United American Insurance Company
Since 1947

# REPLACEMENT OF MEDICARE SUPPLEMENT

Health Insurance Policy – Comparison Form

**Current Policy**

Name of Company: _____

Policy Number: _____

Premium: _____ (Mode) _____

**Proposed Policy**

Name of Company: **United American Insurance Company**

Application Number: _____

Premium: _____ (Mode) _____

Applicant's Name: _____

1. Does the insurer provide a service for an automatic filing of both assigned and unassigned Part B claims?

   **Current Policy** ☐ Yes ☐ No

   **UA Policy** ☐ Yes ☐ No

2. If the current policy is a standardized Medicare Supplement Plan under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), identify the plan category as A, B, C, D, F, HDF, G, K, L, M, or N.

| | ProCare Plan | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Current Plan** | A | B | C | D | F | HDF | G | K | L | N |
| _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**There is no need to complete the rest of this form if the current policy is a model plan.**

3. If the plan being replaced is not a Model Plan, answer the following questions for that plan only.

| | Current Policy | UA Policy (**Y** = Yes ℕ = No) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Part A** | | A | B | C | D | F | HDF | G | K | L | N |
| Pays Medicare Part A Deductible? | ☐ Yes ☐ No | ℕ | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | 50% | 75% | **Y** |
| Pays all expenses after Medicare Part A is exhausted? | ☐ Yes ☐ No | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** |
| Has a Skilled Nursing Facility benefit? | ☐ Yes ☐ No | ℕ | ℕ | **Y** | **Y** | **Y** | **Y** | **Y** | 50% | 75% | **Y** |
| **Part B** | | A | B | C | D | F | HDF | G | K | L | N |
| Pays Medicare Part B Deductible? | ☐ Yes ☐ No | ℕ | ℕ | **Y** | ℕ | **Y** | **Y** | ℕ | ℕ | ℕ | ℕ |
| Pays ALL Medicare Part B coinsurance amounts? | ☐ Yes ☐ No | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | * | * | ** |
| Pays 100% of excess charges *(amounts above Medicare approved)*? | ☐ Yes ☐ No | ℕ | ℕ | ℕ | ℕ | **Y** | **Y** | **Y** | ℕ | ℕ | ℕ |
| Has a Foreign Travel Benefit? | ☐ Yes ☐ No | ℕ | ℕ | **Y** | **Y** | **Y** | **Y** | **Y** | ℕ | ℕ | **Y** |
| Is Policy Guaranteed Renewable? | ☐ Yes ☐ No | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** |
| At-Home Recovery Benefit? | ☐ Yes ☐ No | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ |
| Prescription Drug Benefit? | ☐ Yes ☐ No | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ |
| Preventive Care Benefit? | ☐ Yes ☐ No | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ |

Other Benefits or Services (itemize) _____

* Once you meet out-of-pocket annual limit

** Subject to policy copayment for office visits and emergency room visits

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

_____ _____

Agent's 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.**

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Since 1947

# REPLACEMENT OF MEDICARE SUPPLEMENT

Health Insurance Policy – Comparison Form

**Current Policy**

Name of Company: _____

Policy Number: _____

Premium: _____ (Mode) _____

**Proposed Policy**

Name of Company: **United American Insurance Company**

Application Number: _____

Premium: _____ (Mode) _____

Applicant's Name: _____

1. Does the insurer provide a service for an automatic filing of both assigned and unassigned Part B claims?

   **Current Policy** ☐ Yes ☐ No

   **UA Policy** ☐ Yes ☐ No

2. If the current policy is a standardized Medicare Supplement Plan under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), identify the plan category as A, B, C, D, F, HDF, G, K, L, M, or N.

| | ProCare Plan | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Current Plan** | **A** | **B** | **C** | **D** | **F** | **HDF** | **G** | **K** | **L** | **N** |
| _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**There is no need to complete the rest of this form if the current policy is a model plan.**

3. If the plan being replaced is not a Model Plan, answer the following questions for that plan only.

| | **Current Policy** | **UA Policy** **Y** = Yes ℕ = No | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Part A** | | **A** | **B** | **C** | **D** | **F** | **HDF** | **G** | **K** | **L** | **N** |
| Pays Medicare Part A Deductible? | ☐ Yes ☐ No | ℕ | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | 50% | 75% | **Y** |
| Pays all expenses after Medicare Part A is exhausted? | ☐ Yes ☐ No | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** |
| Has a Skilled Nursing Facility benefit? | ☐ Yes ☐ No | ℕ | ℕ | **Y** | **Y** | **Y** | **Y** | **Y** | 50% | 75% | **Y** |
| **Part B** | | **A** | **B** | **C** | **D** | **F** | **HDF** | **G** | **K** | **L** | **N** |
| Pays Medicare Part B Deductible? | ☐ Yes ☐ No | ℕ | ℕ | **Y** | ℕ | **Y** | **Y** | ℕ | ℕ | ℕ | ℕ |
| Pays ALL Medicare Part B coinsurance amounts? | ☐ Yes ☐ No | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | * | * | ** |
| Pays 100% of excess charges *(amounts above Medicare approved)*? | ☐ Yes ☐ No | ℕ | ℕ | ℕ | ℕ | **Y** | **Y** | **Y** | ℕ | ℕ | ℕ |
| Has a Foreign Travel Benefit? | ☐ Yes ☐ No | ℕ | ℕ | **Y** | **Y** | **Y** | **Y** | **Y** | ℕ | ℕ | **Y** |
| Is Policy Guaranteed Renewable? | ☐ Yes ☐ No | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** | **Y** |
| At-Home Recovery Benefit? | ☐ Yes ☐ No | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ |
| Prescription Drug Benefit? | ☐ Yes ☐ No | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ |
| Preventive Care Benefit? | ☐ Yes ☐ No | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ | ℕ |

Other Benefits or Services (itemize) _____

* Once you meet out-of-pocket annual limit

** Subject to policy copayment for office visits and emergency room visits

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

_____ _____

Agent's Signature and Agent Number — Date

_____ _____

Applicant's Signature — Date

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