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.

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

- 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.

1. Proposed insured 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

Height *Feet and inches*

Weight *Pounds*

○ Male
○ Female

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

Have you used any form of tobacco in the past 12 months? ○ 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

Medicare Part B

For Agent Use Only:

Check if application is for: ○ Open Enrollment ○ Guaranteed Issue

Deliver policy to: ○ Agent ○ Applicant ○Electronically

Go paperless! To receive your Policy documents online, select “Electronically” and provide your current e-mail address in Section 1. You will not receive paper policy documents, but instead, will receive an e-mail with a link to access them on our secure website.

2. Plan and premium information

Plan selected:

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

Initial premium collected/draft:

$

Payment mode

○ Annually ○ Quarterly
○ Semi-Annually ○ Monthly EFT (Electronic Funds Transfer)

Payment method

○ Check ○ EFT
○ List Bill billing file identifier

Initial premium:

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

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 the best of your knowledge:

1. Did you turn age 65 in the last 6 months? ○ Y ○ N
   A. Did you enroll in Medicare Part B in the last 6 months? ○ Y ○ N
   B. If yes, what is the effective date?
   . / /

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

2. Are you covered for medical assistance through the state Medicaid program? ○ Y ○ N
   A. If yes: Will Medicaid pay your premiums for this Medicare Supplement policy? ○ Y ○ N
   B. Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium? ○ 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.
   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
   B. Was this your first time in this type of Medicare plan? ○ Y ○ N
   C. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ○ Y ○ N

4. Do you have another Medicare Supplement policy inforce? ○ Y ○ N
   A. If so, with what company, and what plan do you have?
   Company . Plan .
   B. If so, do you intend to replace your current Medicare Supplement policy with this policy? ○ Y ○ N

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.

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
   A. If so, with what company, and what kind of policy?
   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.)
   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 and will be returned.

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

1. Are you dependent on a wheelchair or any motorized mobility device?	○ 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
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
B. leukemia, lymphoma, multiple myeloma, cirrhosis	○ Y	○ N
C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy	○ Y	○ N
D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease	○ Y	○ N
E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant	○ Y	○ N
F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV)	○ Y	○ N
4. Do you have diabetes?		
A. that requires use of insulin	○ Y	○ N
B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage	○ Y	○ N
C. with history of heart attack or stroke (at any time)	○ Y	○ N
D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar	○ 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
B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder	○ Y	○ N
C. internal cancer, melanoma, Hodgkin's Disease	○ Y	○ N
D. hepatitis, disorder of the pancreas	○ 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
B. myasthenia gravis, systemic lupus or connective tissue disorder	○ Y	○ N
C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living	○ 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
E. any lung or respiratory disorder and currently use tobacco products	○ 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
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
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

Health questions *continued*

	10. Within the past 12 months, do any of the following apply to you?		
	A. had a pacemaker implanted	○ Y	○ N
	B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer	○ Y	○ N
	C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer	○ Y	○ N
Systolic is the upper number and Diastolic is the bottom number of a blood pressure reading.	D. had a seizure	○ Y	○ N
	11. Was your last blood pressure reading higher than 175 Systolic or higher than 100 Diastolic?	○ Y	○ N

5. 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 five 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. Physician information

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? ○ Y ○ N

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 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.

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
X	.

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 relationship to proposed insured: ◯ Business owned by proposed insured ◯ Living trust ◯ Employer ◯ Power of Attorney ◯ Conservator/guardian ◯ Family member; specify

Financial institution name

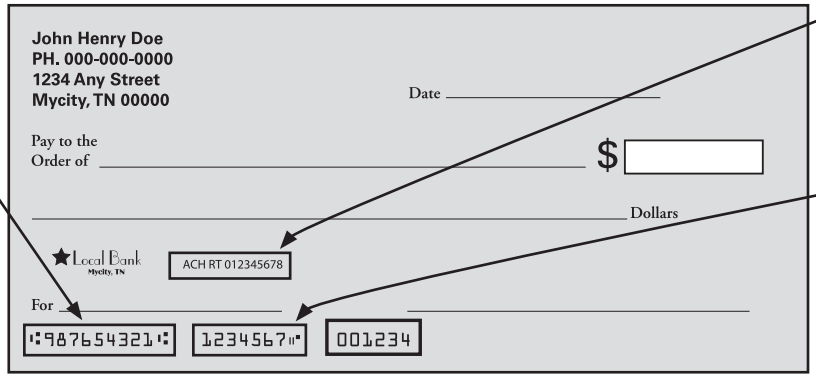
◯ Checking ◯ Savings

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 nine-character bank **routing number**, which appears between the ⑆ symbols, usually at the bottom left corner of the check.

For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the ⑈ symbol at the bottom of the check and usually to the right of the bank routing number.

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 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 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

12. Agent

All information **must** 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 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*	Writing number (agent or company)
.	.
Agent signature	State license ID number (for FL only)
X	.
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*

Writing Agent		Percentage
. **TIFFANY JACKSON**		. %
Secondary Agent	Writing number	Percentage
.	. **GNW0040457**	. %

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

Writing Agent Signature

X

NOTICE TO APPLICANT REGARDING REPLACEMENT OF
MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

Aetna Health and Life Insurance Company
P.O. Box 14399 Lexington, KY 40512

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to terminate existing Medicare Supplement or Medicare Advantage and replace it with a policy to be issued by Aetna Health and Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY PRODUCER: I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

_____ Additional benefits
_____ No change in benefits, but lower premiums
_____ Fewer benefits and lower premiums
_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D
_____ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment
_____ Other (please specify) _____
_____

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate, may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

(3) If, you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

(4) Do not cancel your present policy or certificate until you have received your new policy or certificate and are sure that you want to keep it.

_____ _____
Signature of Agent Signature of Applicant

_____ Date: _____
Printed Name of Agent

TIFFANY JACKSON

Address of Agent **2160 W 11TH AVE STE D, EUGENE OR 97402**

Date: _____

ONE COPY: home office with completed application – ONE COPY: applicant