Important Changes to ProCare Medicare Supplement Applications

The Balanced Budget and Reconciliation Act of 1997 contains a provision for "Guaranteed Issue without Pre-existing Conditions for Continuously Covered Individuals." This means that individuals who have had health coverage without interruption are eligible (under certain situations, such as the involuntary disenrollment from an HMO, Medicare+Choice or Medicare SELECT program) for guaranteed issuance of a Medicare Supplement — Plans A, B, C or F without a pre-existing condition exclusion.

To comply with this legislation, every insurer selling Medicare Supplement products is required to add additional language to their Medigap applications.

Please note that plan benefits remain the same.

Effective January 1, 2001, Agents writing United American ProCare Medicare Supplement business will be required to use a new application — the *MA12* shown here, in states where it has been approved. See chart below.

Specific sections of this application are new. To facilitate your review of the new app we have highlighted the changes in ***Parts I, II and III*** on the application at right.

As additional states approve the new MA12 application, it will replace the MA11 application currently being used. Upon state approval, United American will send Branches a mailing containing the new brochure, updated underwriting guidelines and ordering information. See the chart below for your state(s) approval status.

MA12 is available in jurisdictions marked "X" at press time.

AL	X	GA	X	MD		NC	X	TX	X
AK		HI	X	MI	X	ND		UT	X
AZ		ID	X	MN		OH	X	VT	
AR		IL		MS	X	OK	X	VA	X
CA	X	IN	X	MO		OR	X	WA	
CO	X	IA	X	MT	X	PA	X	WV	X
CT	X	KS		NE	X	RI	X	WI	
DE		KY		NV	X	SC	X	WY	X
DC	X	LA		NH		SD	X		
FL	X	ME		NM		TN	X		

Part I: Applicant Information

E-mail: We are now requesting the proposed insured's email address (if applicable) in order to better serve customers' needs.

Draft Date: A draft date for policyholders using the Automatic Payment Plan enables customers to have the bank draft coincide with the arrival date of their Social Security check.

Part II: Eligibility Questions

Waiver: Health questions are waived if the applicant is within 6 months of Medicare enrollment or is otherwise qualified for open enrollment.

Question 8: We have added a question on Gaucher's Disease which is a form of lipidosis (any disorder of fat metabolism). The term lipid refers in general to a fat or fatlike substance. One form is Gaucher's Disease; Niemann-Pick is another form of lipidosis. Other forms are very rare and generally result in death in infancy. Gaucher's Disease is associated with an enlarged liver and spleen, increased skin pigmentation and painful bone lesions. Enzyme replacement therapy is one way to treat this disease.

Part III:

This entire section of the application is new. Applicants must answer whether they were involuntarily disenrolled or voluntarily terminated their coverage.

Ordering Information:

If your state has approved the MA12, Branch Managers can order 2001 Med-Supp supplies through the Home Office.

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE
UNITED AMERICAN INSURANCE COMPANY • A DELAWARE STOCK CO., WILMINGTON, DE • ADMIN. OFFICE: McKINNEY, TX

PART I: APPLICANT INFORMATION

1. Name of Applicant _____
Applicant's Phone # (___) _____
E-Mail Address _____

Adv. Effective Date Requested	Date of Birth Mo.	Day	Yr.	Age	Sex	Plan Code

HOME OFFICE USE ONLY (Not applicable in NH & WV) — Draft Date for Automatic Payment Plan — Premium Payment Method: ❑ Send Premium Notices ❑ Automatic Payment Plan (see over)

2. PRINT – Mailing address:
Name _____
No. & St. or Rt. No. _____
City _____ County _____
State _____ Zip _____
If residence address is different for mailing show below:
Name _____
Street _____
City _____ County _____
State _____ Zip _____

PART II: ELIGIBILITY QUESTIONS

TO THE BEST OF YOUR KNOWLEDGE:

Questions 7-12 not required if you are within 6 months of your enrollment in Medicare Part B or are otherwise qualified for open enrollment.

3. Do you have another (or pending applications for)Medicare Supplement policy or certificate in force? ❑ Yes ❑ No
(a) If so, with which company? _____
(b) If so, do you intend to replace your current Medicare Supplement policy with this policy? ❑ Yes ❑ No
4. 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? _____
(b) What kind of policy? _____
5. Are you covered under Medicare Parts A & B? ❑ Yes ❑ No
If yes, what is your Medicare Claim Number? _____ (exactly as shown on your Medicare card)
6. Are you covered for medical assistance through the state Medicaid program:
(a) As a Specified Low Income Medicare Beneficiary (SLMB)? ❑ Yes ❑ No
(b) As a Qualified Medicare Beneficiary (QMB)? ❑ Yes ❑ No
(c) For other Medicaid medical benefits? ❑ Yes ❑ No

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

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? ❑ Yes ❑ No
8. Are you bedridden or do you require a wheelchair for any daily activity, or have you been diagnosed with Gaucher's Disease or any other type of lipidosis, or during the past 2 years, have you had any type of amputation caused by disease? ❑ Yes ❑ No
9. Within the past year, have you been medically advised to have surgery for cataracts, or for joint replacement, or for a heart condition, but not had such surgery? ❑ Yes ❑ No
10. Within the past year, have you been diagnosed or treated for internal cancer? ❑ Yes ❑ No
11. Within the past 2 years, have you been diagnosed or treated for heart valve surgery, Alzheimer's disease, or cirrhosis of the liver? ❑ Yes ❑ No
12. Within the past 2 years, have you been advised to have kidney dialysis? ❑ Yes ❑ No

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? _____ 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? _____ Reason for termination? _____

If you voluntarily terminated coverage under a Medicare+Choice plan* or Medicare Select policy, please answer the following questions:
1. Was this the first time you were ever enrolled in a Medicare+Choice plan or purchased a Medicare Select policy? ❑Yes ❑No
If so, did you have the Medicare+Choice plan or Medicare Select policy for less than 12 months? ❑Yes ❑No
2. Did you have a Medicare Supplement policy before applying for the Medicare+Choice plan or Medicare Select policy? ❑Yes ❑No
If yes, with which Company and which Medicare Supplement plan? _____
Is that Company still offering that Medicare Supplement plan? ❑Yes ❑No

*Medicare+Choice plan means a plan of coverage for health benefits under Medicare Part C as defined in Section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, 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+Choice medical savings account; and (3) Medicare+Choice private fee-for-service plans.

MA12 10-00

(Application continued on reverse side)