



Please return signed applications via one of the following methods:

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

FAX: [1-541-284-2994](tel: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](tel: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.

Washington Medicare Supplement
Enrollment Application for Plans A, C,
G, High Deductible G, and N

PO Box 327, MS 295
Seattle, WA 98111
800-752-6663
Fax: 425-918-5278



You are eligible to apply for a Premera Blue Cross (Premera) Medicare Supplement Plan if you:

- Reside in Washington (excluding Clark County),
- Currently have both Medicare Part A and Part B, and
- Don't receive Medicaid assistance other than payment of your Medicare Part B Premium
- 65 years of age or older

Please type your answers or print clearly in ink so we can process your application quickly. Be sure to return all pages to us. Omissions, incomplete answers, or the use of correction fluid or tape will result in the return of your application and may cause a delay in the effective date of your coverage.

A Personal Information

Last Name	Suffix	First Name	Middle Initial	
Home Address (cannot be a PO Box or business address)	City	County	State WA	Zip
Mailing Address (if different from above)	City	County	State	Zip
Billing Address (if different from both above)	City	County	State	Zip
Phone Number	Alternate Phone Number			
Email Address*	Birthdate (Month/Day/Year)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
<p>*Important Note: We can send enrollment notifications, information about how to use your plan, your Welcome Kit, and a copy of this application to you by email instead of a paper copy.</p> <p>Do you want to receive enrollment notifications, information about how to use your plan, your Welcome Kit, and a copy of this application to you by email?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>				

Race (Optional)

Premera is committed to serving the diverse needs of all our members. These fields are completely optional. If you'd like to self-identify, please do so. The collection of this information will not determine eligibility, rating, or claim payments.

(Check one)

America Indian or Alaska Native
 Black or African American
 White
 Other race

Asian
 Native Hawaiian or Other Pacific Islander
 Two or more races

Ethnicity (Optional)

Hispanic or Latino
 Not Hispanic or Latino

Language (Optional)

Please select the language in which you're proficient. If you're proficient in the English language, as well as others, please select English from the list. The collection of this information will not determine eligibility, rating, or claim payments.

(Check one)

<input type="checkbox"/> Arabic	<input type="checkbox"/> Chinese	<input type="checkbox"/> English	<input type="checkbox"/> French/Haitian Creole French
<input type="checkbox"/> German	<input type="checkbox"/> Greek	<input type="checkbox"/> Italian	<input type="checkbox"/> Japanese
<input type="checkbox"/> Korean	<input type="checkbox"/> Polish	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Russian
<input type="checkbox"/> Spanish	<input type="checkbox"/> Tagalog	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Other: _____

B Plan Selection

Which Medicare Supplement plan do you want to enroll in?

Plan A Plan C Plan G Plan G High Deductible Plan N

Note: Only those applicants who are initially eligible for Medicare before January 1, 2020, may apply for Plan C.

Plan Start Date

You are eligible for coverage to start on the first of the month after the postmark date if all information is completed and accurate and we approve your application. Please indicate the month you want your coverage to start.

I want this plan to begin on the first of _____ (No more than 90 days after the application is signed.)
(enter month)

C Medicare Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. **Please answer all questions:**

To the best of your knowledge:

Y **N** 1. Did you turn 65 in the last 6 months?

Y **N** 2. Will you turn 65 in the next 6 months?

Y **N** 3. Did you enroll in Medicare Part B in the last 6 months?



Medicare Number (11 alphanumeric characters as seen in the image above)

Hospital (Part A) Effective Date

Medicare (Part B) Effective Date

Please fill in your Medicare Number and effective dates in the box above using the information from your Medicare card or attach a copy of your Medicare Card. We need all characters to enroll you.

If you answered YES to 1 or 2, please skip the Health Statements (Section F). The law guarantees that for six months immediately following enrollment in Medicare medical coverage Part B, individuals cannot be denied insurance due to health conditions.

D Payment and Premium Discounts (optional)

DO NOT send payments with this application.

You will get monthly paper bills if you do not select automatic monthly withdrawals.

A government agency or any other third party may not sponsor or pay for your individual health plan, except as required by law.



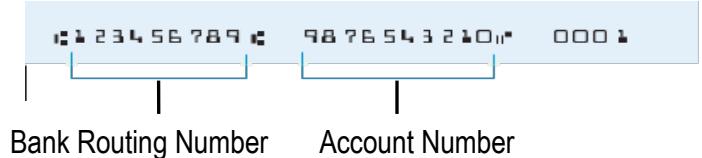
Tip – Save on your premiums Sign up for our automatic monthly withdrawals (AFT) or our spousal discount (if eligible) and you will save on your monthly premiums. Call us at 800-722-1471 for more information.

Please complete this section if you are selecting automatic monthly withdrawal

I have selected automatic monthly withdrawal and I hereby authorize Premera to initiate funds transfer from the bank or financial institution account indicated below. I authorize my financial institution to honor these transfers.

Account holder's name (print)			
Financial institution or bank name			
Bank routing number (see below)	Account number (see below)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings

Fill out the information above. To ensure accuracy of your automatic withdrawal, we recommend that you send us a photocopy of your voided check.



Additional terms and conditions:

- Funds are transferred on the fifth business day of each month to pay for that month's coverage. For example, the deduction on February 5th pays for coverage in February.
- I understand that my monthly subscription charges will be automatically withdrawn from my bank account each month until I notify Premera that it should be cancelled. To ensure cancellation, I must notify Premera no later than the twentieth of the month to be effective for the following month's automatic withdrawal. I have the right to stop payment on a specific bank transfer at least 3 days prior to the next scheduled withdrawal date.
- It may take as long as 45 days to set up the funds transfer. I may receive a paper bill to cover the initial month(s) while the transfer is being set up.

Bank account holder signature	Today's date
X	

Please complete this section if you are applying for our spousal discount

You may be eligible for a discount on your premium if you qualify for our spousal discount. Eligibility requires both beneficiaries to be enrolled on a standard Washington Individual Premera Blue Cross Medicare Supplement plan (effective 2010 and later) and have the same address. Spouse is defined as married or as state-registered domestic partners.

Please check one:

My spouse is currently covered under a standard Washington Individual Premera Blue Cross Medicare Supplement plan (effective 2010 and later).

Spouse's First Name	Spouse's Last Name
Spouse's Date of Birth	
Spouse's Premera ID Number (9-digit number)	

My spouse is applying for a standard Washington Individual Premera Blue Cross Medicare Supplement plan (effective 2010 and later).

Spouse's First Name	Spouse's Last Name
Spouse's Date of Birth	
Spouse's Medicare Beneficiary Number (11 alphanumeric characters)	

Additional terms and conditions:

- Each applicant must complete a separate application and be approved.
- The spousal discount will continue as long as both members are enrolled.
- If we are unable to verify your eligibility, you will be enrolled, however, you will not receive the spousal discount.
- NOTE: The discount may not appear on your next invoice. It could take up to 60 days to reflect on your account. The discount will not be applied retroactively, it will go into effect on the day it is activated on your account.

E

Other Healthcare Information

Please review the statements below, then answer all questions to the best of your knowledge.

- You do not need more than one Medicare Supplement insurance policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 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 benefit 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 the suspension.
- 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).

1. Tell us about any help you receive from your state's Medicaid program (required):

Y N

a. Are you covered for any medical assistance through the state Medicaid program?

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.

Y N

b. If yes, will Medicaid pay your premiums for this Medicare Supplement plan?

Y N c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium?

Y N d. Have you recently lost coverage for medical assistance through the state Medicaid program?

If yes, when did it end? _____

2. Tell us about your Medicare Supplement coverage (required):

Y N Do you have another Medicare Supplement policy in force? If so, with what company, and what plan do you have?

Company & plan type: _____

Member ID: _____

Start date: _____ End date: _____

Customer Service Phone Number: _____

Y N If so, do you intend to replace your current Medicare Supplement policy with this plan?

3. Tell us about your Medicare Advantage coverage (required):

Y N a. If you've had coverage from any Medicare plan other than original Medicare within the last 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 date blank.

Company & plan type: _____

Member ID: _____

Start date: _____ End date: _____

Customer Service Phone Number: _____

Y N b. 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 c. Was this your first time in this type of Medicare plan?

Y N d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

4. Tell us about any other group or individual health insurance coverage (required):

Y N a. Have you had coverage under any other health insurance within the past 63 days? For example, an employer, union, or individual plan.

If so, with what company, and what kind of policy?

Company & plan type: _____

Member ID: _____

Start date: _____ End date: _____

Customer Service Phone Number: _____

F Do I need to complete health questions?

When applying for Plan A, C, G, High Deductible G, or N, you do not need to complete Section G if any of the following is true.

1. Your Medicare managed care plan or PACE program coverage ends because the plan is leaving the Medicare program, stops giving care in your area, or you move out of the plan's service area, and you apply for Medicare Supplement (Medigap) coverage after you receive notice that your coverage is terminating or ceasing, and no later than 63 days after your coverage terminates or ceases.
2. Your employer group health plan coverage that supplements the benefits under Medicare ends or ceases to provide all such supplemental benefits to you, and you apply for Medicare Supplement (Medigap) coverage after (a) your coverage is met or ceases, or (b) you receive notice that your coverage is terminating or ceasing, whichever is later, and no later than 63 days after your coverage terminates.
3. Your Medicare Supplement (Medigap) insurance company goes bankrupt, and you lose your coverage, or your Medicare Supplement (Medigap) policy coverage ends through no fault of your own, and you apply for Medicare Supplement (Medigap) coverage beginning on the earlier of your coverage terminating or you are receiving notice of termination or bankruptcy, and no later than 63 days after your coverage terminates.
4. You enrolled in a Medicare Part D plan during your initial enrollment period and were enrolled under a Medicare Supplement (Medigap) policy that covers outpatient prescription medications, and you apply for Medicare Supplement (Medigap) coverage up to 60 days before the initial Medicare Part D enrollment period and no later than 63 days after the effective date of your Medicare Part D coverage. Please enclose proof of enrollment in Medicare Part D.
5. You joined a Medicare Advantage or PACE program when you were first eligible for Medicare Part A (and you're enrolled in Medicare Part B). Within the first year of joining, you want to switch to Original Medicare, and you apply for a Medicare Supplement (Medigap) coverage up to 60 days before and no later than 63 days after your Medicare Advantage or PACE program coverage terminates.
6. You dropped a Medicare Supplement (Medigap) policy to join a Medicare Advantage or PACE program for the first time and now you want to leave. You have been in the plan for no more than a year and you apply for a Medicare Supplement (Medigap) policy up to 60 days before and no later than 63 days after your plan terminates. A health statement is not required if you enroll in the same Medicare Supplement (Medigap) policy (with the same company) that you had previously, if available.
7. You leave a Medicare Advantage plan or drop a Medicare Supplement (Medigap) plan because the company or its representatives haven't followed the rules or misled you, and you apply for a Medicare Supplement (Medigap) policy up to 60 days before and no later than 63 days after your plan terminates.
8. You currently are enrolled in a standardized Medicare Supplement (Medigap) plan issued in 1990 or later, and you wish to switch to a plan with either greater, equal, or lesser benefits. (For example, from a 1990 standard Plan F to a 2010 standard Plan F.) Exception: if you have Plan A, you can only switch to Plan A without requiring underwriting.

G

Your Health Conditions

Answer these health questions to determine if you are eligible for this coverage.

If any statements in Section F apply to you, skip this section, and move on to Section H.

If no statements in Section F apply to you, fill out this section.

1. Do any of these conditions apply to you?

Y N

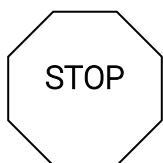
- End stage renal (kidney) disease
- Currently receiving dialysis
- Diagnosed with kidney disease that may require dialysis
- Cirrhosis/liver failure
- Chronic obstructive pulmonary disorder (COPD)
- Have a bleeding (coagulation defect), blood disorder, or leukemia
- Rheumatoid arthritis, joint replacement
- Schizophrenia, bipolar mood, attempted suicide, or eating disorder
- Transplant (excludes corneal)
- Insulin dependent diabetes

2. Within the past 5 years, has a medical professional diagnosed, discussed, or recommended treatment options for any of the following conditions?

Y N

- Alcohol, or chemical/drug abuse or dependence
- DVT (clots) or PVD (peripheral vascular disease)
- Stroke/TIA or paralysis
- Prostatitis
- Heart attack, congestive heart failure, coronary artery disease, pacemaker, stenosis, or heart valve prolapse or transplant
- Ulcerative colitis or Crohn's disease
- Chronic bronchitis or tuberculosis
- Chronic back/neck/disc problems

If you answered YES under questions 1 or 2 in this section, you are NOT eligible for these plans at this time.



If your health status changes in the future, allowing you to answer NO to all of the questions in this section, please submit an application at that time.

For information regarding plans that may be available, contact your local state department on aging.

If you answered NO to both questions 1 and 2, your answer to questions 3 and 4 will be used to determine if your application will be accepted.

3. Height and weight:

Height	Weight / lbs.
Feet Inches	

4. Have you taken medications within the past year?

Yes. Please enter your medication information in the table provided below.

No. Please move to Section H.

Medication Name	How long have you been taking this medication?	What does this medication treat?

Authorization and Verification of Information

I, the undersigned, apply for enrollment with Premera Blue Cross (Premera). I represent that all statements and answers on this application are complete and true. I understand coverage is available to me due to: (1) my residing in Washington (excluding Clark County). (2) my enrollment in Medicare Parts A and B, (3) my eligibility for Medicare due to age (65 or over), and (4) I don't receive Medicaid assistance other than payment of my Medicare Part B premium. I understand and agree that coverage does not begin until Premera accepts this application and assigns an effective date of coverage and that receipt of my money (cash, check or money order) does not constitute enrollment under any Medicare Supplement program. I authorize Premera, at its option, to pay providers directly for services rendered. I also understand and agree that Premera may:

1. Accept this application; or
2. Deny this application, in which case any subscription charges submitted will be refunded to, and accepted by me; or
3. Within the first two years of my coverage, void my contract (in other words, cancel my coverage back to its effective date, as if never existed at all) if I have made any intentionally false or misleading statements on this application or enrollment form that are material enough to affect my acceptability for coverage.

I understand that Premera may collect, use, and disclose personal information about me as required or permitted by law or to perform routine business functions, such as determining my eligibility for enrollment, credit for waiting periods, and benefits; paying claims; and fulfilling other obligations stated

in its contract with me. If Premera discloses my personal information for any other reason, Premera will first remove any data that can be used to easily identify me or will get my signed authorization.

I further understand that any physician, healthcare provider, hospital, insurance or reinsurance company, pharmacy benefits manager or third party benefits administrator may disclose my personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders and mental illness to Premera or its representatives as allowed by law.

I understand that 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 understand that the Medicare Supplement contract will not pay benefits during the first three months after the effective date for any condition for which I have had treatment, medicine, or diagnostic testing within the three months prior to my effective date. I understand that, under certain conditions, this limitation may be shortened or waived. **The waiting period may be waived if I apply for this contract within 63 days of leaving other healthcare coverage and I provide proof with this application.**

I understand I am responsible for canceling any prior coverage.

If you answered yes to questions 2 or 3 in Section E, you must complete and sign the attached replacement notice.

I acknowledge receipt of the Guide to Health Insurance for People with Medicare and the Outline of Coverage.

I have read all the information and have answered all questions to the best of my ability.

Signature of applicant	Today's date
	

Note: if you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

!!! IMPORTANT: Be Sure to Return the Entire Application !!!

Continue to the next page for the Replacement Notice



For producer use only

Be sure to return this page to us even if you do not have a producer.

If this application is being submitted through a producer, they must complete the information below and the attached Notice of Replacement, if appropriate. If all questions are not answered completely, the application will be returned.

Completion of this section by a producer is required.

1. List any other medical or health insurance policies sold to the applicant. _____

2. List policies sold which are still in force. _____

3. List policies sold in the past five years which are no longer in force. _____

Producer name (please print)	Premera producer number (5 numeric digits)
Producer email address	Producer contact number
Producer signature X	Date

