Union Security Insurance Company
Medicare Supplement Administrative Office
800 Crescent Centre Dr., Ste 200, Franklin, TN 37067
Telephone: 1-833-552-0827

Application for **Medicare Supplement Insurance**

Issued by

Union Security Insurance Company

TENNESSEE

Application for Medicare Supplement Insurance

- Type or Print clearly and use blue or black ink.
- If only one applicant, just complete **Applicant A** information.
- Complete all required sections of the application. Any incomplete or missing information could delay processing of your application.

☐ New Business
☐ Coverage Change

1 Applicant A information

Write the name as stated on the Medicare card. Provide a copy of the Medicare card with the application if possible.

Full name of proposed insured *First, M.I., Last*
BETTY YNZUNZA

Address: **252 Heritage Sq**
Phone: **510-676-1691**
City: **MEDINA**
State: **TN**
Zip: **38355**
E-mail: **betty.ynz@msn.com**
Social Security Number: **XXX-XX-5588**

Write the date of birth that is on the birth certificate.

Birth date *mm/dd/yyyy*: **06/01/1949**
Age: **70**
☐ Male ☑ Female

Are you a legal resident of the United States? ■ Yes ☐ No

Include any letters associated with the Medicare number and in the appropriate position. If applicant has not received a Medicare card yet, put "No Medicare number yet".

Medicare card number: **6A91YQ5GA18**

Date enrolled in: Medicare Part A *mm/dd/yyyy*: **05/01/2014** Medicare Part B *mm/dd/yyyy*: **02/01/2016**

Applicant B information

Write the name as stated on the Medicare card. Provide a copy of the Medicare card with the application if possible.

Full name of proposed insured *First, M.I., Last*

Address
Phone
City
State
Zip
E-mail
Social Security Number

Write the date of birth that is on the birth certificate.

Birth date *mm/dd/yyyy*
Age
☐ Male ☐ Female

Are you a legal resident of the United States? ☐ Yes ☐ No

Include any letters associated with the Medicare number and in the appropriate position. If applicant has not received a Medicare card yet, put "No Medicare number yet".

Medicare card number

Date enrolled in: Medicare Part A *mm/dd/yyyy* Medicare Part B *mm/dd/yyyy*

For Agent Use Only

Check if application is for:

Applicant A ☐ Open Enrollment ☐ Guaranteed Issue
Applicant B ☐ Open Enrollment ☐ Guaranteed Issue

Deliver: ☐ To Agent ■ To Applicant(s) ☐ Electronically

2 Plan and premium information

You have a choice of payment options or modes for paying your premium.

Please see Household Premium Discount Eligibility Information below.

If applying for household discount: provide the discounted and non-discounted premium amounts.

Applicant A Plan selected:

Plan F

Requested Medicare Supplement effective date: *mm/dd/yyyy*

04/11/2020

Modal premium:

$ **126.00**

Modal premium with discount:

$

Application fee:

$ 25.00

Total initial premium collected/draft:

$ **151.00**

Payment mode:
- ☐ Annually
- ☐ Semi-Annual
- ☐ Quarterly
- ■ Monthly EFT (Electronic Funds Transfer)

Initial Premium:
- ■ Draft initial premium upon policy approval
- ☐ Draft initial premium on policy effective date

Applicant B Plan selected:

Requested Medicare Supplement effective date: *mm/dd/yyyy*

Modal premium:

$

Modal premium with discount:

$

Application fee:

$ 25.00

Total initial premium collected/draft:

$

Payment mode:
- ☐ Annually
- ☐ Semi-Annual
- ☐ Quarterly
- ☐ Monthly EFT (Electronic Funds Transfer)

Initial Premium:
- ☐ Draft initial premium upon policy approval
- ☐ Draft initial premium on policy effective date

Household Premium Discount Eligibility Information

Applicant: **A** ☐ Y ■ N **B** ☐ Y ☐ N

You may be eligible for a policy with a lower premium rate based on your answers to the questions in this section.

A. Do you currently live with your spouse, including validly recognized civil union and domestic partners, or do you currently have a household resident (at least one, no more than three) with whom you have continuously resided for the last 12 months?

B. If you answered "YES" to Question 1 above, please fill out the following information about the household resident, unless both applicants are applying for coverage on this application.

Full name *First, M.I., Last* — Union Security Insurance Company Policy Number

Address — City — State — Zip

Full name *First, M.I., Last* — Union Security Insurance Company Policy Number

Address — City — State — Zip

Full name *First, M.I., Last* — Union Security Insurance Company Policy Number

Address — City — State — Zip

3 Eligibility questions

Please answer all questions.

State law allows a 6 month open enrollment period beginning with the first day of the first month in which an applicant is enrolled in Medicare Part B.

An additional 6 month open enrollment period is granted to Medicare enrollees under the age of 65 that are:

- Involuntarily disenrolled from Medicaid or SCHIP; or
- Involuntarily disenrolled from other health insurance coverage, unless disenrollment is due to the enrollee's status, conduct or nonpayment of premium.

If you are a qualified open enrollee, you may apply for and receive any Medicare Supplement Plan available from us.

NOTE: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to question 2.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

To the best of your knowledge:	**Applicant:**	**A**		**B**	
1. Did you turn age 65 in the last 6 months?		☐ Y	■ N	☐ Y	☐ N
A. Did you enroll in Medicare Part B in the last 6 months?		☐ Y	■ N	☐ Y	☐ N
B. If yes, what is the effective date?					
Applicant A effective date _____ **Applicant B** effective date _____					
2. Are you covered for medical assistance through the state Medicaid program?		☐ Y	■ N	☐ Y	☐ N
A. If yes: Will Medicaid pay your premiums for this Medicare Supplement policy?		☐ Y	☐ N	☐ Y	☐ N
B. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?		☐ Y	☐ N	☐ Y	☐ N
3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "End" blank.					
Applicant A start date _____ End date _____					
Applicant B start date _____ End date _____					
A. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?		☐ Y	☐ N	☐ Y	☐ N
B. Was this your first time in this type of Medicare plan?		☐ Y	☐ N	☐ Y	☐ N
C. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?		☐ Y	☐ N	☐ Y	☐ N
4. Do you have another Medicare Supplement policy inforce?		☐ Y	■ N	☐ Y	☐ N
A. If so, with what company, and what plan do you have?					
Applicant A - Company _____ Plan _____					
Applicant B - Company _____ Plan _____					
B. If so, do you intend to replace your current Medicare Supplement policy with this policy?		☐ Y	☐ N	☐ Y	☐ N
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)		☐ Y	■ N	☐ Y	☐ N
A. If so, with what company, and what kind of policy?					
Applicant A - Company _____ Plan _____					
Applicant B – Company _____ Plan _____					
B. What are your start and end dates of coverage under the other policy? (if you are still covered under the other policy, leave "End" blank.)					
Applicant A start date _____ End date _____					
Applicant B start date _____ End date _____					

4 Health questions

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

If the health questions are answered for an Open Enrollment or Guaranteed Issue application, the application cannot be processed.

If any health questions are answered "yes" in Section 4, the applicant(s) does not qualify for this insurance with us.

	Applicant: A		B	
1. Are you dependent on a wheelchair or any motorized mobility device?	☐ Y	■ N	☐ Y	☐ N
2. Do any of the following apply to you? Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy	☐ Y	■ N	☐ Y	☐ N
3. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?				
A. congestive heart failure, unoperated aneurysm, defibrillator	☐ Y	■ N	☐ Y	☐ N
B. leukemia, lymphoma, multiple myeloma, cirrhosis	☐ Y	■ N	☐ Y	☐ N
C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy	☐ Y	■ N	☐ Y	☐ N
D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease	☐ Y	■ N	☐ Y	☐ N
E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant	☐ Y	■ N	☐ Y	☐ N
4. Do you have diabetes?				
A. that requires use of insulin	☐ Y	■ N	☐ Y	☐ N
B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage	☐ Y	■ N	☐ Y	☐ N
C. with history of heart attack or stroke (at any time)	☐ Y	■ N	☐ Y	☐ N
D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar	☐ Y	■ N	☐ Y	☐ N
5. Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following?				
A. alcoholism, drug abuse	☐ Y	■ N	☐ Y	☐ N
B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder	☐ Y	■ N	☐ Y	☐ N
C. internal cancer, melanoma, Hodgkin's Disease	☐ Y	■ N	☐ Y	☐ N
D. hepatitis, disorder of the pancreas	☐ Y	■ N	☐ Y	☐ N
6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?				
A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease	☐ Y	■ N	☐ Y	☐ N
B. myasthenia gravis, systemic lupus or connective tissue disorder	☐ Y	■ N	☐ Y	☐ N
C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living	☐ Y	■ N	☐ Y	☐ N
D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder	☐ Y	■ N	☐ Y	☐ N
E. any lung or respiratory disorder and currently use tobacco products	☐ Y	■ N	☐ Y	☐ N
7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or any surgery that has not been performed?	☐ Y	■ N	☐ Y	☐ N
8. Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?	☐ Y	■ N	☐ Y	☐ N
9. Within the past 12 months, have you been medically diagnosed with wet macular degeneration and have taken or are currently receiving injections?	☐ Y	■ N	☐ Y	☐ N
10. Have you ever tested positive for the Human Immunodeficiency Virus (HIV) infection or been diagnosed by a medical professional as having ARC or AIDS caused by the HIV infection or other sickness or conditions derived from such infection?	☐ Y	■ N	☐ Y	☐ N

4 Health questions continued

	Applicant:	A		B	
	11. Within the past 12 months, do any of the following apply to you?				
	A. had a pacemaker implanted	☐ Y	■ N	☐ Y	☐ N
	B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer	☐ Y	■ N	☐ Y	☐ N
	C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer	☐ Y	■ N	☐ Y	☐ N
Systolic is the upper number and Diastolic is the bottom number of a blood pressure reading.	D. had a seizure	☐ Y	■ N	☐ Y	☐ N
	12. Was your last blood pressure reading higher than 175 Systolic or higher than 100 Diastolic?	☐ Y	■ N	☐ Y	☐ N
	13. Have you used any form of tobacco in the past 12 months (including vaping and e-cigarettes)?	☐ Y	■ N	☐ Y	☐ N

Applicant A *Height Feet and inches*	Weight *Pounds*
5'4"	155
Applicant B *Height Feet and inches*	Weight *Pounds*

5 Applicant A health history

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

1. Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:

no

2. Within the past 5 years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:

no

Use an additional sheet of paper if needed for explanation.

3. Prescribed medications	**Reason for medications (diagnosis)**
levothyroxid 1 qd 100mcg	very mild hypothyroid
atorvastatin 10 mg qd	very mild cholosteral
1 qd hydrochlothizide 25 mg	slightly elevated blood pressure

Applicant B health history

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

1. Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:

2. Within the past 5 years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:

Use an additional sheet of paper if needed for explanation.

3. Prescribed medications	**Reason for medications (diagnosis)**

6 Applicant A physician information

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

Your primary physician Phone

Dr. heladio gonzales 510-248-3055

Physician's office name

kaiser permanente

City State

freemont CA

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Have you seen any additional physicians other than those listed above in the past 24 months? ☐ Yes ☐ No

Applicant B physician information

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

Your primary physician Phone

Physician's office name

City State

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Have you seen any additional physicians other than those listed above in the past 24 months? ☐ Yes ☐ No

7 Important statements

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. 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 reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. 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 reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
6. 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).

8 Privacy notice

Although your application is our initial source of information, we may collect information, including health history, prescription drug use and medical records, from persons other than you and we may conduct a telephone interview with you. Union Security Insurance Company, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures. Upon request, we will provide a detailed privacy notice.

9 Agent compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our companies, or for the percentage of completed sales. Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

10 Applicant(s) agreement

I hereby apply to Union Security Insurance Company for a policy to be issued in reliance on my written answers to the questions on this application. I have read and understand all statements and answers and acknowledge that to the best of my knowledge and belief, they are true, complete and correctly recorded. I acknowledge that I have received an outline of coverage for the policy applied for and *"Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare"*.

I understand that I will receive a copy of the signed application and that a copy is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that upon acceptance of the completed application, each applicant will receive a separate policy with a copy of this application attached.

I agree this application and any policy, riders, endorsements, and amendments issued will constitute the entire contract of insurance and the Company will not be bound in any way by any statements, promises or information made or given by or to any agent or other person at any time unless the same is in writing and submitted to the Company at its Medicare Supplement Administrative Office and made a part of such contract. Only a Company Officer can make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I authorize Union Security Insurance Company to withdraw my insurance premium from my account and accept the terms and conditions of the EFT authorization attached to this application. This authorization is to remain in effect until I request cancellation. Cancellation may be made by calling 1-833-552-0827 or writing to the Medicare Supplement Administrative Office address.

I understand that if any answers on this application are incorrect, incomplete or untrue, as to a material fact, Union Security Insurance Company has the right to adjust my premium, reduce my benefits or rescind this policy.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Applicant A signature — Date signed **04/11/2020**

X Secure **BETTY YNZUNZA**

Applicant B signature — Date signed

X

11 Applicant A account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 10 days greater than the policy's paid to date will draft a month in advance.

Name
BETTY YNZUNZA

Account owner name, if different than proposed insured's

Account owner relationship to proposed insured:

☐ Business owned by proposed insured ☐ Living trust ☐ Employer ☐ Power of Attorney

☐ Conservator/guardian ☐ Family member; specify

Initial premium:

☒ Draft initial premium upon policy approval
☐ Draft initial premium on policy effective date

Total Modal Premium:
126.00

☒ Checking ☐ Savings

Financial Institution Name
PATELCO CREDIT UNION

Routing number:
321076470

Account number:
XXXXXXXXX1410

Draft date if different from effective date:
14

Applicant B account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 10 days greater than the policy's paid to date will draft a month in advance.

Name

Account owner name, if different than proposed insured's

Account owner relationship to proposed insured:

☐ Business owned by proposed insured ☐ Living trust ☐ Employer ☐ Power of Attorney

☐ Conservator/guardian ☐ Family member; specify

Initial premium:

☐ Draft initial premium upon policy approval
☐ Draft initial premium on policy effective date

Total Modal Premium:

☐ Checking ☐ Savings

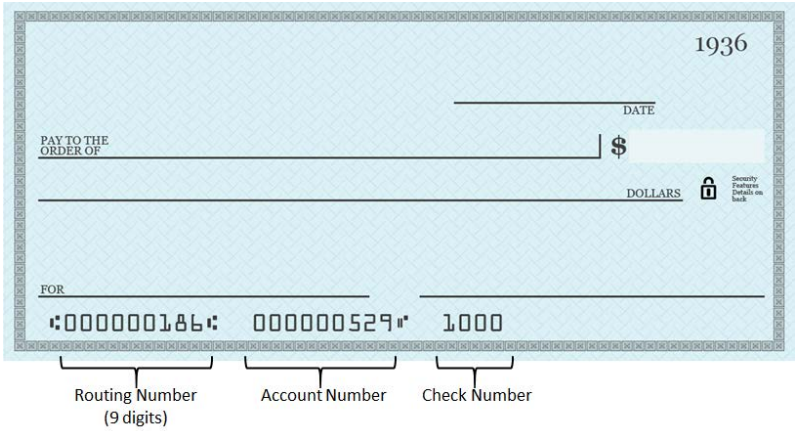
Financial Institution Name

Routing number:

Account number:

Draft date if different from effective date:

This is an example of a personal check. A business check may be different



12 Electronic funds transfer (EFT) authorization

We will deliver to you, either electronically, or by mail, a copy of this application which contains your EFT authorization.

I understand and accept these terms and conditions:

- Union Security Insurance Company is authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either annually or monthly for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal, you may contact us at 1-833-552-0827.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner for **Applicant A** Date signed

X _____ _____

Signature of account owner for **Applicant B** Date signed

X _____ _____

13 Agent

All information **must** be completed.

Please list any other medical or health insurance policies sold to **Applicant A**

1. List policies sold which are still in force

_____

_____

2. List policies sold in the past 5 years which are no longer in force

_____

_____

Please list any other medical or health insurance policies sold to **Applicant B**

1. List policies sold which are still in force

_____

_____

2. List policies sold in the past 5 years which are no longer in force

_____

_____

I certify that:

1. I have accurately recorded the information supplied by the applicant(s).
2. The application was provided to the applicant(s) to review and the applicant(s) has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy(ies).
3. I have provided an outline of coverage for the policy(ies) applied for and *"Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare"* to applicant(s) prior to completing the application.

The writing number reflects where commissions will be paid.

Agent name *Printed* Writing number (agent or company)

Elizabeth Amick **USW0006080**

Agent signature ELIZABETH.AMICK@OUTLOOK.CO State license ID number (for FL only)

X Elizabeth Amick

Cell Phone E-mail

(731) 616-2436 **ELIZABETH.AMICK@OUTLOOK.COM**

14 Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through Union Security Insurance Company, the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with Union Security Insurance Company in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective Union Security Insurance Company commission schedule.

Agent Information *Print*

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Writing Agent		Percentage
Elizabeth Amick		100.00 %
Secondary Agent	**Writing number**	**Percentage**
		%

Writing Agent signature ELIZABETH.AMICK@OUTLOOK.COM

X **Elizabeth Amick**

Union Security Insurance Company
MEDICARE SUPPLEMENT
ADMINISTRATIVE OFFICE
800 Crescent Centre Dr., Ste 200
Franklin, TN 37067
Telephone: 1-833-552-0827

Payment Receipt for Medicare Supplement Insurance

- Type or Print clearly and use blue or black ink.
- Applicant(s) keeps this receipt for their records.
- If only one applicant, just complete **Applicant A** information.

Applicant A name *Printed*: BETTY YNZUNZA

Date of application: 04/11/2020

Initial payment collected (if applicable): $ 151.00

☐ Check
☐ Money order

EFT draft amount: $ 151.00

EFT draft date: 14

Applicant B name *Printed*:

Date of application:

Initial payment collected (if applicable): $

☐ Check
☐ Money order

EFT draft amount: $

EFT draft date:

This acknowledges receipt of your application for a Union Security Insurance Company Medicare Supplement insurance policy.

Agent name *Printed*: Elizabeth Amick

Phone: (731) 616-2436

Signature of agent: ELIZABETH.AMICK@OUTLOOK.COM

X Elizabeth Amick

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to Union Security Insurance Company.
- DO NOT make any check payable to the agent and do not leave the payee blank on the check.
- A recorded interview may be required as part of the underwriting on your application for insurance.

Medicare Supplement Insurance - A. If this payment equals the full, initial premium for the mode of premium payment selected by the applicant(s); and B. if the answers are true and correct in the application and if Union Security Insurance Company issues a Medicare Supplement policy according to its rules, limits, and standards for the plan and amount applied for by the applicant(s); then this payment shall be applied to the payment of the first premium of the issued Medicare Supplement policy. No Medicare Supplement policy shall be effective until it has actually been issued by Union Security Insurance Company.

Thank you for choosing Union Security Insurance Company