# **Attention Agents:**

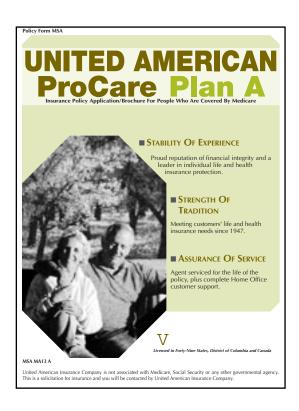
## Important ProCare Update

United American continuously strives to deliver the best possible products and services to our Agents and policyholders. With this goal in mind, UA is implementing the new ProCare MA13 application/brochure effective March 1, 2002. (Please note the MA13 application does not affect the underage disability [DMSB] product.) The new application/brochure has been redesigned and contains an increased number of health questions as well as a height/weight requirement. Adding these extra underwriting requirements will help decrease our claims loss, which over time will help reduce annual rate increases. See explanation below:

### Re: Part I — Height & Weight Requirements

If the applicant's weight is in excess of the maximum amount indicated, the individual is not eligible for a Med-Supp policy.

Height	Weight (max)
Ft. In.	<u>lbs.</u>
4' 10"	251
4' 11" 5' 0" 5' 1" 5' 2"	257
5' 0"	260
5' 1"	262
5' 2"	268
5' 3"	272
5' 4" 5' 5" 5' 6" 5' 7"	281
5' 5"	287
5' 6"	295
5' 7"	301
5' 8" 5' 9" 5' 10"	311
5' 9"	321
5' 10"	324
5' 11"	333
6' 0"	337
6' 1"	348
6' 2"	353
6' 3"	364
6' 4"	385



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#### Part II — Question 16

The criteria for answering question number 16 is as follows: If an applicant has had a heart attack or stroke more than two years ago and is on maintenance or preventive medicine only, question 16 may be answered "No." However, if within the past two years the applicant has been diagnosed or is taking any type of medicine prescribed by a physician for peripheral vascular disease, congestive heart failure, heart valve disorder, stroke, or transient ischemic attacks (TIA), then the individual is not eligible for a Med-Supp policy.

The	new M	AI3 is r	equire	d in stat	es mark	ced with	an "X"	as of 3	/1/02.	A mailing containing a sta
<b>AL</b> AK	X	GA <b>HI</b>	X	MD MI		NM NC	X	TN TX		£ ,
AR	N/A		x̂	MN		ND	N/A	UT		application/brochures, ar
AZ CA <b>CO</b>		IL IN	×	MS MO	X	OK OK	×	VA VT	N/A	underwriting information
CO	Х	IA	X	MT	X	OR		WA	X	been sent to Branch Ager
CT <b>DE</b>	×	KS KY	×	NE NV	X	PA <b>RI</b>	×	WV	×	If you need additional
DC		LA		NH	N/A	SC	X	WY	X	supplies, please contact
FL N/A —	- MΔ13	ME is not r	equire	N	le to us	SD	nt app/b	rochure		the Home Office.
N/A — MAI3 is not required, continue to use current app/brochure.										

# **Replacement Review:**

## What You Need to Know

Essential areas regarding replacement business are featured on this page. In order to comply with federal law and avoid policy issue delays, review these application submission tips and maximize onthe-spot field underwriting! Be sure to check compliance sheets for forms specific to your state.

# Shown right is a portion of the Replacement Form U-1318MSM.

Every state and the federal government requires the submission of a Replacement Form with each Medicare

- (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.

Supplement replacement policy written. Item #2 states that waiting periods do not apply to replacement business. Item #3 reserves the right of United American to deny future claims if all questions on an application have not been truthfully and accurately completed.

PART II: ELIGIBILITY QUESTIONS	
TO THE BEST OF YOUR KNOWLEDGE:	
Do you have another (or pending applications for) Medicare Supplement policy or certificate in force?  (a) If so, with which company?	□ Yes □ No
(b) If so, do you intend to replace your current Medicare Supplement policy with this policy?	☐ Yes ☐ No
Do you have any other health insurance coverage that provides benefits similar to this     Medicare Supplement policy?	□ Yes □ No
(a) If so, with which company?	
(c) Do you intend to replace your other health coverage with this policy?	☐ Yes ☐ No

Shown left are questions three and four of *Part II:* Eligibility Questions on a standard UA Medicare Supplement application.

Question #3 asks the client if they have another Med-Supp policy or certificate in-force and clarifies the intent of the client to replace any existing coverage. Question #4 asks if the client has any other coverage similar to the Med-Supp policy for which he or she is applying.

If so, which company currently carries the policy and what kind of coverage must be disclosed.

# **Shown here is** *Part V: Agent Certification of UA's MA13* **application**. In this section, the Agent attests that the Applicant has read, or had read to them, the completed application, and the Agent understands any misrepresentation may result in loss of coverage. Item #1 requires the Agent to list any other health insurance he or she has sold to the applicant which is still in-force. Item #2 asks for any other health insurance policy the Agent has sold to the applicant in the past five years which may no longer be in-force.

	PART V: AGENT CERTIFICATION	
	es that the Applicant has read, or had read to him, a that any false statement or misrepresentation in thick.	
AGENT COMPLETES (Attack	ch separate sheet, if necessary.)	
1. List any other health insuran	ce policy you have sold to the Applicant which is still	in force:
<ol><li>List any other health insuran in force:</li></ol>	ce policy you have sold to the Applicant in the past five	ve (5) years which is no longer
1		
* ' '	recorded the information supplied by the Applica licy applied for and a Medicare Supplement Buye	,
(Print Agent's Name)	(Agent's Signature)	(Agent #)

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