



AARP Medicare Supplement Online Enrollment Guide

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Learning Objectives

- Describe the benefits of online enrollment for AARP® Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company
- Identify the technical requirements for online enrollment
- Complete an online enrollment application using the signature pad
- Use the AARP membership portal to verify or renew AARP membership or sign-up a new member
- Upload the proper documents needed for the application
- Identify resources you can go to for help

Getting Started with Online Enrollment

Benefits

UnitedHealthcare is pleased to introduce an online enrollment application for AARP Medicare Supplement Insurance Plans. This online enrollment application will speed up processing time, prevent errors, and enroll consumers more quickly!

The tool also allows you to:

- Fill out state-specific enrollment applications
 - “Smart” enrollment application populates sections of the paper application based on information provided
- Join, renew or verify AARP membership for the consumer
- Fill out ancillary forms, such as the Replacement Notice, if required
- Sign up the consumer for Electronic Funds Transfer (EFT) for:
 - Recurring premium payments, or
 - One-time premium payment and coupon booklet.
- Upload documents such as guaranteed issue and legal documents (i.e. Power of Attorney)
- Save a draft and resume filling out an AARP Medicare Supplement enrollment application (up to 90 days)
- View submitted AARP Medicare Supplement enrollment applications (up to 90 days)



Technical Specifications

Hardware



Signature Pad

- The AARP Medicare Supplement enrollment application requires signatures to be captured from you and the consumer. If you wish to submit an online enrollment application for a consumer, signatures must be captured via a signature pad.
- To **purchase**, please go to: <http://www.ctimeprivatetore.com/UHC-Producers>
- **Important!** For the signature pad to work within the AARP Medicare Supplement online enrollment tool, you need a one-time installation software downloaded to your computer. Please go to the signature pad's manufacturer website here to download: http://www.topazsystems.com/Software/sigplus_su.exe
 - Note: This initial installation is required for all agents using this tool, regardless of whether you use your signature pad with the iEnroll tool.

Printer

- We strongly recommend that agents provide applicants with a printed copy of the completed application and associated forms after the application has been submitted.

Scanner

- The online enrollment tool gives you the ability to upload additional documents that may be necessary in order to process the application. A scanner is not required but recommended to utilize this functionality.
 - If you do not have a scanner, then please fax in required documents to the following fax number: 888-836-3985. Please include a cover sheet with the consumer's name, address and AARP membership number.
- Files size of each document must be less than 1MB. Please check the resolution on your scanner to keep file sizes below 1MB. File type must be PDF or JPG

Technical Specifications

Software

Operating System (OS)

- Windows XP or Windows 7
- Windows 8, Apple/Macintosh computers and tablet operating systems are currently not supported. This is a future enhancement. Please look for future communications on availability.

Internet Browser Compatibility

- Internet Explorer versions 6-9
 - **Internet Explorer 9 users** – Active X must be enabled to use the upload documents feature. Please review the technical requirements document for instructions.

- Firefox 18

Note: Internet Explorer 10, Google Chrome and Safari browsers are currently not supported. This is a future enhancement.

Signature pad software installation

- Please go to the signature pad's manufacturer website here to download:
http://www.topazsystems.com/Software/sigplus_su.exe

Adobe Acrobat Reader

- Available for free download at <http://get.adobe.com/reader>

Technical Specifications

Other

E-mail addresses

- Required for both the agent and consumer. The consumer must provide consent to allow UnitedHealthcare to send important account information and product offers via email.
- If they do not consent, then please submit a paper enrollment application and exclude the consumer's email address from the paper enrollment application.

Full-disk Encryption Solution

- As Business Associates of UnitedHealthcare, agents are required to encrypt all desktops and laptops.
- For more information, click on the following:
 - [Privacy and Security: Protecting Member Information and Incident Reporting](#)
 - [Privacy and Security: Encryption Changes](#)

Security and Privacy Check

All UnitedHealth Group employees, contracted workers and business associates (including agents) have a responsibility to protect consumer and member Protected Health Information (PHI).

To protect PHI, agents are prohibited from:

- Storing documents electronically on their desktop/laptop and scanner.
- Placing consumer/member information on a jump drive (or similar portable storage device).

Before Getting Started

Items to note before starting an online enrollment application:

- ✓ You must provide the consumer with the full AARP Medicare Supplement **enrollment kit** (which also includes the Centers for Medicare & Medicaid Services Guide *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*)
- ✓ Using the enrollment kit, **review** the available plans in your state/area and **quote** applicable rate(s) prior to starting a new online enrollment application.
- ✓ When using the online enrollment tool, the initial premium payment is required through **Electronic Funds Transfer (EFT)**.
 - Subsequent monthly payments can be set up as recurring EFT payments or ongoing coupon payments via check.
 - Remind the consumer to have their bank information available for your appointment so they can read it to you when it comes to the EFT section of the tool.
- ✓ If the consumer is not an AARP member, **AARP membership** must be purchased either by credit card within the online enrollment tool or by calling 1-866-331-1964, Monday-Friday 7 a.m. – 11 p.m., Saturday, 9 a.m. – 5 p.m. ET
- ✓ Consumers must consent to providing an **electronic signature** prior to entering this tool. At the end of the enrollment process, you and the consumer must review all forms in Adobe Acrobat PDF prior to submission.
- ✓ Save yourself time! If there are documents that should be included with the online enrollment application (i.e. legal documents such as Power of Attorney), **scan** them first prior to starting a new application.

Completing an Online Enrollment Application

Access to the tool

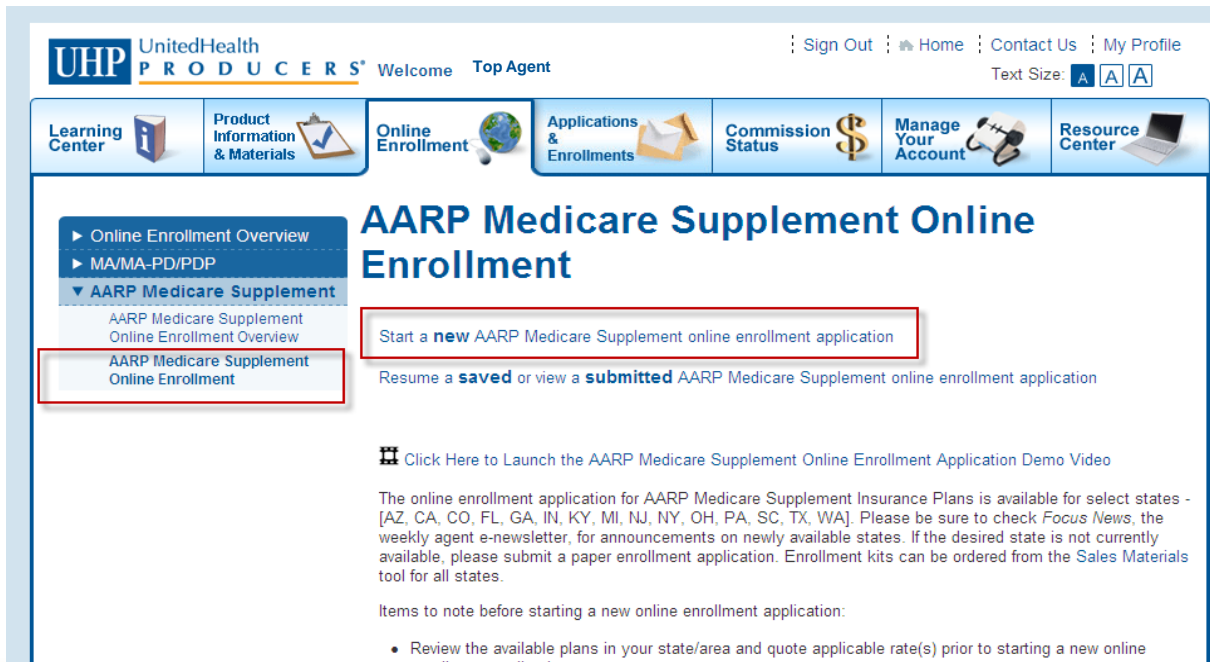
To access the tool, you must be:

- Contracted with UnitedHealthcare
- Certified and authorized to offer AARP Medicare Supplement Plans for the current or future year
- Licensed and appointed in the states where the tool is available.
 - State availability can be found on the AARP Medicare Supplement Online Enrollment Overview portal webpages.



Getting into the Tool

- Log into the Agent Portal
 - Please make sure your signature pad is plugged in
- Select the “Online Enrollment” tab
- Select “AARP Medicare Supplement Online Enrollment”
- Select “Start a new AARP Medicare Supplement Online Enrollment Application” to launch a new online enrollment application
- Select “Resume a saved or view a submitted AARP Medicare Supplement online enrollment application” to resume a saved or view a submitted enrollment application



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Learning Center Product Information & Materials Online Enrollment Applications & Enrollments Commission Status Manage Your Account Resource Center

▶ Online Enrollment Overview
 ▶ MA/MA-PD/PDP
 ▼ AARP Medicare Supplement
 AARP Medicare Supplement Online Enrollment Overview
AARP Medicare Supplement Online Enrollment

AARP Medicare Supplement Online Enrollment

Start a **new** AARP Medicare Supplement online enrollment application

Resume a **saved** or view a **submitted** AARP Medicare Supplement online enrollment application

Click Here to Launch the AARP Medicare Supplement Online Enrollment Application Demo Video

The online enrollment application for AARP Medicare Supplement Insurance Plans is available for select states - [AZ, CA, CO, FL, GA, IN, KY, MI, NJ, NY, OH, PA, SC, TX, WA]. Please be sure to check *Focus News*, the weekly agent e-newsletter, for announcements on newly available states. If the desired state is not currently available, please submit a paper enrollment application. Enrollment kits can be ordered from the Sales Materials tool for all states.

Items to note before starting a new online enrollment application:

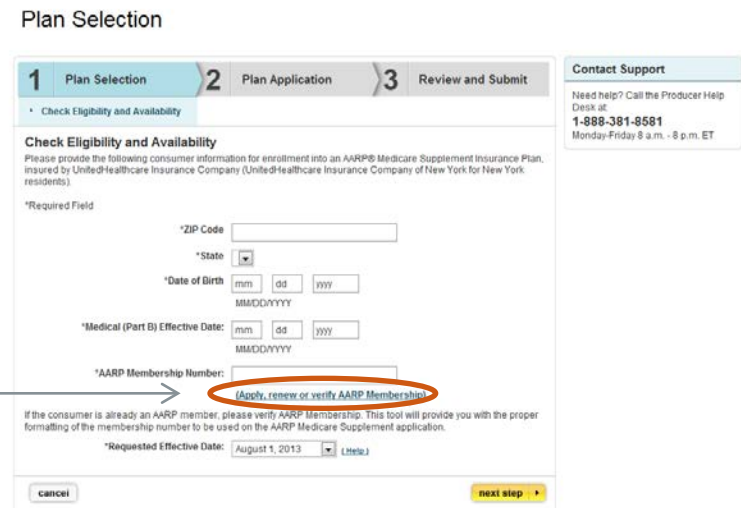
- Review the available plans in your state/area and quote applicable rate(s) prior to starting a new online enrollment application.

Plan Selection

Check Eligibility and Availability

- Enter the consumer's resident ZIP code.
- The "State" field will be pre-populated based on the ZIP code.
 - If a ZIP code crosses state lines, select the correct state from the provided drop-down menu.
- Enter the consumer's date of birth and the Medicare Part B effective date (including future effective date, if applicable).
- AARP membership is required to enroll in an AARP Medicare Supplement Plan. Please click on the link next to the corresponding field to apply, renew and verify AARP membership.
- Select the consumer's requested effective date. Effective dates can be entered up to three months into the future. The consumer must be age 65 or older at the time of the requested effective date to use this tool.

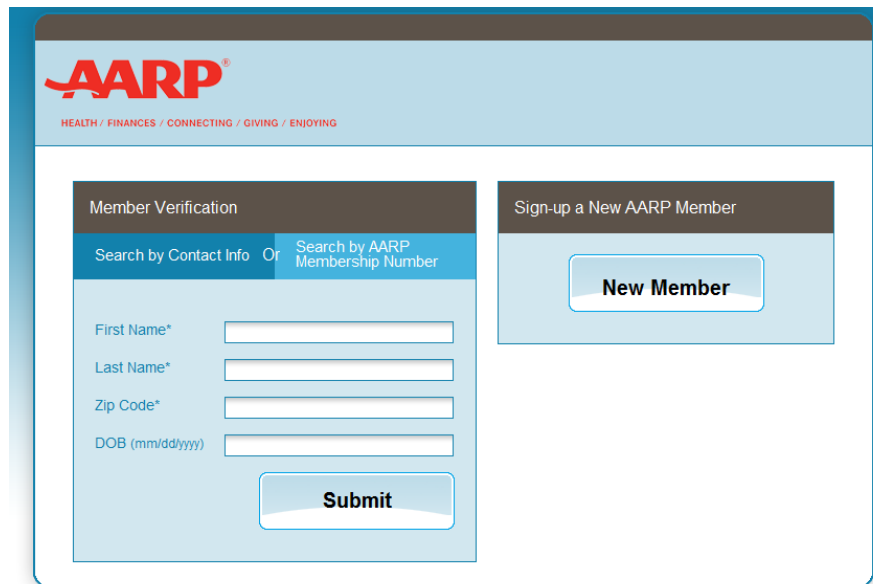
Link for AARP Membership



The screenshot shows a web form titled "Plan Selection" with a progress bar at the top indicating three steps: 1. Plan Selection (active), 2. Plan Application, and 3. Review and Submit. A "Contact Support" box is visible on the right. The main form area is titled "Check Eligibility and Availability" and contains several input fields: "ZIP Code" (text), "State" (dropdown), "Date of Birth" (MM/DD/YYYY), "Medical (Part B) Effective Date" (MM/DD/YYYY), and "AARP Membership Number" (text). A link "(Apply, renew or verify AARP Membership)" is circled in red and highlighted by a blue arrow pointing from the text "Link for AARP Membership" on the left. Below the fields, there is a note about AARP membership verification and a "Requested Effective Date" field with a dropdown menu. At the bottom, there are "cancel" and "next step" buttons.

AARP Membership Portal

If you select to join, renew or verify AARP membership, a new window will appear.



The screenshot displays the AARP Membership Portal interface. At the top left is the AARP logo with the tagline "HEALTH / FINANCES / CONNECTING / GIVING / ENJOYING". Below the logo, there are two main sections: "Member Verification" and "Sign-up a New AARP Member".

The "Member Verification" section has two tabs: "Search by Contact Info" (selected) and "Search by AARP Membership Number". Below the tabs are four input fields: "First Name*", "Last Name*", "Zip Code*", and "DOB (mm/dd/yyyy)". A "Submit" button is located at the bottom of this section.

The "Sign-up a New AARP Member" section contains a single "New Member" button.

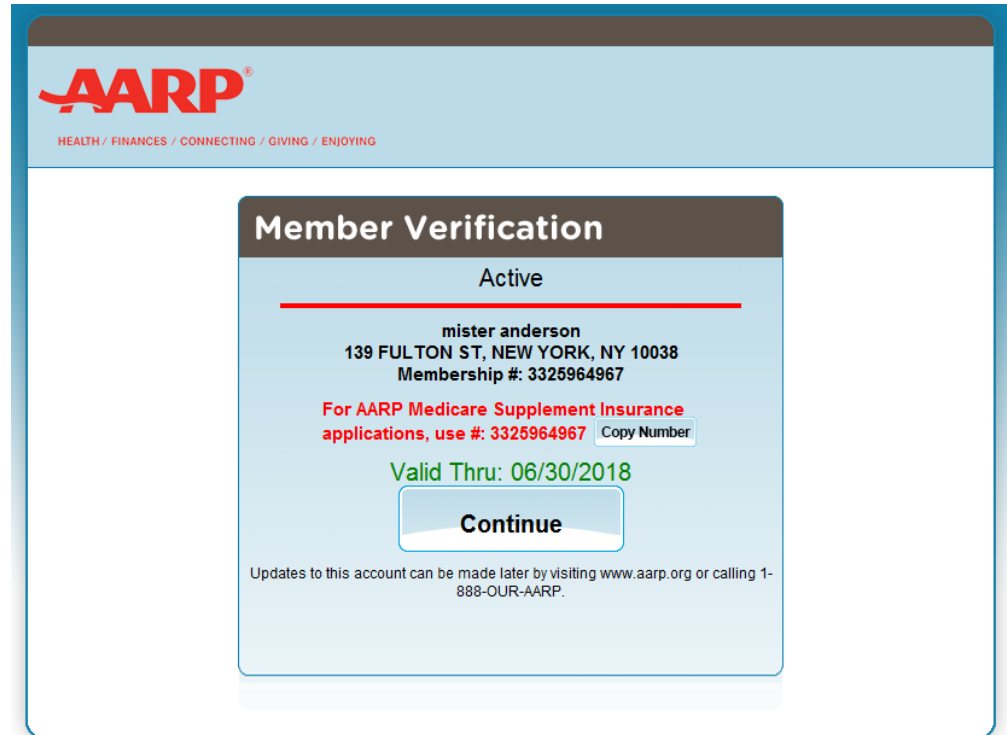
Member Verification

- If the consumer is already an AARP member or resides in the same household as an AARP member, you can verify the member number or look the member up by contact information of it is not known.
- Member search is based on exact member information. Please make sure the entered information is accurate.

AARP Membership Portal

Search Results

- When an AARP membership number is found, clicking the 'Copy Number' button will copy the number into memory, which can be pasted into the product application screen.
- If the membership expires within six months, the consumer has the option to renew. A credit card must be used to renew.

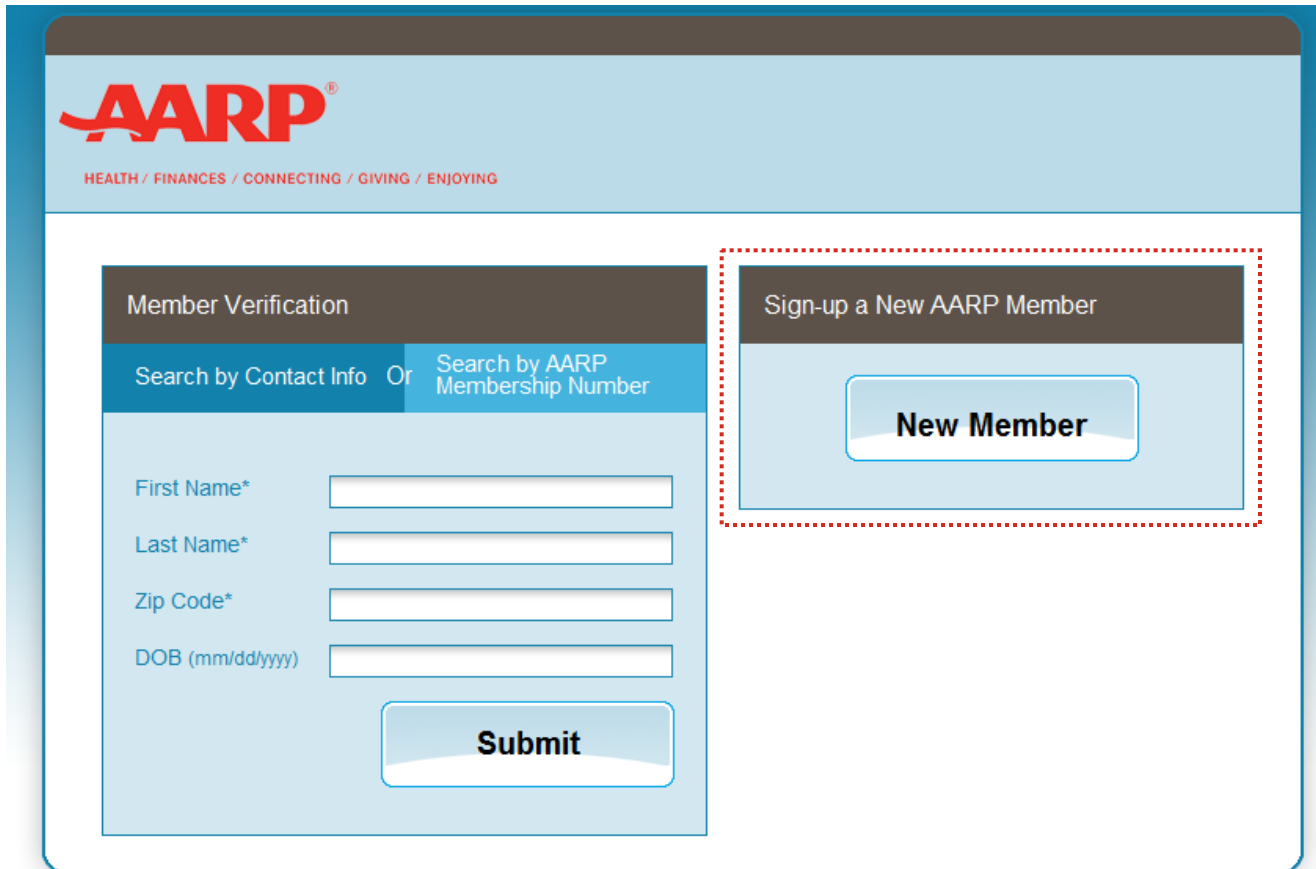


Close the AARP membership window to return back to the Online Enrollment tool.

AARP Membership Portal

New Member

- Click on “New Member” to sign-up a consumer for AARP Membership.

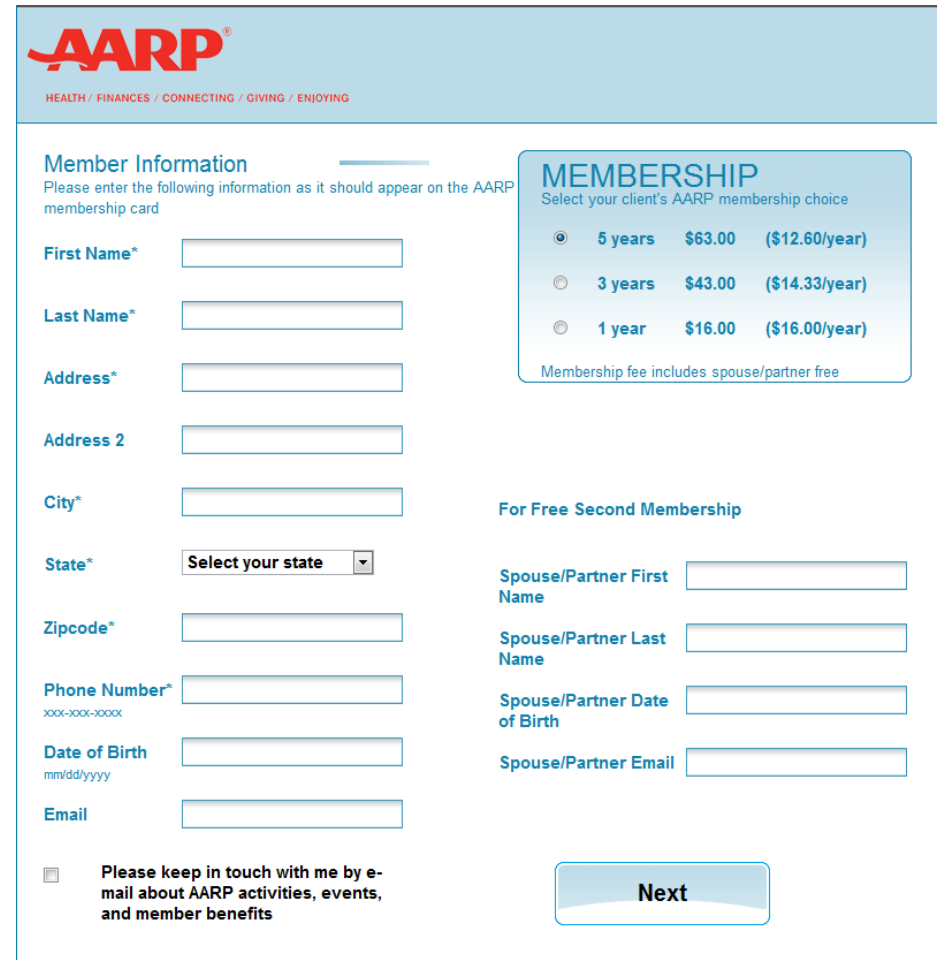


The screenshot displays the AARP Membership Portal interface. At the top left is the AARP logo in red, with the tagline "HEALTH / FINANCES / CONNECTING / GIVING / ENJOYING" below it. The main content area is divided into two sections. On the left is the "Member Verification" section, which includes two search options: "Search by Contact Info" and "Search by AARP Membership Number". Below these are four input fields for "First Name*", "Last Name*", "Zip Code*", and "DOB (mm/dd/yyyy)". A "Submit" button is located at the bottom of this section. On the right is the "Sign-up a New AARP Member" section, which features a prominent "New Member" button. This button is highlighted with a red dashed rectangular border.

AARP Membership Portal

New Member

- Please complete the fields for new AARP membership.
- Please make sure the address is correct. The system verifies the address against a national database
- Note: 5-year membership is pre-selected



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Member Information

Please enter the following information as it should appear on the AARP membership card

First Name*

Last Name*

Address*

Address 2

City*

State*

Zipcode*

Phone Number*
xxx-xxx-xxxx

Date of Birth
mm/dd/yyyy

Email

Please keep in touch with me by e-mail about AARP activities, events, and member benefits

MEMBERSHIP

Select your client's AARP membership choice

- 5 years \$63.00 (\$12.60/year)
- 3 years \$43.00 (\$14.33/year)
- 1 year \$16.00 (\$16.00/year)

Membership fee includes spouse/partner free

For Free Second Membership

Spouse/Partner First Name

Spouse/Partner Last Name

Spouse/Partner Date of Birth

Spouse/Partner Email

Next

AARP Membership Portal

AARP Membership Billing Information

- Please enter the consumer's credit card information
 - Note: Agents cannot purchase an AARP membership for the consumer.

The screenshot shows the AARP Membership Billing Information form. The form is divided into two main sections: BILLING and PAYMENT METHOD. The BILLING section includes a checkbox for 'Billing info is the same as my application info.' and several text input fields for name, address, city, state, and zip code. The PAYMENT METHOD section includes radio buttons for credit card type (Visa, Mastercard, American Express, Discover), a credit card number field, and expiration date and CVV fields. A 'Security provided by CyberSource' logo is visible in the bottom right of the form area. At the bottom of the form are 'Back' and 'Next' buttons.

AARP
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BILLING

Please enter the following information as it appears on the credit card billing statement.

Billing info is the same as my application info.

First Name*

Last Name*

Address*

Address Line 2

City*

State*

Zip Code*

PAYMENT METHOD

Credit Card Type*

- Visa
- Mastercard
- American Express
- Discover

Credit Card #*

Expiration* / CV #

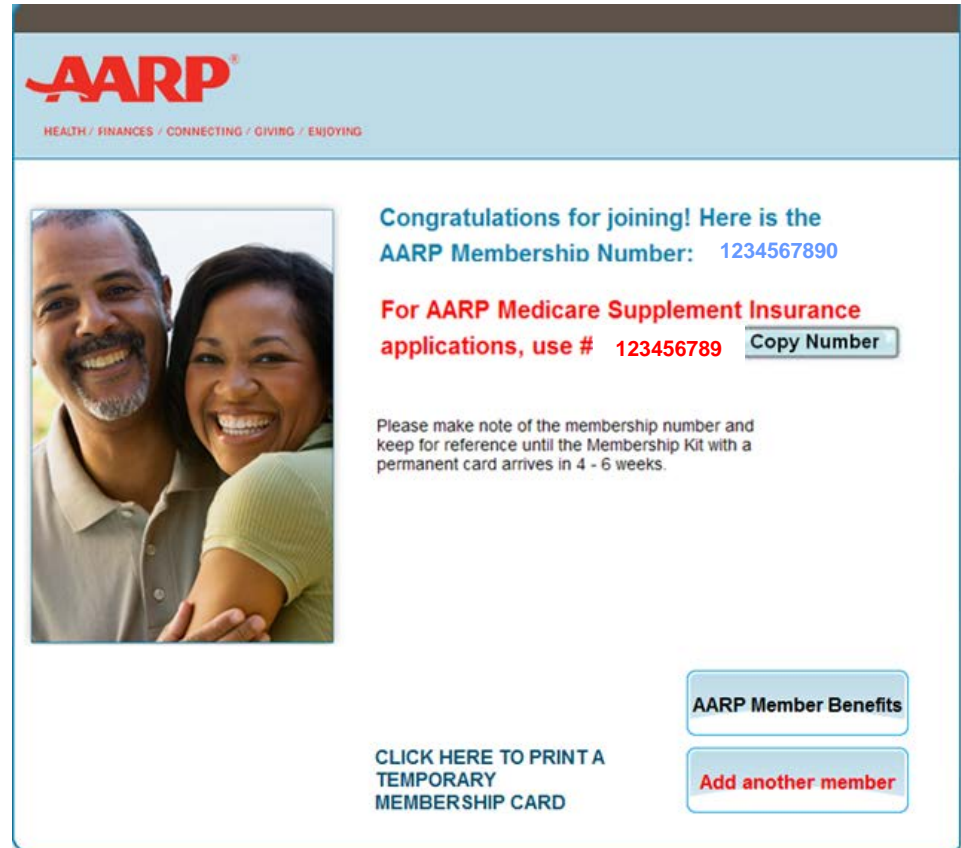
(mm/yyyy)

Security provided by
CyberSource

AARP Membership Portal

Confirmation Screen

- The first number displayed is the 10-digit AARP Membership number that should be shared with the AARP member (and will display on the temporary AARP Membership card).
- **The second number is a reformatted number required for AARP Medicare Supplement application processing.**
- Click the 'Copy Number' button to copy the number into memory, which can be pasted into the product application screen.



The screenshot shows the AARP Membership Confirmation screen. At the top left is the AARP logo with the tagline "HEALTH / FINANCES / CONNECTING / GIVING / ENJOYING". Below the logo is a photo of a smiling man and woman. To the right of the photo, the text reads: "Congratulations for joining! Here is the AARP Membership Number: 1234567890". Below this, it says "For AARP Medicare Supplement Insurance applications, use # 123456789" followed by a "Copy Number" button. At the bottom right, there are three buttons: "AARP Member Benefits", "CLICK HERE TO PRINT A TEMPORARY MEMBERSHIP CARD", and "Add another member".

Close the AARP membership window to return back to the Online Enrollment tool.

Plan Selection

Check Eligibility and Availability

- When you return from the AARP membership portal, paste the consumer's AARP membership number into the field indicated below.
- Select the consumer's requested effective date. Effective dates can be entered up to three months into the future. The consumer must be age 65 or older at the time of the requested effective date to use this tool.

Plan Selection

1 Plan Selection **2** Plan Application **3** Review and Submit

▶ Check Eligibility and Availability

Contact Support
Need help? Call the Producer Help Desk at:
1-888-381-8581
Monday-Friday 8 a.m. - 8 p.m. ET

Check Eligibility and Availability
Please provide the following consumer information for enrollment into an AARP® Medicare Supplement Insurance Plan, insured by UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents).

*Required Field

*ZIP Code:

*State:

*Date of Birth: mm dd yyyy
MM/DD/YYYY

*Medical (Part B) Effective Date: mm dd yyyy
MM/DD/YYYY

*AARP Membership Number: ← Paste AARP Membership Number
[\(Apply, renew or verify AARP Membership\)](#)

If the consumer is already an AARP member, please verify AARP Membership. This tool will provide you with the proper formatting of the membership number to be used on the AARP Medicare Supplement application.

*Requested Effective Date: August 1, 2013 [\(Help\)](#)

Plan Selection

Consumer Information

- Please fill out the consumer and agent information on this page. Any information that was entered on the previous page will pre-populate on this and future screens. If you need to make a change, you will be prompted to return to the original page where you initially entered the information.
- Information provided may be used to contact them via mail, phone or email if additional information is needed to complete this enrollment application.

Plan Selection

1	Plan Selection	2	Plan Application	3	Review and Submit
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Check Eligibility and Availability

Consumer Information

Plan Selection

Plan Confirmation

Contact Support

Need help? Call the Producer Help Desk at:
1-888-381-8581
 Monday-Friday 8 a.m. - 8 p.m. ET

Consumer Information

***Required field**

Information provided by the consumer may be used to contact them via mail, phone or email if additional information is needed to complete this application.

AARP Membership Number: 7000010241

Salutation:

*First Name:

Middle Initial:

*Last Name:

Suffix:

*Address Line 1:

Address Line 2:

*City:

*State: NJ

*Zip Code: 07514

*E-mail Address:

*Confirm E-mail Address:

Please read to the consumer: By providing your email address, you are agreeing to receive important account information and product offers.

Be sure to write all the necessary periods (.) and symbols (@) in the space above.

Phone Number (Primary):

Phone Number (Secondary):

*Date Of Birth: 05 18 1945
MM/DD/YYYY

Gender:

Medicare Claim #: [\(Help\)](#)

*Medical (Part B) Effective Date: 05 01 2010 [\(Help\)](#)
MM/DD/YYYY

*Hospital (Part A) Effective Date: mm 05 yyyy [\(Help\)](#)
MM/DD/YYYY

*Are both Medicare Parts A and B active? Yes No [\(Help\)](#)

Agent Email Address

Please provide an email address that we can use to communicate with you about this application.

*Agent Email Address:

*Confirm Email Address:

Plan Selection

Plan Selection

- Based on the information provided on previous screens, the available plans and estimated monthly premium rates for each plan will be displayed. A single estimated amount is provided after all the application questions have been answered.
- Premium rates in this tool do not include discounts for multi-insured, electronic funds transfer, and annual payer. Relevant discounts will be applied when the application is processed.
- If the consumer is eligible, potential premium rates will include the Enrollment Discount.
- Please select the plan that best fits the consumer's needs.

Plan Selection

1 Plan Selection

2 Plan Application

3 Review and Submit

- ✔ Check Eligibility and Availability
- ✔ Consumer Information
- ▶ Plan Selection
- Plan Confirmation

Plan Selection

There are 7 plans for CO, 80011

Based on the consumer's birth date 05/07/1945

Medicare Part B Effective Date 05/01/2010

and Requested Effective Date 09/01/2013

[Change Eligibility and Availability Information](#)

* Rates are subject to change. Actual rate will be determined upon acceptance into the program based upon eligibility criteria and the consumer's medical conditions, if applicable.
 * Any rate change will apply to all members of the same class insured under the consumer's plan who reside in their state/area.

A non-tobacco user rate for 09/01/2013 will be shown. Rates only apply for the month shown and are based on information entered. If the consumer uses tobacco, higher rates may apply.

For all available plans, answers to questions on the enrollment application will be used to determine which rate applies to the consumer.

All rates are subject to change. Any rate change will apply to all members of the same class insured under the consumer's plan who reside in their state/area. Note: Rates shown do not include applicable discounts that may be available to the consumer.

Medicare Supplement Plan	Rates*	
Plan A	Standard Rate With Enrollment Discount: \$74.06	
	Standard Rate With Enrollment Discount For Tobacco Users: \$81.46	apply now ▶
	Level 2 Rate: \$140.62	
	Level 2 Rate For Tobacco Users: \$154.68	
Plan B	Standard Rate With Enrollment Discount: \$140.81	
	Standard Rate With Enrollment Discount For Tobacco Users: \$154.89	apply now ▶
	Level 2 Rate: \$267.37	
	Level 2 Rate For Tobacco Users: \$294.10	
Plan C	Standard Rate With Enrollment Discount: \$168.46	
	Standard Rate With Enrollment Discount For Tobacco Users: \$185.31	apply now ▶
	Level 2 Rate: \$319.87	
	Level 2 Rate For Tobacco Users: \$351.85	

Contact Support

Need help? Call the Pr Desk at:
1-888-381-8581
 Monday-Friday 8 a.m.

Plan Application

What You Need and Document Review

- Before you start to answer the application questions, you must provide the consumer with a copy of the AARP Medicare Supplement enrollment kit.
- The next steps will display the enrollment application questions and associated forms (Replacement Notice, Electronic Funds Transfer Form, and state-specific forms for FL, IL, KY and OH). You must review each question and statement with the consumer – either by sharing your computer screen with them, or asking them to read along in the enrollment kit.

Plan Application

1	Plan Selection	2	Plan Application	3	Review and Submit
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- What You Need and Document Review
 - Application Questions
 - Current Insurance Coverage
 - Notice to Applicant

What You Need and Document Review

Please ensure that the consumer has received a copy of the enrollment kit for AARP® Medicare Supplement Insurance Plans. For your reference, we have provided you with the required documents below. Please check the box below to confirm that the consumer has a copy of the enrollment kit that contains copies of these documents.

The next steps will display the application questions and associated forms. You must review each question and statement with the consumer - either by sharing your computer screen with him/her or asking the consumer to read along in the enrollment kit. At the end of this process, you and the consumer will be required to review the application and associated forms to ensure completeness.

Take a few minutes and review these important plan documents with the consumer. When you are ready, click "next step" to proceed.

[Plan Overview](#)
[Benefits Table](#)
[Rules and Disclosures](#)
[Your Guide to AARP Medicare Supplement Insurance Plans](#)
[Guide To Health Insurance for People with Medicare](#)

*An enrollment kit for AARP Medicare Supplement Insurance Plans has been provided to the consumer.

Plan Application

Print and Save for Later

Starting from this page forward, you have the option to “Save For Later” and “Print Application.”

Print

- You can print an application with the data you have entered thus far and submit the application via mail, if you or the consumer desires.
- **Note:** The Electronic Funds Transfer (EFT) forms in this online enrollment PDF should not be submitted via mail. Please use the EFT forms in the paper enrollment kit when submitting an enrollment application via mail.

Save for Later

- The “Save for Later” functionality allows you to save an incomplete online enrollment application for up to 90 days.
- **Note:** If you choose the “Save for Later” option, signatures will be cleared. When resuming an enrollment application, you must review the entire enrollment application again. Please ask all questions and reconfirm all prior answers, as the consumer’s status or medical conditions may have changed. Signatures must be recaptured via signature pad, and documents will need to be re-uploaded (if applicable).

Plan Application

Guaranteed Acceptance

- Please answer all questions on this page. The responses to the Guaranteed Acceptance questions have been pre-populated based on the consumer's date of birth, Medicare Part B Effective Date and Requested Effective Date that you entered earlier.
- Please review that the answers are accurate.
- As you answer questions, the tool displays only the subsequent questions required for the consumer.

Plan Application

1 Plan Selection **2 Plan Application** **3 Review and Submit**

- ✓ What You Need and Document Review
- Application Questions
 - Current Insurance Coverage
 - Notice to Applicant

Contact Support
Need help? Call the Producer Help Desk at:
1-888-381-8581
Monday-Friday 8 a.m. - 8 p.m. ET

Save For Later
Note: Signatures and any uploaded documents (if applicable) will not be saved.
[save application](#)

Print Application
The application and associated forms will be pre-populated with any information provided prior to this screen. Adobe Acrobat Reader is required.
[print application and associated forms](#)

Application Questions
Please review each question with the consumer.

Tobacco Usage
*Have you smoked cigarettes or used any tobacco product at any time within the past twelve months?
 Yes No

Guaranteed Acceptance Questions
Answer these questions to determine if your acceptance is guaranteed.
The responses to the questions below have been pre-populated based on the date of birth, Medicare Part B Effective Date and Requested Effective Date that were previously entered. If this information is incorrect, please return to the [Check Eligibility and Availability](#) page and update accordingly.

*Did you turn 65 in the last 6 months?
 Yes No

*Did you enroll in Medicare Part B within the last 6 months?
 Yes No

*Will your plan effective date be within 6 months after turning age 65 and enrolling in Medicare Part B?
 Yes No

*Have you lost other health insurance coverage and, if so, are you an "eligible person" as defined within the termination notice you received from your prior insurer?
 Yes No

Agent Only Documents
[Guaranteed Issue Chart](#)
[Glossary of Terms](#)

Eligibility Health Questions

*Do any of these apply to you?
• have end stage renal (kidney) disease
• currently receiving dialysis
• diagnosed with kidney disease that may require dialysis
• admitted to a hospital as an inpatient within the past 90 days
 Yes No

*Within the past two years, has a medical professional recommended or discussed as a treatment option, any of the following that has NOT been completed:
• hospital admittance as an inpatient
• organ transplant
• back or spine surgery
• joint replacement
• surgery for cancer
• heart surgery
• vascular surgery
 Yes No

Health History Questions

Plan Application

Current Insurance

- Review the statements and questions regarding past and current insurance coverage with the consumer. The consumer must answer all questions to the best of his/her knowledge.
- Additional questions may display, depending on how the consumer answers each question.

Plan Application

1 Plan Selection	2 Plan Application	3 Review and Submit
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- ✓ What You Need and Document Review
- ✓ Application Questions
 - Current Insurance Coverage Notice to Applicant

Current Insurance Coverage

Please review the statements and questions below with the consumer. The consumer must answer all questions to the best of his/her knowledge.

- You do not need more than one Medicare Supplement insurance policy.
- You may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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).

For your protection, you are required to answer all the questions below and sign in the signature box below.

*Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the Federal Medicare 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

*Have you had coverage from any Medicare plan other than original Medicare within the past 6 months (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)?

Yes No

*Has your coverage under the previous plan been involuntarily terminated for reasons other than nonpayment of premiums or for fraud?

Yes No

*Do you have another Medicare Supplement policy in force?

Contact Support

Need help? Call the Producer Help Desk at:
1-888-381-8581
Monday-Friday 8 a.m. - 8 p.m. ET

Save For Later

Note: Signatures and any uploaded documents (if applicable) will not be saved.

save application →

Print Application

The application and associated forms will be pre-populated with any information provided prior to this screen. Adobe Acrobat Reader is required.

print application and associated forms →

Plan Application

Consumer Signature using the Signature Pad

- The consumer must sign the application using a signature pad.
- Please have the consumer consent to the statements above by clicking the yellow button to activate the signature pad and then sign on the signature pad. Their signature will appear on the screen.
- To clear and re-sign, click the yellow button again.

days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)?

Yes No

*Do you have another Medicare Supplement policy in force?

Yes No

*Have you had coverage under any other health insurance within the past 63 days? (for example, an employer, union, or individual plan)

Yes No

***Applicant Signature:**

By signing here using the signature pad, I have read and agree to the above

Note: If you are signing as the legal representative for the applicant, please provide a copy of the appropriate legal documentation.

Review and Submit

Review and Sign

- The consumer must be able to read all of the statements on this page and agree.
- If the consumer agrees, he/she needs to sign, using the signature pad in the boxes indicated.

Review and Submit

1 Plan Selection	2 Plan Application	3 Review and Submit
-------------------------	---------------------------	----------------------------

Contact Support

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Save For Later

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[save application](#)

Print Application

The application and associated forms will be pre-populated with any information provided prior to this screen. Adobe Acrobat Reader is required.

[print application and associated forms](#)

Review and Sign

Please review the statements and questions below with the consumer. If the consumer agrees, he/she must sign using the signature pad in the boxes below.

Authorization and Verification of Information

- My signature indicates I have read and understand the contents of this application form.
- I affirm that the answers on this application are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that the enrollment form becomes a part of the insurance contract and that if the answers are untrue, UnitedHealthcare Insurance Company may have the right to rescind my coverage or adjust my premium.
- Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.
- I understand the agent or broker cannot grant approval. This application and payment of the initial premium does not guarantee coverage will be provided. I understand coverage, if provided, will not take effect until issued by UnitedHealthcare Insurance Company, and actual rates are not determined until coverage is issued.
- I understand the agent or broker may not change or waive any terms or requirements related to this application and its contents, underwriting, premium, or coverage.
- I acknowledge receipt of the **Guide to Health Insurance for People with Medicare** and the Outline of Coverage.
- I understand the person discussing plan options with me is either employed by or contracted with UnitedHealthcare Insurance Company. This person may be compensated based on my enrollment in a plan.

Please see "Your Guide" to determine if the following pre-existing condition waiting period applies to you. The pre-existing condition exclusion does not apply to you if you are in your Open Enrollment or entitled to guaranteed issue.

I understand the plan will not pay benefits for expenses incurred during the first 3 months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within 3 months prior to the insurance effective date.

Note: If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

I have read all information and have answered all questions to the best of my ability.

***Applicant Signature:**

[By signing here using the signature pad, I have read and agree to the above](#)

Please review the statements and questions below with the consumer. If the consumer agrees, he/she must sign using the signature pad in the boxes below.

Authorization and Verification of Information

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, or insurance company to give UnitedHealthcare Insurance Company and its affiliates (The Company) any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine the eligibility of and/or amount payable for my claims and for analytic studies. I understand I may end this authorization if I notify The Company, in writing, except to the extent that The Company has already acted on my authorization. If not revoked, this authorization is valid for the term of the coverage.

Note: If you are signing as the legal representative for the applicant, please submit a copy of the appropriate legal documentation.

***Applicant Signature:**

[By signing here using the signature pad, I have read and agree to the above](#)

Once your application is processed, you'll be notified of your acceptance, rate and insurance start date.

Review and Submit

Agent Verification

- As an agent, you must complete the information on this page. Leave blank if the questions do not apply.
- Sign your name, using the signature pad, to confirm you have read and agree with the information on this page.

Review and Submit

1 Plan Selection **2** Plan Application **3** Review and Submit

- Review and Sign
- Agent Verification
- Plan Payment Options
- Payment Details Summary
- Document Upload

Contact Support

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Monday-Friday 8 a.m. - 8 p.m. ET

Save For Later

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[save application](#)

Print Application

The application and associate forms will be pre-populated with any information provided prior to this screen. Adobe Acrobat Reader is required.

[print application and associated forms](#)

Agent Verification

Agent must complete the following; and if appropriate, the notice of replacement coverage included with this application. All information must be completed or the application will be returned.

List any other medical or health insurance policies sold to the applicant:

List any policies that are still in force:

List policies sold in the past five years that are no longer in force:

For Agents who assist the Applicant in answering the health questions on the Application: I attest that the information on this Application Form is complete and accurate to the best of my knowledge; and that I have explained to the Applicant in clear, easy to understand language the risk of providing inaccurate information, and the Applicant understood. I understand that an Agent who willfully attests falsely is subject to a civil penalty of up to \$10,000.

If you did not assist in answering the health questions on this Application, click here.

Agent Name

*First Name

Middle Initial

*Last Name

*Agent Phone Number

Agent ID

*Agent Signature

[By signing here using the signature pad, I have read and agree to the above](#)

[cancel](#) [back](#) [next step](#)

Review and Submit

Plan Payment Options

- Choose the payment option that best fits the consumer's needs. The consumer can choose either a one-time EFT and ongoing monthly coupon booklet payments OR a recurring EFT premium payment.
- An estimated monthly plan rate is calculated and provided. This rate is based on the answers provided.
- **Note:** Please inform the consumer that the rate is subject to change upon additional review of the application.

Review and Submit

1 Plan Selection	2 Plan Application	3 Review and Submit
-------------------------	---------------------------	----------------------------

- ✓ Review and Sign
- ✓ Agent Verification
- ▶ Plan Payment Options
 - Payment Details Summary
 - Document Upload

Plan Payment Options

Please choose the payment option that best fits the consumer's needs:

- Make first payment and set up automated ongoing monthly payments via Electronic Funds Transfer
- Make a one-time payment for the first month's premium via Electronic Funds Transfer and receive a coupon book to mail future ongoing monthly plan payments

Plan A: Standard : \$81.46

Please note: Based on the information you provided, the monthly rate shown reflects the current premium level in effect. All rates are subject to change. Any rate change will apply to all members of the same class insured under the same plan who reside in the consumer's geographic area.

Rates for 09/01/2013 will be shown and are only valid for month shown based on information entered.

All rates are subject to change. Any rate change will apply to all members of the same class insured under the consumer's plan who reside in their state/area.

Review and Submit

Payment Details Summary

- Depending on which option was selected on the previous page, you will be presented with the appropriate EFT form. The consumer must read all of the statements and agree.
- Complete all required banking information fields.
- The name on the bank account must match the name on the enrollment application.
- The consumer must sign by using the signature pad.

AARP Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

Review and Submit

1 Plan Selection	2 Plan Application	3 Review and Submit
-------------------------	---------------------------	----------------------------

- Review and Sign
- Agent Verification
- Plan Payment Options
- Payment Details Summary Document Upload

Contact Support
 Need help? Call the Proc Help Desk at:
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 Monday-Friday 8 a.m. - ET

Save For Later
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Print Application
 The application and associated forms will be pre-populated with information provided on this screen. Adobe Acrobat Reader is required.

Payment Details Summary

Plan Premium Payment
 Plan Selected: B
 Payment Option: First month's payment and set up recurring monthly payment via Electronic Funds Transfer
[Change Plan Payment Option](#)
 Estimated monthly plan payment: \$204.75
 I allow UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) hereafter named UnitedHealthcare to take a one-time withdrawal for my initial month's payment and set up recurring monthly withdrawals for the then-current monthly rate from the account named on this form. I also authorize the financial institution where the account is held (BANK) to charge such a withdrawal to my account.

This authority is active until UnitedHealthcare and the BANK receive notice from me to end withdrawals in enough time to give UnitedHealthcare and the BANK a reasonable opportunity to act on it. I have the right to stop payment of a withdrawal by giving notice to the BANK in such time as to give the BANK a reasonable opportunity to act upon it. I understand such action may make my health care insurance coverage past due and subject to cancellation.

I understand that after submitting my Application it will be processed in 1 to 15 business days (pending receipt of any missing or additional required information). Once my application is accepted my initial payment will be withdrawn the next business day.

Thereafter, recurring monthly payments will be withdrawn on or about the fifth of each month that a premium is due. Monthly withdrawal amounts will be for the total household payment due each month. This will include premiums for a spouse or other member(s) of the household on the same membership account. If my coverage is effective in the future or my account is paid in advance, EFT withdrawals will begin for the next payment due. If my coverage is effective in the past or my account is past due, a letter will be sent that explains how to make the payment that is due.

Billing Information

*Required field

Please Note: The name on your bank account must match the name on your application.

First Name:

Middle Initial:

Last Name:

Address 1:

Address 2:

City:

State:

Zip Code:

*Bank Name:

*Bank Routing Number: (help)

*Confirm Bank Routing Number: (help)

*Bank Account Number: (help)

*Confirm Bank Account Number:

*Account Type: Checking

*Applicant Signature

By signing here using the signature pad, I have read and agree to the above

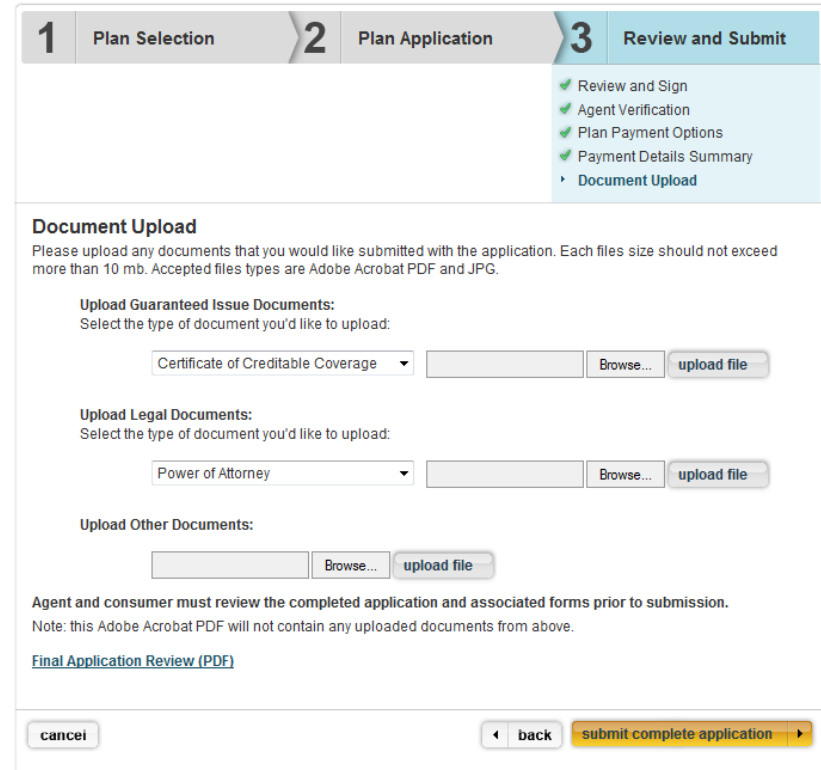
You may [print](#) this page for your records.

Review and Submit

Document Upload

- Upload any documents you would like to submit with the enrollment application, including guaranteed issue (i.e. termination letters), legal (i.e. Power of Attorney documents) or other documents.
- The size of each document should not exceed 1 MB. Accepted file types are Adobe Acrobat PDF and JPG.
- **Note:** If a file exceeds more than 1MB size limitation, try scanning the document at a lower resolution. If not, please fax documentation to 888-836-3985. Please include a cover sheet with the consumer's name, address and AARP membership number.

Review and Submit



1 Plan Selection **2** Plan Application **3** Review and Submit

- ✓ Review and Sign
- ✓ Agent Verification
- ✓ Plan Payment Options
- ✓ Payment Details Summary
- Document Upload

Document Upload
Please upload any documents that you would like submitted with the application. Each files size should not exceed more than 10 mb. Accepted files types are Adobe Acrobat PDF and JPG.

Upload Guaranteed Issue Documents:
Select the type of document you'd like to upload:

Certificate of Creditable Coverage Browse... upload file

Upload Legal Documents:
Select the type of document you'd like to upload:

Power of Attorney Browse... upload file

Upload Other Documents:

Browse... upload file

Agent and consumer must review the completed application and associated forms prior to submission.
Note: this Adobe Acrobat PDF will not contain any uploaded documents from above.

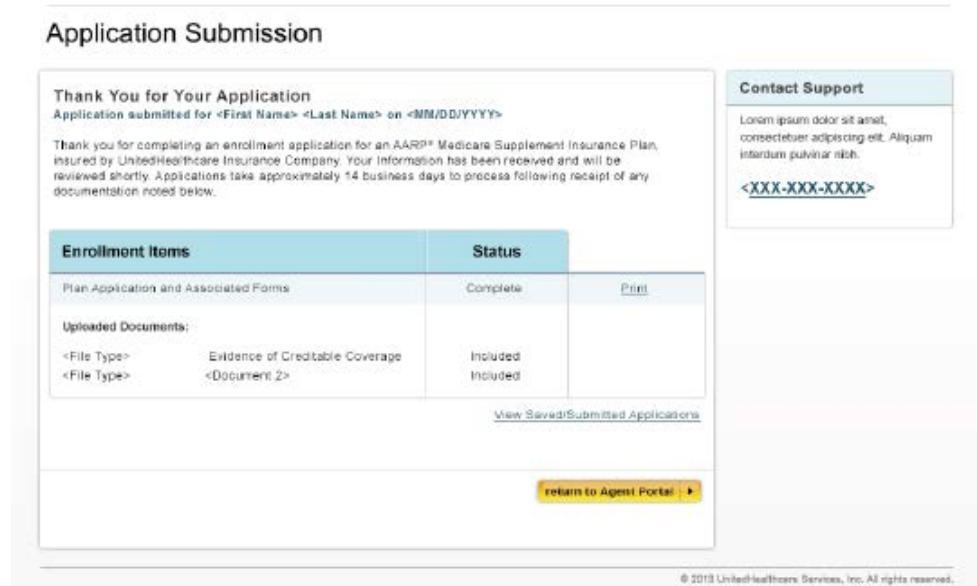
[Final Application Review \(PDF\)](#)

cancel back submit complete application

Application Submission

Submission Confirmation

- Upon submitting the application, you will be presented with a confirmation screen. Confirmation emails will also be sent to you and the consumer. Enrollment applications take approximately 14 business days to process, following the receipt of any additional documentation that may be required.
- We strongly encourage that you provide a print copy of the enrollment application and associated forms to the applicant.



Application Submission

Thank You for Your Application
Application submitted for <First Name> <Last Name> on <MM/DD/YYYY>

Thank you for completing an enrollment application for an AARP® Medicare Supplement Insurance Plan, insured by UnitedHealthcare Insurance Company. Your information has been received and will be reviewed shortly. Applications take approximately 14 business days to process following receipt of any documentation noted below.

Enrollment Items	Status	
Plan Application and Associated Forms	Complete	Print
Uploaded Documents:		
<File Type> Evidence of Creditable Coverage	Included	
<File Type> <Document 2>	Included	

[View Saved/Submitted Applications](#)

[Return to Agent Portal](#)

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Applications

Saved Application

- In-progress enrollment applications will be automatically deleted 90 days after they were last saved. When resuming an enrollment application, you must ask all questions and reconfirm all prior answers, as the consumer's status or medical conditions may have changed. Signatures must be recaptured via signature pad, and documents will need to be re-uploaded (if applicable).

Submitted Application

- Submitted enrollment applications and associated forms will be available for viewing and printing for up to 90 days.
- Uploaded documents will be included in the Application PDF one day after enrollment application submission. Any documents that were scanned for the purposes of uploading in this tool must be deleted from your computer and scanner.

Saved Applications 1-6 of 6

In-progress applications will be automatically deleted 90 days after they were last saved.

Last Name	First Name	AARP Membership #	Date Saved		
Gottschalk	Cheryl	123456789	05/02/2012	delete	resume
Roob	Kevin	123456789	05/02/2012	delete	resume
Medot	Amy	123456789	05/02/2012	delete	resume
Jesperson	Tom	123456789	05/02/2012	delete	resume
Lyngan	Carol	123456789	05/02/2012	delete	resume
Odekoven	Mark	123456789	05/02/2012	delete	resume

Submitted Applications 1-10 of 960

First << Prev < Next >> Last

Last Name	First Name	AARP Membership #	System ID	Submitted	Status	Agent ID	
Obrig	Lisa	123456789	123456789	05/02/2012	<status>	123456789	view
Danielson	Julie	123456789	123456789	05/02/2012	<status>	123456789	view
McNulty	Gary	123456789	123456789	05/02/2012	<status>	123456789	view
Cleveland	Margaret	123456789	123456789	05/02/2012	<status>	123456789	view
Fraser	Beth	123456789	123456789	05/02/2012	<status>	123456789	view
Munzinger	Eric	123456789	123456789	05/02/2012	<status>	123456789	view
Tanner	Aaron	123456789	123456789	05/02/2012	<status>	123456789	view
Walner	Wayna	123456789	123456789	05/02/2012	<status>	123456789	view
Obrig	Lisa	123456789	123456789	05/02/2012	<status>	123456789	view
Danielson	Julie	123456789	123456789	05/02/2012	<status>	123456789	view

Close

Support Help

For additional support with questions related to the online enrollment tool, please contact the Producer Help Desk (PHD):

Email phd@uhc.com

Please include your full name, writing number, contact information and a brief description of your issue

Call 888-381-8581

Hours of Operation – Monday through Friday

8 am to 8 pm EST

Please be prepared to enter your agent ID.