



May 13, 2016

[REDACTED]  
Apache Junction, AZ 85120

*via overnight delivery*

**Member:** [REDACTED]  
**Carrier Name:** All Savers Insurance Company  
**Policy #:** [REDACTED]

Dear [REDACTED]:

Thank you for your payment in the amount of \$240.24 on April 27, 2016, for the above medical policy.

Our records show that the American Kidney Fund may have improperly paid your premiums in the past. Your medical policy does not allow a party like the American Kidney Fund to pay your medical premium.

We need to make sure that you paid your premium with your own money. We also need to make sure you do not expect to be reimbursed for this payment from a party like the American Kidney Fund.

**What do I need to do?**

We want to ensure that you get the help you need. Please sign the attached document and send it back in the envelope we have provided by **May 23, 2016**.

**What happens if I don't send back the document?**

If you don't sign and return the document, we will not be able to accept your payment. We will return any payment received and you will not have coverage.

**What happens if I did receive money from American Kidney Fund to pay my premium?**

Please call us right away. You will need to make your payment from your own money.

**Do I have any other options?**

- You may be eligible to enroll in Medicare if you have End-Stage Renal Disease. We have nurses available to talk to you about this option and other aspects of managing your care. Please call us toll-free at 866-561-7518, TTY 711. We will help you understand all of your options.
- You may be eligible to enroll in Arizona Medicaid coverage. Please contact the Arizona Health Care Cost Containment System to discuss whether you can access the care you need through their program. Call toll-free 1-800-962-6690, TTY 1-800-826-5140.



If you have any questions about this letter, please call us toll-free 877-887-0441, TTY 711.

Sincerely,

The UnitedHealthcare Team

If you need help in a language other than English, or need to request this document in another format, please call us. This is provided at no additional cost to you.

Para obtener asistencia en español, llame al 877-887-0441, TTY Dial 711

若需要中文协助，请拨打 877-887-0441, TTY Dial 711

Para sa tulong sa Tagalog, tawagan ang 877-887-0441, TTY Dial 711

Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih 877-887-0441, TTY Dial 711

**DECLARATION**

**Under penalty of perjury**, I, [REDACTED] hereby state that the following information is true and correct to the best of my knowledge and belief, as of the date that I signed this document.

1. I am over the age of majority, suffer from no legal disabilities, and have personal knowledge of the information contained in this Declaration.
2. I am the policyholder listed on Policy Number [REDACTED] issued by All Savers Insurance Company (the "Policy").
3. I applied for the Policy of my own free will after considering available options.
4. I am aware that the Policy states that I must pay my own premium unless payment is made by one of the following parties:
  - a. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
  - b. Indian tribes, tribal organizations or urban Indian organizations; or
  - c. State and Federal Government programs.
5. I hereby certify that the funds used to make the payment on April 27, 2016, in the amount of \$240.24, were not supplied to me (and will not be reimbursed to me) by any third party entity other than one listed in 4 above. Further, I will not pay any future premium for the Policy with funds received from (or reimbursed by) a prohibited third party entity.

I declare under penalty of perjury under the laws of the United States of America and the state identified below that the foregoing is true and correct.

Executed \_\_\_\_\_, 2016, at \_\_\_\_\_, \_\_\_\_\_.  
DATE CITY STATE

\_\_\_\_\_  
SIGNATURE



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