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.

INSURANCE COMPANY OF NORTH AMERICA

Home Office: Philadelphia, Pennsylvania
Administration: P.O. Box 10856, Clearwater, Florida 33757-8856

APPLICATION FOR MEDICARE SUPPLEMENT COVERAGE

SECTION A. PROPOSED INSURED INFORMATION

Applicant Name *(exactly as it appears on your Medicare card)*	
Resident Address	Phone *(with area code)*
City	State, Zip Code
Mailing Address (if different from Resident Address)	
City	State, Zip Code
Date of Birth	Age (as of effective date)
Male ☐ Female ☐	Social Security No
Medicare Number	
Email Address	
Height *Feet and inches*	Weight *Pounds*

SECTION B. PLAN AND PREMIUM INFORMATION

Plan A ☐ Plan F* ☐ Plan G ☐ Plan HDG ☐ Plan N ☐

*Plan F is only available to individuals who were eligible for Medicare prior to January 1, 2020.

Requested Policy Effective Date	Premium $
Premium Collected $	Initial Bank Draft: $

Payment Mode: Bank Draft ☐ Monthly ☐ (Bank Draft ONLY) Annual ☐ Semi-Annual ☐ Quarterly ☐

SECTION C. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS

1. Have you used tobacco in any form, including cigarettes, vapes, nicotine gum or patches, cigars, chewing tobacco, pipes, or eCigarettes in the past twelve (12) months?	Yes ☐ No ☐
2. Are you covered under Medicare Part A?	Yes ☐ No ☐
If NO, what is your future Part A effective date? _____	
If YES, what is your Part A effective date? _____	
3. Are you covered under Medicare Part B?	Yes ☐ No ☐
If NO, what is your future Part B effective date? _____	
If YES, what is your Part B effective date? _____	
Have you enrolled in Medicare Part B more than once?	Yes ☐ No ☐
4. Are you applying during a guaranteed issue or state special enrollment period? (If YES please provide proof of eligibility).	Yes ☐ No ☐
5. Are you eligible for Medicare due to Disability or End Stage Renal Disease (ESRD)?	Yes ☐ No ☐
(If YES please check the box that applies. Disability ☐ End Stage Renal Disease (ESRD) ☐	

SECTION D. HEALTH QUESTIONS

If applying during Open Enrollment or a Guaranteed Issue period, go to **SECTION F**.

If not, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. If you answer YES to any of the following questions 1–15, you are not eligible for coverage.

1. Are you currently hospitalized or in a nursing home or assisted living facility; or, are you bedridden or confined to a wheelchair, or require the assistance of motorized mobility aid, or have you had any amputation caused by disease? Yes ☐ No ☐

2. Are you currently receiving any occupational, speech, or physical therapy, or are you currently receiving any services from a home healthcare agency? Yes ☐ No ☐

3. Within the past ten years have you had, been medically diagnosed with, or treated at any time for Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any other chronic pulmonary disorders, or any medical condition requiring the use of oxygen? Yes ☐ No ☐

4. Within the past ten years have you had, been medically diagnosed with, or treated at any time for Parkinson's Disease, Arthritis that restricts mobility, Osteoporosis with fracture, Systemic Lupus, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Scleroderma, Chronic kidney disease (stage 3-5), Chronic Hepatitis, Cirrhosis of the liver, or renal failure requiring dialysis? Yes ☐ No ☐

5. Within the past ten years have you been diagnosed with Alzheimer's Disease, Dementia, Muscular Dystrophy, or any other cognitive disorder? Yes ☐ No ☐

6. Within the past ten years have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or human immunodeficiency virus (HIV) infection? Yes ☐ No ☐

7. If you have diabetes or take prescription medication to control your blood sugar, have you been medically diagnosed with or treated for any of the following conditions: peripheral vascular disease, peripheral venous thrombotic disease, peripheral artery disease, kidney failure, kidney disease, stroke, transient ischemic attack (TIA), congestive heart failure, or any heart disorder? If you do **not** have diabetes or do not take prescription medication to control your blood sugar, this question should be answered "NO." Yes ☐ No ☐

8. If you have diabetes or take prescription medication to control your blood sugar, do you take three (3) or more medications (oral or injections) to control your blood sugar? If you do **not** have diabetes or do not take prescription medication to control your blood sugar, this question should be answered "NO." Yes ☐ No ☐

9. If you have diabetes or take prescription medication to control your blood sugar, do you take four (4) or more medications to control your high blood pressure? If you do **not** have diabetes or do not take prescription medication to control your blood sugar, this question should be answered "NO." Yes ☐ No ☐

10. Within the past ten years have you had a medical professional advise you to take more than 50 units of insulin daily or have you ever required more than 50 units of insulin daily for diabetes or to control your blood sugar? Yes ☐ No ☐

SECTION D. HEALTH QUESTIONS (continued)

11. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for internal cancer (examples include but are not limited to liver, breast or lung cancer, etc.), malignant melanoma, lymphoma, leukemia, Hodgkin's disease, alcoholism or drug abuse, or have you been advised to have a joint replacement? Yes ☐ No ☐

12. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for heart attack, cardiac angioplasty, implantation of a pacemaker, bypass surgery, stent placement or replacement, vascular angioplasty, endarterectomy, stroke or transient ischemic attack (TIA)? Yes ☐ No ☐

13. Within the past ten years have you been advised by a physician to have surgery (including cataract or joint replacement surgery), medical tests, infusions, treatment or therapy that has not been performed? Yes ☐ No ☐

14. Have you been hospital confined three (3) or more times in the last two (2) years? Yes ☐ No ☐

15. Within the past ten years have you had, been medically diagnosed with, or treated at any time for an organ transplant, been advised by a physician to have an organ transplant (excluding cornea transplants) or had a cardiac defibrillator implanted? Yes ☐ No ☐

If you answer YES to any of the following health questions 16-19, you may be eligible for coverage.

16. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for angina, heart attack, heart disease, heart valve disease, coronary artery disease, aortic or cardiac aneurysm, cardiomyopathy, carotid artery disease (not including high blood pressure), congestive heart failure, atrial fibrillation, peripheral vascular disease, peripheral venous thrombotic disease, enlarged heart, or other heart rhythm disorder? Yes ☐ No ☐

17. Within the past two (2) years have you been treated for degenerative bone disease, rheumatoid arthritis, or spinal stenosis? Yes ☐ No ☐

18. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for a mental or nervous disorder requiring treatment by a psychiatrist? Yes ☐ No ☐

19. Are you currently receiving, or within the past ten years have you been advised to receive injections in a physician's office excluding vaccines, boosters, the flu shot or B12 injections? If yes, please answer below. Yes ☐ No ☐

(Please explain any yes answers to questions 16 – 19 below)

SECTION E. MEDICATION HISTORY

Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes ☐ No ☐

If YES, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Date prescription last filled	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Date prescription last filled	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Date prescription last filled	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Date prescription last filled	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Date prescription last filled	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Date prescription last filled	
Dosage and Frequency	
Diagnosis/Condition	

SECTION F. REPLACEMENT QUESTIONS

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 age 65 in the last six months? Yes ☐ No ☐
   (b) Did you enroll in Medicare Part B in the last six months? Yes ☐ No ☐
   (c) If YES, indicate your 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, answer (a) – (b) below.
   (a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes ☐ No ☐
   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? Yes ☐ No ☐

3. Have 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.) Yes ☐ No ☐
   If YES, answer (a) – (g) below.
   (a) Name of Company _____
   Plan Type & Policy/Certificate No _____
   Company Telephone Number _____
   Coverage Dates: START DATE / /
   (if you are still covered under this plan, leave end date blank) END DATE / /
   (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 ☐
   If YES, have you received a copy of the replacement notice? Yes ☐ No ☐
   (c) Reason for termination/disenrollment? _____
   (d) Planned date of termination/disenrollment? / /
   (e) Was this your first time in this type of Medicare plan? Yes ☐ No ☐
   (f) Did you drop a Medicare supplement policy to enroll in this Medicare plan? Yes ☐ No ☐
   (g) Is your former Medicare supplement policy still available? Yes ☐ No ☐

4. Do you have another Medicare supplement policy in force? Yes ☐ No ☐
   If YES, answer (a) – (d) below.
   (a) Name of Company _____
   Plan Type & Policy/Certificate No _____
   Company Telephone Number _____
   Issue Date / /
   (b) Do you intend to replace your current Medicare supplement policy with this policy? Yes ☐ No ☐
   (c) Indicate termination date. / /
   (d) Have you received a copy of the replacement notice? Yes ☐ No ☐

SECTION F. REPLACEMENT QUESTIONS (continued)

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.) Yes ☐ No ☐

If YES, answer (a) – (c) below.

(a) Name of Company

Plan Type & Policy/Certificate No

Company Telephone Number

Coverage Dates: START DATE / /

(if you are still covered under this plan, leave end date blank) END DATE / /

(b) Reason for termination/disenrollment?

(c) Planned date of termination/disenrollment? / /

This section to be completed only by an agent, if applicable.

Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

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

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- 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.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance 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 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 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.
- 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).

ELECTRONIC INSTRUCTIONS

Authorization is requested by Insurance Company of North America to act on electronic instructions from the applicant, and to electronically deliver statements and other documents to the applicant. Proper identification must be provided. The Company will be held harmless for any claim, liability, loss or cost, when it has used reasonable procedures to confirm these transactions are authorized and genuine, and these procedures have been followed.

(Check One)

☐ I authorize Insurance Company of North America to act on electronic instructions, and to electronically deliver statements and other documents for the purposes of accepting electronic delivery of the documents and a means by which I can provide a current Internet email address. I acknowledge that should I desire to revoke this written authorization, I will inform the Company in writing, of such revocation.

☐ I DO NOT authorize Insurance Company of North America to act on electronic instructions, and to electronically deliver statements and other documents.

Note: I acknowledge that I am responsible for notifying Insurance Company of North America in the event that the email address should change and that I have the option to receive written communication in paper form.

AGENT CERTIFICATION

I, the authorized agent, have on the date of application recorded the information as given to me by the Applicant, and certify that during an interview with the proposed applicant, I have truly and accurately recorded in the application the information supplied by the applicant.

I	8	5	6	M				

Agent Writing Number | Agent's Signature | Signature Date | Signed at: State

Secondary Agent (if applicable):

Agent Writing Number | Printed Name of Agent | Percentage of commissions

Policy Mailing Preference: ☐ Mail to Insured ☐ Mail to Licensed Agent

AUTHORIZATION AND CERTIFICATION

Statements made in this application are representations and not warranties. It is very important that you review your application carefully. Misstatements or omissions could cause an otherwise valid claim to be denied. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("my providers") to disclose my entire medical record, prescription history, medications prescribed and any other health information concerning me ("protected health information") to the Company. I also authorize any insurance company or agent from which I have applied for or obtained insurance, and any other entity or person having protected health information about me, to disclose it to the Company. Protected health information includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Protected health information also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my providers and other entities or persons referred to above to release and disclose my entire medical record without restriction.

I further authorize the disclosure of protected health information by the Company to its affiliates, service providers, reinsurers, agents and representatives.

I understand that this protected health information is to be used or disclosed under this authorization so that the Company may: 1) underwrite my application for insurance, make eligibility, risk rating, and policy issuance determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Company at their Medicare Supplement Administrative Office: P.O. Box 10856, Clearwater, Florida 33757-8856. I understand that a revocation is not effective to the extent that any person or entity has already relied on this authorization to disclose or use information about me or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that if any of my protected health information is re-disclosed, it may no longer be protected by federal rules governing privacy and confidentiality of health information.

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that I or my authorized representative am entitled to a copy of this authorization. A photocopy of this authorization will be treated in the same manner as the original.

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

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an Outline of Coverage for the policy applied for, and (b) a "*Guide to Health Insurance for People with Medicare*."

Signed at:

State	Applicant's Signature	Signature Date

MEDICARE SUPPLEMENT
Medicare Supplement Administration
PO Box 10858
Clearwater, FL 33757-8858

Office: 1-866-718-8733
Fax: 1-727-373-1081
Online: INAMedSupp.chubb.com

ELECTRONIC PAYMENT AUTHORIZATION FORM

Insured Name: Insurance Policy Number:

Sign and date this authorization below

As a convenience to me, I hereby request and authorize you to pay and charge to my bank account checks drawn by and payable to the order of the Company, provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of the Company to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn by you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Please indicate below when you would like your account drafted. The options below allow you to select the date that best fits your needs.

Section 1 – Select one of the following date options.

Initial Premium Payment: **(choose one)**

- ☐ Same as subsequent payment date selected below, on or after the requested Effective Date
- ☐ On the Policy Issue Date
- ☐ Paid by enclosed check

Subsequent Premium Payments **(choose one):**

Specific day of the month from 1 to 28 _____ (if this date falls on a weekend or holiday, the deduction may be on the ***next*** business day)

Or

☐ 2nd Wednesday of the Month ☐ 3rd Wednesday of the Month ☐ 4th Wednesday of the Month

(If one of these dates fall on a weekend or holiday, the deduction may be on the ***prior*** business day.)

Section 2 – Select one of the payment options.

☐ **Checking (Attach voided check)** ☐ **Savings**

Branch/Bank Name: _____

Routing Number: _____ Account Number: _____

Section 3 – Complete name and address as shown on account.

Accountholder Name: _____

Address/City/State/Zip: _____

Section 4 – Please sign and date.

Signature: _____ Date: _____

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

INSURANCE COMPANY OF NORTH AMERICA

Home Office: Philadelphia, Pennsylvania
Medicare Supplement Administrative Office: P. O. Box 10856, Clearwater, Florida 33757-8856

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Insurance Company of North America. 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 new 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 AGENT:

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 (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ Change in benefits. **(Gaining additional benefit(s) but losing some existing benefit(s)).**

_____ My plan has outpatient drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____ Other (please specify) _____

If, you still wish to terminate your present policy 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 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.

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

_____
Signature of Agent, Broker or Other Representative

TIFFANY JACKSON 2160 W 11TH AVE STE D EUGENE, OR 97402
Name and Address of Agent

The above “Notice to Applicant” was delivered to me on:

_____ _____
Applicant’s Signature Date