy is a standardized Medicare Supplement Plan under the 1990 OBRA Law, identify the plan category as A, B, C, D, E, F, High Deductible F, G, H, I, J, High Deductible J, K, or L.

Current Policy

Yes No

FUA Policy

Yes No

Current Plan

ProCare Plan

A	B	C	D	F	HDF	G	K	L
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

There is no need to complete the rest of this form if the current policy is a standardized Plan.

- If the current policy is not a standardized Plan, answer the following questions for the current policy only.

PART A

Current Policy

- Pays Medicare Part A Deductible? Yes No
- Pays all expenses after Medicare Part A is exhausted up to 365 days? Yes No
- Has a Skilled Nursing Facility benefit? Yes No

First UA Policy Y = Yes N = No								
A	B	C	D	F	HDF	G	K	L
N	Y	Y	Y	Y	**	Y	50%	75%
Y	Y	Y	Y	Y	**	Y	Y	Y
N	N	Y	Y	Y	**	Y	50%	75%

PART B

- Pays Medicare Part B Deductible? Yes No
- Pays ALL Medicare Part B coinsurance amounts? Yes No
- Pays at least 80% of excess charges (amounts above Medicare approved)? Yes No
- Has a Foreign Travel Benefit? Yes No
- Is Policy Guaranteed Renewable? Yes No
- At-Home Recovery Benefit? Yes No
- Prescription Drug Benefit? Yes No
- Preventive Care Benefit? Yes No

A	B	C	D	F	HDF	G	K	L
N	N	Y	N	Y	**	N	N	N
Y	Y	Y	Y	Y	**	Y	*	*
N	N	N	N	Y	**	Y	N	N
N	N	Y	Y	Y	Y	Y	N	N
Y	Y	Y	Y	Y	Y	Y	Y	Y
N	N	N	Y	N	N	Y	N	N
N	N	N	N	N	N	N	N	N
N	N	N	N	N	N	N	N	N

Other Benefits or Services (itemize) _____

* once you meet out-of-pocket annual limit
** once you meet your calendar year deductible

The Applicant's actual current policy **was** **was not** made available to me for review.

The Applicant's current policy **is** **is not** a Medicare Advantage Plan.

The Applicant's current policy **is** **is not** employer-provided coverage.

Agent Signature and Agent Number

Date

Applicant's Signature

Date

A copy of this form must be returned with the application when a replacement is involved.

FIRST UNITED AMERICAN LIFE INSURANCE COMPANY

P.O. Box 3125 • Syracuse, New York 13220

REPLACEMENT OF MEDICARE SUPPLEMENT

Health Insurance Policy – Comparison Form

Current Policy

Proposed Policy

Name of Company: _____

Name of Company: First United American Life Insurance Company

Policy Number: _____

Application Number: _____

Premium: _____ Type: _____

Premium: _____ Type: _____

Applicant's Name: _____

1. Does the current policy provide a service for an automatic filing of both assigned and unassigned Part B claims?
2. If the current policy is a standardized Medicare Supplement Plan under the 1990 OBRA Law, identify the plan category as A, B, C, D, E, F, High Deductible F, G, H, I, J, High Deductible J, K, or L.

Current Policy

Yes No

FUA Policy

Yes No

Current Plan

ProCare Plan

A	B	C	D	F	HDF	G	K	L
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

There is no need to complete the rest of this form if the current policy is a standardized Plan.

3. If the current policy is not a standardized Plan, answer the following questions for the current policy only.

PART A

Current Policy

- Pays Medicare Part A Deductible? Yes No
- Pays all expenses after Medicare Part A is exhausted up to 365 days? Yes No
- Has a Skilled Nursing Facility benefit? Yes No

First UA Policy Y = Yes N = No								
A	B	C	D	F	HDF	G	K	L
N	Y	Y	Y	Y	**	Y	50%	75%
Y	Y	Y	Y	Y	**	Y	Y	Y
N	N	Y	Y	Y	**	Y	50%	75%

PART B

- Pays Medicare Part B Deductible? Yes No
- Pays ALL Medicare Part B coinsurance amounts? Yes No
- Pays at least 80% of excess charges (amounts above Medicare approved)? Yes No
- Has a Foreign Travel Benefit? Yes No
- Is Policy Guaranteed Renewable? Yes No
- At-Home Recovery Benefit? Yes No
- Prescription Drug Benefit? Yes No
- Preventive Care Benefit? Yes No

A	B	C	D	F	HDF	G	K	L
N	N	Y	N	Y	**	N	N	N
Y	Y	Y	Y	Y	**	Y	*	*
N	N	N	N	Y	**	Y	N	N
N	N	Y	Y	Y	Y	Y	N	N
Y	Y	Y	Y	Y	Y	Y	Y	Y
N	N	N	Y	N	N	Y	N	N
N	N	N	N	N	N	N	N	N
N	N	N	N	N	N	N	N	N

Other Benefits or Services (itemize) _____

* once you meet out-of-pocket annual limit
** once you meet your calendar year deductible

The Applicant's actual current policy **was** **was not** made available to me for review.
 The Applicant's current policy **is** **is not** a Medicare Advantage Plan.
 The Applicant's current policy **is** **is not** employer-provided coverage.

Agent Signature and Agent Number

Date

Applicant's Signature

Date

A copy of this form must be returned with the application when a replacement is involved.