CDA Insurance LLC

Please return signed applications via one of the following methods:

EMAIL: secure email link (Ctrl+Click)
tiffany@lowinsure.com

FAX: 1-541-284-2994

MAIL: CDA Insurance LLC
P.O. Box 26540
Eugene, OR 97402

OFFICE: CDA Insurance LLC
2160 W 11th Ave Ste D
Eugene, OR 97402

CONTACT: Tiffany Jackson, independent agent, with any questions or concerns, or if you prefer an electronic application.
Email: tiffany@lowinsure.com or phone: 1-541-434-9613

DOCUMENTS: The 'Outline of Coverage' and Medicare's 'Choosing a Medigap' book are located under each company heading.

- www.medicare-oregon.com
- www.medicare-washington.com
- www.medicare-idaho.com
- www.medicare-texas.net

TPMO disclaimer: CDA Insurance LLC may not offer every plan available in your area. Currently represented in the Medicare Advantage market are all plans available from: 9 insurance companies in the state of Oregon, 9 in the state of Washington, 4 in the state of Idaho, and 3 in the state of Texas. Any information provided is limited to those plans we do offer in your area. For a breakdown by county, please visit our websites: Oregon, Washington, Idaho, Texas Please contact Medicare.gov, 1-800-MEDICARE , or your local SHIP to obtain information on all of your options.

Blue Cross of Idaho MEDICARE

Medicare Supplement Application

APPLICANT INFORMATION

Your Name (first, middle initial, last)	Date of Birth	Age	☐ Male ☐ Female
Physical Address (street or route)	City, State, Zip Code		County
Mailing Address (if different than physical address)	City, State, Zip Code		County
Billing Address (if different from physical address)	City, State, Zip Code		County
Social Security Number	Preferred Phone	Alternate Phone	
Email Address (Optional)*	Medicare Number		
Marital Status ☐ Single ☐ Married	Do you now or have you ever smoked or used tobacco in the past 12 months? ☐ Yes ☐ No		
Do you have Part A of Medicare? ☐ Yes ☐ No Effective Date_____	Do you have Part B of Medicare? ☐ Yes ☐ No Effective Date_____		

*By providing us with your email address you are agreeing to receive communications regarding your plan benefits and well-being. You can opt out at any time.

CONFIRM THE PLAN YOU ARE APPLYING FOR BY CHECKING THE BOX BELOW:

☐ MedPlus – Plan A ☐ MedPlus – Plan F (For those eligible for Medicare prior to January 1, 2020)
☐ MedPlus – Plan G ☐ MedPlus – Plan G, High Deductible

Requested Effective Date:_____

The effective date on the policy will be the first of the month following receipt and acceptance of the application by Blue Cross of Idaho Care Plus, Inc. or the requested effective date, whichever comes later.

You may be eligible for a lower premium if another person that currently has a Blue Cross of Idaho Medicare Supplement plan resides at the same address.

☐ I live with a person who's currently covered under a Blue Cross of Idaho Medicare Supplement plan.

Name of Covered Person:_____ Enrollee ID Number: _____

☐ I live with a person who is in the process of applying for a Blue Cross of Idaho Medicare Supplement plan.

Name of Covered Person:_____ Enrollee ID Number: _____

☐ I do not currently live with another person who has a Blue Cross of Idaho Medicare Supplement plan, and am not eligible for the household discount.

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IMPORTANT INFORMATION BEFORE YOU APPLY

You do not need more than one (1) Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. 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 twenty-four (24) months. You must request this suspension within ninety (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 ninety (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. 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 ninety (90) days of losing your employer or union-based 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 the suspension. Counseling services are available through the Senior Health Insurance Benefit Advisors program (SHIBA), 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).

OTHER COVERAGE INFORMATION

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. PLEASE ANSWER ALL QUESTIONS.

To the best of your knowledge:

1. (a) Did you turn 65 in the last six (6) months? ☐ Yes ☐ No
   (b) Did you enroll in Medicare Part B in the last six (6) months? ☐ Yes ☐ No
   (c) If **YES**, what is the effective date?
2. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No
   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.

If **YES**:

   (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No
   (b) Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium? ☐ Yes ☐ No

3. (a) Did you have coverage from any Medicare plan other than original Medicare within the past sixty-three (63) days (for example, a Medicare Advantage Plan, or a Medicare HMO or PPO)?
   (i) If so, with what company and what kind of policy? _____
   (ii) What are your dates of coverage under the other policy? _____
   (iii) List the full member ID number as printed on your member ID card. _____
   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No
   (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   (d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No
4. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No
   (b) If so, with what company?_____ What plan do you have? _____
   (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No
5. Have you had coverage under any other health insurance within the past sixty-three (63) days (for example, with an employer, union, or individual plan)? ☐ Yes ☐ No
   (a) If so, with what company and what kind of policy? _____
   (b) What are your dates of coverage under the other policy? _____
   (c) List the full member ID number as printed on your member ID card. _____

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HEALTH STATEMENT

Please disregard if you are applying during Medicare initial enrollment period (within six months of your plan B effective date) or have federal/state guarantee issue rights.

Height_____ Weight_____

Answer each question Yes or No. If **YES**, in the chart below, write the item number along with specific condition details.

Has the applicant had or been told he or she has any of the following within the past five years:

1. Cancer, cyst or tumor (malignant or benign)? ☐ Yes ☐ No	8. Parkinson's, Multiple Sclerosis (MS) or Amyotrophic Lateral Sclerosis (ALS)? ☐ Yes ☐ No
2. Heart trouble, chest pain, stroke, hemophilia or any other disorder of the blood or circulatory system? ☐ Yes ☐ No	9. Emphysema, tuberculosis (TB) or removal of any part of the lung? ☐ Yes ☐ No
3. High blood pressure or heart murmur? ☐ Yes ☐ No	10. Rheumatoid arthritis or osteoarthritis? ☐ Yes ☐ No
4. End-stage renal disease, dialysis, chronic hepatitis, cirrhosis or any other disorder of the kidney, liver or intestines? ☐ Yes ☐ No	11. HIV infection or AIDS? ☐ Yes ☐ No
5. Diabetes or thyroid disorder? ☐ Yes ☐ No	12. Amputations or prosthetic devices? ☐ Yes ☐ No
6. Epilepsy, convulsions, Alzheimer's disease, dementia, loss of consciousness or any other cognitive disorder? ☐ Yes ☐ No	13. Any illness, condition or irregular symptoms not named above? ☐ Yes ☐ No
7. Organ transplant or any disorder of the stomach, bladder or prostate? ☐ Yes ☐ No	14. Advised to have surgery or hospitalization that has not yet been performed? ☐ Yes ☐ No

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If you answered **YES** to any question above, please explain below. Use extra paper if needed.

Item No.	Diagnosis	Type of Treatment	Date of Illness	Date of Last Visit	Was Recovery Complete?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

List any medications or drugs taken by applicant within the past 12 months. Use extra paper if needed.

Item No.	Medication Name (Dosage)	Condition Requiring Medication	Still Taking?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

STATEMENT OF UNDERSTANDING

- I understand and agree that the statements and answers on this Application and Health Statement are complete and accurate, and that any false statement, misrepresentation or concealment of fact may, at the option of Blue Cross of Idaho Care Plus, bar recovery of any benefits, and shall be grounds for voidance or cancellation of the policy.
- I acknowledge and understand my health plan may request or disclose health information about me from time to time for the purpose of facilitating healthcare treatment, payment or for the purpose of business operations necessary to administer healthcare benefits, or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Care Plus Notice of Privacy Practices that is available at ***medicare.bcidaho.com***.
- I understand and agree that the deposit, $_____(if any), submitted with the Application is not binding upon Blue Cross of Idaho Care Plus for the benefits applied for herein until the application is approved; after approval, the deposit then is payment of premiums for _____ month(s) from the effective date.

The Notice to Applicant and Outline of Coverage were furnished to me on _____(Date).

Applicant's Signature_____ Date _____

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FOR AGENT USE ONLY

Independent Producer (agent) Certification

1. Who actually completed this application? ❑ Applicant ❑ Independent Producer ❑ Other
   If Independent Producer or Other, please explain: _____
2. Were you present at the time the application was filled out? ❑ YES ❑ NO
   If **NO**, please explain: _____
3. Are you aware of any medical information relating to the applicant or any family member that has not been disclosed on this application? ❑ YES ❑ NO
   If **YES**, please explain: _____
4. Was money collected from the applicant? ❑ YES ❑ NO Amount $_____
5. (a) List policies you have sold the applicant which are still in force (use extra paper if needed)

   _____

   _____

   (b) List policies you have sold to the applicant in the past five (5) years which are no longer in force (use extra paper if needed)

   _____

   _____

- I hereby certify that I personally solicited and completed this application, that I personally asked each question on this application, and have accurately recorded the answers.
- That the answers to all of the questions are complete and accurate to the best of my knowledge and belief.
- That I have explained the eligibility provisions to the applicant and have not made any representations about benefits, conditions or limitations of the policy, except through written material furnished by Blue Cross of Idaho Care Plus.
- That I have verified the dates on the applicant's member ID card.
- I hereby certify that the information supplied to me by the applicant has been completely and accurately recorded.

Type of Company Appointment: ❑ Personal ❑ Agency (Name) _____

Tiffany Jackson	008145BC
Agent's Name	ID Number
_____	_____
Signature of Agent	Date

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Medicare Supplement plans are offered by Blue Cross of Idaho Care Plus, Inc. When this document says Blue Cross of Idaho Care Plus, it means Blue Cross of Idaho Care Plus, Inc.