

#### 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 11<sup>th</sup> 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

to obtain information on all of your options.

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



P.O. Box 14399 Lexington, KY 40512-9700 800-264-4000 aetnaseniorproducts.com

# Application Medicare Supplement Insurance

Underwritten by

## Aetna Health and Life Insurance Company

#### Idaho



## Aetna Health and Life Insurance Company

P.O. Box 14399 Lexington, KY 40512-9700

## Application for Medicare Supplement Insurance

## from Aetna Health and Life Insurance Company

Page 1 of 8

- Print clearly and use blue or black ink.
- Complete all required sections of the application. Any incomplete or missing information could delay processing of your application.

Write the name as stated on the Medicare card. Provide a copy of the	Full name of proposed insured Fin	rst, M.I., Last			
Medicare card with the application if possible.	Address		Phone		
r	City		State	Zip	
	E-mail		Social Security Nu	• mber	
Write the date of birth that is on the birth certificate.	Birth date mm/dd/yyyy		Age		
3 <del>0</del>	Height Feet and inches		Weight <i>Pounds</i>		
	Are you a legal resident of the Unit	ed States?		○ Yes	○ No
	Have you used any form of tobacco			○ Yes	$\bigcirc$ No
Include any letters associated with the Medicare number and in the	Medicare card number				
appropriate position. If applicant has not received a Medicare card yet, put "No Medicare number yet".	Date enrolled in: Medicare Pa	art A	Medicare Part B		
		- '	Guaranteed Issue Applicant	Electronically	ļ
	Go paperless! To receive your Po current e-mail address in Section will receive an e-mail with a lin	on 1. You will not recei	ve paper policy docun		
2. Plan and premium information					
	Plan selected:				
	Requested Medicare Supplement	effective date: mm/dd/y	уууу		
	Initial premium collected/draft:	Payment mode  O Annually O Semi-Annual	○ Quarterly ly ○ Monthly EFT (EI	ectronic Func	ds Transfe
		Payment metho Check List Bill billing	○ EFT		
		Initial premiu	<b>m:</b> premium upon policy app	oroval	

AHLMS07484ID 121721

O Draft initial premium on policy effective date

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#### Plan and premium information continued

#### PAYMENT MODES

You have a choice among several payment options or mode for paying your premium (annual, semi-annual, quarterly and monthly electronic funds transfer). You may change your payment mode, among the modes available, during the life of your policy.

#### 3. Eligibility questions

Please answer all questions.	To	he best of your knowledge:		
	1.	olid you turn age 65 in the last 6 months?	$\bigcirc$ Y	$\bigcirc$ N
		A. Did you enroll in Medicare Part B in the last 6 months? B. If yes, what is the effective date?	ΟY	$\bigcirc$ N
		· / /		
NOTE: If you are participating in		are you covered for medical assistance through the state Medicaid program?	ΟY	$\bigcirc$ N
a "Spend-Down Program" and have not met your "Share of Cost," please		A. If yes: Will Medicaid pay your premiums for this Medicare Supplement policy?	$\bigcirc$ Y	$\bigcirc$ N
answer NO to question 2.		B. Do you receive any benefits from Medicaid <b>other than</b> payments toward your Medicare Part B premium?	$\bigcirc$ Y	$\bigcirc$ N
		f 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.  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?	ΟY	$\bigcirc$ N
		B. Was this your first time in this type of Medicare plan?	$\bigcirc$ Y	$\bigcirc$ N
		Did you drop a Medicare Supplement policy to enroll in the Medicare plan?	$\bigcirc$ Y	$\bigcirc$ N
		Oo you have another Medicare Supplement policy inforce? A. If so, with what company, and what plan do you have? Company Plan	ΟY	O N
If you lost or are losing other health		8. If so, do you intend to replace your current Medicare Supplement policy with this policy?	ΟY	$\bigcirc$ N
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,		lave you had coverage under any other health insurance within the past 63 days?  For example, an employer, union, or individual plan)  A. If so, with what company, and what kind of policy?  Company  Plan  •	ΟY	○ N
you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a		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.)		
copy of the notice from your prior insurer with your application.		Start date End date  - / / / / / /		

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4. Health questions				
If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.		Are you dependent on a wheelchair or any motorized mobility device?	ΟY	$\bigcirc$ N
		Do any of the following apply to you?		
If the health questions are answered		Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy	ΟY	$\bigcirc$ N
for an Open Enrollment or	3.	At any time, have you been medically diagnosed, treated, or had surgery for any or	f the follov	ving?
Guaranteed Issue application, the		A. congestive heart failure, unoperated aneurysm, defibrillator	ΟY	$\bigcirc$ N
application cannot be processed and		B. leukemia, lymphoma, multiple myeloma, cirrhosis	$\bigcirc$ Y	$\bigcirc$ N
will be returned.		C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy	$\bigcirc$ Y	$\bigcirc$ N
If any health questions are answered "yes" in Section 4, the applicant		D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease	ΟY	$\bigcirc$ N
does not qualify for this insurance with us.		E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant	ΟY	$\bigcirc$ N
		F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV)	ΟY	$\bigcirc$ N
	4.	Do you have diabetes?		
		A. that requires use of insulin	$\bigcirc$ Y	$\bigcirc$ N
		B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage	○ Y	$\bigcirc$ N
		C. with history of heart attack or stroke (at any time)	$\bigcirc$ Y	$\bigcirc$ N
		D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar	ΟY	$\bigcirc$ N
	5.	Within the past 36 months, have you been medically diagnosed, treated, or had su the following?	irgery for a	iny of
		A. alcoholism, drug abuse	$\bigcirc$ Y	$\bigcirc$ N
		B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder	$\bigcirc$ Y	$\bigcirc$ N
		C. internal cancer, melanoma, Hodgkin's Disease	$\bigcirc$ Y	$\bigcirc$ N
		D. hepatitis, disorder of the pancreas	$\bigcirc$ Y	$\bigcirc$ N
	6.	Within the past 24 months, have you been medically diagnosed, treated, or had su the following?	irgery for a	iny of
		A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease	○ Y	$\bigcirc$ N
		B. myasthenia gravis, systemic lupus or connective tissue disorder	$\bigcirc$ Y	$\bigcirc$ N
		C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living	ΟY	$\bigcirc$ 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	$\bigcirc$ N
		E. any lung or respiratory disorder and currently use tobacco products	$\bigcirc$ Y	$\bigcirc$ 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?	ΟY	O 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?	ΟY	$\bigcirc$ N
	9.	Within the past 12 months, have you been medically diagnosed with wet macular degeneration and have taken or are currently receiving injections?	ΟY	$\bigcirc$ N

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Health questions continued			
	10. Within the past 12 months, do any of the following apply to you?		
	A. had a pacemaker implanted	$\bigcirc$ Y	$\bigcirc$ N
	B. had a PSA blood test greater than 4.5, under age 70, with no h prostate cancer	·	$\bigcirc$ N
	C. had a PSA blood test greater than 6.5, age 70 or older, with no prostate cancer	history of Y	$\bigcirc$ N
Systolic is the upper number and Diastolic is the bottom number of a	D. had a seizure	$\bigcirc$ Y	$\bigcirc$ N
blood pressure reading.	11. Was your last blood pressure reading higher than 175 Systolic or 100 Diastolic?	higher than Y	$\bigcirc$ N
5. Health history			
If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.	Within the past 24 months if you have been medically diagnosed, brain, mental or nervous disorder, provide reason and diagnosis:	treated, or had surgery	for any
	Within the past five years if you have been hospitalized, treated a emergency room, provide reason and diagnosis:	it an outpatient facility,	or
	3. Prescribed medications Reason for medication	ıs (diagnosis)	
	· · · · · · · · · · · · · · · · · · ·		
Use an additional sheet of paper if needed for explanation.			
6. Physician information	·		
•	Your primary physician Pho	ne	
	Physician's office name		
	City Sta	te	
	•		
	Specialist seen in the past 24 months Spe	ecialty	
	Reason for seeing (diagnosis) •		
	Specialist seen in the past 24 months Spe	ecialty	
	Reason for seeing (diagnosis)		
	Specialist seen in the past 24 months Spe	ecialty	
	Reason for seeing (diagnosis)		
	Have you seen any additional physicians other than those listed abo 24 months?	ve in the past Y	○ N

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#### 7. Important statements

- 1. You do not need more than one Medicare Supplement policy.
- 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 and medical records, from persons other than you and we may conduct a telephone interview with you. Aetna Health and Life 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.

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#### 9. Applicant agreement

I hereby apply to Aetna Health and Life 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 certify 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 *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 (1) this application and any policy 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 Home 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; and (2) this application shall not be approved until the first premium is paid, there has been no change in my health as stated in the application and a policy has been issued by the Company.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

I understand that if any answers on this application are incorrect, incomplete or untrue, Aetna Health and Life Insurance Company has the right to adjust my premium, reduce my benefits or rescind the policy.

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 containing any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

	Applicant signature	Date signed
Х .	X	

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#### 10. Account information

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

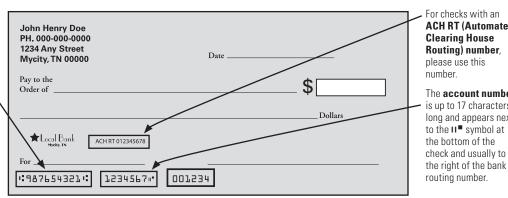
Include a voided check with the application.

Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 15 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 O Business owned O Living trust ○ Employer relationship to by proposed insured O Power of Attorney O Conservator/guardian proposed insured: O Family member; specify Financial institution name Checking Savings 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.

> For all other checks, use the ninecharacter bank routing number, which appears between the I symbols, usually at the bottom left corner of the check



ACH RT (Automated **Clearing House** Routing) number, please use this

The account number is up to 17 characters long and appears next to the II symbol at the bottom of the check and usually to

#### 11. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the
- 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 quarterly or less frequently 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.
- 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	Date
X	

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#### 12. Agent

All information <b>must</b> be completed.	Please list any other medical or health insurance policies sold to the proposed insured.
	1) List policies sold which are still in force
	_
	2) List policies cold in the post Eugers which are no larger 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.
- 2. The application was provided to the applicant to review and the applicant 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.
- 3. I have provided an outline of coverage for the policy applied for and *A Guide to Health Insurance for People with Medicare* to applicant prior to completing the application.

The writing number reflects where commissions will be paid.

Agent name Printed	Tiffany Jackson	Writing number (agent or company) . GNW0040457
Agent signature <b>X</b>		State license ID number (for FL only) •
Phone		E-mail
		•

#### 13. 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 Aetna Health and Life Insurance Company (AHLIC), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with AHLIC 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 AHLIC commission schedule.

#### **Agent Information** *Print*

X

Writing Agent -	Tiffany Jackson	Percentage • 100	%
Secondary Agent	Writing number	Percentage	
	•		%
Writing Agent Signature			

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



#### Aetna Health and Life **Insurance Company**

P.O. Box 14399 Lexington, KY 40512-9700 800-264-4000 aetnaseniorproducts.com

office hours 7:00 a.m. - 7:00 p.m. CST

Receipt

### from Aetna Health and Life Insurance Company

Page 1 of 1

- Print clearly and use blue or black ink.
- Applicant keeps this receipt for their records.
- Complete all required sections of the application. Any incomplete or missing information could delay processing of your application.

Proposed insured's name Printed		Date of application			
Initial payment collected (i	f applicable)				
\$		○ Chec	k OMoney order		
EFT draft amount		EFT draf	t date		
\$					
This acknowledges receipt Medicare Supplement insu	of your application for an Aetna Burance policy.	a Health and Li	fe Insurance Company		
Agent name Printed	Tiffany Jackson	Phone	541-434-9613		
	,	•			
Signature of agent					
X					

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to Aetna Health and Life 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; and B. if the answers are true and correct in the application and if Aetna Health and Life Insurance Company issues a Medicare Supplement policy according to its rules, limits, and standards for the plan and amount applied for by the applicant; 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 Aetna Health and Life Insurance Company.

Thank you for choosing Aetna Health and Life Insurance Company!