



**Please return signed applications via one of the following methods:**

**EMAIL:**        [secure email link](#) (Ctrl+Click)  
                  [tiffany@lowinsure.com](mailto: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](mailto: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](http://www.medicare-oregon.com)
- [www.medicare-washington.com](http://www.medicare-washington.com)
- [www.medicare-idaho.com](http://www.medicare-idaho.com)
- [www.medicare-texas.net](http://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**

<b>SECTION A. PROPOSED INSURED INFORMATION</b>	
Applicant Name <i>(exactly as it appears on your Medicare card)</i>	
Resident Address	Phone <i>(with area code)</i>
City	State, Zip Code
Mailing Address <i>(if different from Resident Address)</i>	
City	State, Zip Code
Date of Birth	Age <i>(as of effective date)</i>
Male <input type="checkbox"/> Female <input type="checkbox"/>	Social Security No
Medicare Number	
Email Address	
Height <i>Feet and inches</i>	Weight <i>Pounds</i>

<b>SECTION B. PLAN AND PREMIUM INFORMATION</b>	
Plan*	Requested Policy Effective Date
*Only those applicants who are initially eligible for Medicare before January 1, 2020 may apply for Plan F.	
Spousal Premium Discount <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(please complete the Spousal Discount Form)</i>	
Premium \$	
Premium Collected \$	Initial Bank Draft: \$
Payment Mode: Bank Draft <input type="checkbox"/> Monthly <input type="checkbox"/> <i>(Bank Draft ONLY)</i>	Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/>

<b>SECTION C. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS</b>	
1. Are you covered under Medicare Part A? If NO, what is your future Part A effective date? _____ If YES, what is your Part A effective date? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Are you covered under Medicare Part B? 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 <input type="checkbox"/> No <input type="checkbox"/>
3. Are you applying during a guaranteed issue or state special enrollment period? <i>(If YES please provide proof of eligibility).</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**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 2–16, you are not eligible for coverage.

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 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
3. Are you currently receiving any occupational, speech, or physical therapy, or are you currently receiving any services from a home healthcare agency? Yes  No
4. 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
5. 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
6. Have you been diagnosed with Alzheimer's Disease, Dementia, Muscular Dystrophy, or any other cognitive disorder? Yes  No
7. 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
8. 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
9. 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
10. 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
11. Have you ever 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)**

- 12. 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
  
- 13. 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
  
- 14. 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
  
- 15. Have you been hospital confined three (3) or more times in the last two (2) years? Yes  No
  
- 16. 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 17-20, you may be eligible for coverage.

- 17. 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
  
- 18. Within the past two (2) years have you been treated for degenerative bone disease, rheumatoid arthritis, or spinal stenosis? Yes  No
  
- 19. 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
  
- 20. Are you currently receiving, or have you been advised to receive injections in a physician's office? Yes  No

(Please explain any yes answers to questions 17 – 20 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 or Medicare select policy/certificate to enroll in this Medicare plan? Yes  No   
 (g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes  No

4. Do you have another Medicare supplement or Medicare select insurance 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 or Medicare select policy/certificate 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 insurance producer, if applicable.**

Insurance producers 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 reinstated, 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 reinstated 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 reinstated, 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy 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.

**INSURANCE PRODUCER CERTIFICATION**

I, the authorized insurance producer, 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					
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Signed at:

Insurance producer  
Writing Number

Insurance producer's Signature

Signature Date

State

Secondary Insurance producer (if applicable):

--	--	--	--	--	--	--	--	--	--

Insurance producer  
Writing Number

Printed Name of Insurance  
producer

Percentage of  
commissions

Policy Mailing Preference:

Mail to Insured

Mail to Licensed Insurance producer

## AUTHORIZATION AND CERTIFICATION

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 insurance producer 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, insurance producers 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.

**It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.**

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

**INSURANCE COMPANY OF NORTH AMERICA**

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

**Medicare Supplement Spousal Discount Form**

Applicant Name:		Applicant Social Security Number:	
<p>To qualify for the Spousal Discount, the applicant must meet the following criteria below. Both boxes below must be checked in order to qualify:</p> <p><input type="checkbox"/> I am currently residing with my legal spouse, civil union partner, or domestic partner named below.</p> <p style="text-align: center;"><b>AND</b></p> <p><input type="checkbox"/> My legal spouse, civil union partner, or domestic partner has an existing Medicare Supplement policy, or is applying for such a policy, with Insurance Company of North America.</p> <p>The Spousal Discount will be removed if the other Medicare Supplement policyholder chooses to terminate his or her Medicare Supplement policy or he or she no longer resides with you (other than in the case of his or her death).</p>			
Legal Spouse or Civil Union Partner or Domestic Partner Name:			
Address:	City:	State:	Zip Code:
Last Four Digits of Social Security Number:		Date of Birth (mm/dd/yyyy):	
Relationship to Applicant: Existing Medicare Supplement Policy Number (if applicable):			
<b>Insurance Producer/Applicant Signature:</b>			
By signing this form I certify that I qualify for the Spousal Discount by meeting the criteria listed above.			
Insurance Producer Signature			Date
Applicant 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

2<sup>nd</sup> Wednesday of the Month                      3<sup>rd</sup> Wednesday of the Month                      4<sup>th</sup> 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 INSURANCE 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 (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- 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 Insurance Producer, Broker or Other Representative

TIFFANY JACKSON 2160 W 11TH AVE STE D EUGENE, OR 97402

\_\_\_\_\_  
Name and Address of Insurance Producer

The above "Notice to Applicant" was delivered to me on:

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date