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.

Medico® Insurance Company
A Wellabe® Company

Medicare Supplement Insurance

WASHINGTON SALES KIT

PRODUCER INSTRUCTIONS

Submit applications electronically using MyEnroller:

MyEnroller
Electronic Application Submission Tool
Website: wellabe.com/signin

If you need assistance, please call 800-547-2401, Option 3.

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wellabe®

Medico® Insurance Company
A Wellabe® Company
601 Sixth Ave., Des Moines, IA 50309
P.O. Box 10386, Des Moines, IA 50306
www.wellabe.com
Phone (toll-free): 800-228-6080

Application for Medicare Supplement Insurance

Requested effective date of new policy (optional) _____
MM/DD/YYYY

Requested effective date must be after the application date. If no effective date is requested, the effective date will be the day the application is approved by the company.

Policy delivery
Upon approval of this application, the policy will be delivered to the applicant by mail.

Part A: Applicant information (please print)

Full name of applicant: *first, middle, last, suffix* | Date of birth (MM/DD/YYYY) | Age | Gender

Social Security number | Phone number | Email address ❒ No email available

Residence address *(include Apt/Bldg/Unit Nbr if applicable)* | City | State | ZIP code

Spousal or Domestic Partnership Discount

When the applicant is married or in a domestic partnership registered with the state of Washington, and both are insured by Medicare Supplement policies with Medico Insurance Company, a discount is applied to the premium rates.

Are you married or in a domestic partnership registered with the state of Washington and your spouse or domestic partner is either applying for a Medicare Supplement policy or has an existing Medicare Supplement policy with Medico Insurance Company? ❒ Yes ❒ No

Full name: *first, middle, last, suffix*

If this person has Medicare Supplement coverage in force, please provide the policy number: _____

Choose your plan:

❒ Plan A ❒ Plan G ❒ High-deductible Plan G ❒ Plan N

If your Medicare Part A eligibility date is before Jan. 1, 2020, these additional plans are also available:

❒ Plan F ❒ High-deductible Plan F

Are you eligible for **Open Enrollment**? ❒ Yes ❒ No Are you in a **Special Enrollment Period**? ❒ Yes ❒ No

Are you eligible for **Guaranteed Issue coverage** because your coverage is terminating or has terminated in the last 63 days? ❒ Yes ❒ No (If "Yes," please provide proof of eligibility.)

If applying for Open Enrollment, Special Enrollment Period, or Guaranteed Issue coverage, skip Parts C and D.

Part B: Insurance information

If you lost other health insurance coverage and received a notice from your previous insurer that said you were eligible for guaranteed issue of a Medicare Supplement insurance policy or you had certain rights to buy such a policy, you may be guaranteed acceptance in one of Medico's Medicare Supplement plans. Please include a copy of the notice from your previous insurer with your application.

Please answer the following questions to the best of your knowledge.

1. Please enter your Medicare claim number: _____
2. a. Are you within 6 months of your 65th birthday? ❒ Yes ❒ No
   b. Did you enroll in Medicare Part B in the last 6 months? ❒ Yes ❒ No
   c. What is your Part B effective date? _____
   d. What is your Part A effective date? _____
3. a. Are you covered for medical assistance through the state Medicaid program? (If you are participating in a "spend-down program" and have not met your "share of cost," please answer "No" to this question.) ❒ Yes ❒ No

Part B: Insurance information (continued)

b. If "Yes," will Medicaid pay your premiums for this Medicare Supplement policy? ❒ Yes ❒ No

c. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? ❒ Yes ❒ No

4. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days, such as Medicare Advantage, Medicare HMO, or Medicare PPO, provide your start and end dates. (If you are still covered under the policy, leave "End" blank.) Start: _____ End: _____

b. Please indicate the reason for termination/disenrollment:
- ❒ Your Medicare Advantage plan is leaving the Medicare program.
- ❒ Your Medicare Advantage organization stopped offering Medicare Advantage plans.
- ❒ Your Medicare Advantage organization stopped offering coverage in the area in which you live.
- ❒ You moved out of the geographic service area of your Medicare Advantage plan.
- ❒ You have voluntarily ended your Medicare Advantage plan during the 12-month trial period.
- ❒ Other: _____

c. 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

d. Was this your first time in this type of Medicare plan? ❒ Yes ❒ No

e. Did you cancel a Medicare Supplement policy to enroll in this Medicare plan? ❒ Yes ❒ No

5. a. Do you have another Medicare Supplement policy in force? ❒ Yes ❒ No

b. If "Yes," please provide the following information:

_____

Company name Policy number Plan

c. Do you intend to replace your current Medicare Supplement policy with this policy? ❒ Yes ❒ No

If you are replacing another Medicare or Medicare Supplement plan, please complete and submit the Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage.

6. a. Have you had coverage under any other health insurance within the past 63 days (such as an employer, union, or individual plan)? ❒ Yes ❒ No

b. If "Yes," please list the company and policy type:

_____

Company name Policy type

c. What are the dates of coverage under your other policy? (If you are still covered under the other policy, leave "End" blank.) Start: _____ End: _____

d. Have you disenrolled from your current coverage voluntarily? ❒ Yes ❒ No

e. Reason for termination/disenrollment: _____

Part C: General health information

Note: These questions should not be answered if you apply during Open Enrollment or if you are eligible for guaranteed issue or in a Special Enrollment Period (SEP).

Please list your current height and weight. Height: _____ Weight: _____

Qualifying information
(If you do not answer questions 1 through 5 "No" or "None of the above," you are not eligible for coverage.)

Please answer the following questions to the best of your knowledge.

1. Are you currently:
- ❒ Hospitalized, in a nursing facility or assisted living facility, hospice, or receiving home health care?
- ❒ Receiving any occupational, speech, or physical therapy from a medical professional?
- ❒ Confined to a bed, receiving assistance to perform any activities of daily living such as dressing, eating, bathing, toileting or transferring, or are you dependent or been advised by a medical professional to use the assistance of a wheelchair or motorized mobility device?
- ❒ None of the above

2. Have you been treated for or diagnosed with metastatic cancer (cancer that has spread to other parts of the body) or had a recurrence of a previous cancer (excluding basal cell or squamous cell skin cancer)? ❒ Yes ❒ No

3. Do you currently have a cardiac defibrillator implanted? ❒ Yes ❒ No

4. Have you:
   a. Been diagnosed with or treated for diabetes:
      i. Requiring more than 50 units of insulin daily? ❒ Yes ❒ No
      ii. Requiring three (3) or more medications (oral or injections) to control your blood sugar? ❒ Yes ❒ No

Part C: General health information (continued)

b. Had diabetes in combination with a diagnosis at any time in the past of:

- ❒ Stroke/transient ischemic attack (TIA)
- ❒ Nephropathy
- ❒ High blood pressure requiring 3 or more medications
- ❒ Peripheral vascular disease (PVD)
- ❒ Neuropathy
- ❒ Heart attack
- ❒ Diabetic coma or insulin shock
- ❒ Heart disease or disorder
- ❒ Congestive heart failure (CHF)
- ❒ Any circulatory disease that effects the heart and/or blood vessels
- ❒ Retinopathy (excluding mild, non-progressive)
- ❒ Kidney disease/failure
- ❒ Skin ulcer
- ❒ None of the above

c. Had or been advised by a medical professional to have a bone marrow, stem cell, or organ transplant (excluding corneal transplant)? ❒ Yes ❒ No

d. Had, been treated for, or diagnosed by a member of the medical profession with acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC), or tested positive for human immunodeficiency virus (HIV)? ❒ Yes ❒ No

e. Been diagnosed, treated for, tested positive, or been told by a medical professional that you have a mild cognitive impairment, Alzheimer's disease, dementia, organic brain disorder, or a cognitive disorder? ❒ Yes ❒ No

5. Within the past 24 months, have you:

a. Had, been treated for, or diagnosed with internal cancer, leukemia, melanoma, Hodgkin's disease, myeloma, or lymphoma? ❒ Yes ❒ No

b. Had, been treated for, or diagnosed with:

- ❒ Parkinson's disease
- ❒ Amyotrophic lateral (ALS) or Primary lateral (PLS) sclerosis
- ❒ Myasthenia gravis
- ❒ Bipolar disorder
- ❒ None of the above
- ❒ Huntington's disease
- ❒ Multiple sclerosis
- ❒ Muscular dystrophy
- ❒ Schizophrenia

c. Had, been treated for, or diagnosed with chronic liver disease including cirrhosis, hepatitis B or C? ❒ Yes ❒ No

d. Had, been treated for, or diagnosed with chronic kidney disease, kidney/renal failure or insufficiency, or kidney disease requiring dialysis? ❒ Yes ❒ No

e. Had, been treated for, or diagnosed with:

- ❒ Congestive heart failure (CHF)
- ❒ Heart attack
- ❒ Implantation of a pacemaker
- ❒ Aneurysm
- ❒ Stent placement/replacement of any vessel
- ❒ Stroke or transient ischemic attack (TIA)
- ❒ Cardiomyopathy
- ❒ Angina or cardiac chest pain
- ❒ Heart or circulatory surgery
- ❒ Embolus/DVT
- ❒ Peripheral vascular disease (PVD)
- ❒ None of the above

f. Had, been treated for, or diagnosed with any lung or respiratory conditions such as:

- ❒ Emphysema
- ❒ Condition requiring the use of oxygen
- ❒ None of the above
- ❒ Chronic obstructive pulmonary disease (COPD)
- ❒ Any other chronic pulmonary disease (excluding mild asthma)

g. Had, been treated for, or diagnosed with:

- ❒ Degenerative bone disease
- ❒ Arthritis that is disabling or restricts mobility
- ❒ Systemic scleroderma
- ❒ Osteoporosis with related fracture(s)
- ❒ None of the above
- ❒ Rheumatoid arthritis
- ❒ Spinal stenosis (severe, disabling, or surgery advised)
- ❒ Systemic lupus
- ❒ Amputation due to disease

h. Been hospitalized, treated for, diagnosed with, or recommended to have treatment for addiction or abuse of alcohol, drugs, or opioids? ❒ Yes ❒ No

Part D: Medical health information

Note: These questions should not be answered if you apply during Open Enrollment or if you are eligible for guaranteed issue or in a Special Enrollment Period (SEP).

If you answer "Yes" or check a medical condition for any of the following questions, please provide details in the space allotted after question 6. If you need additional space, attach a separate page that you have signed and dated.

1. Has a member of the medical profession recommended that you have medical tests, treatment, therapy, or surgery (including cataract surgery or joint replacement) or do you have pending

Part D: Medical health information (continued)

diagnostic evaluations, that have not yet been performed or are anticipated? (This excludes mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only.) ❒ Yes ❒ No

2. In the past 12 months, have you had, or been advised by a member of the medical profession to receive injections or infusions including, but not limited to, the following conditions:
   - ❒ Eye conditions
   - ❒ Migraines
   - ❒ Osteoporosis
   - ❒ Other:_____
   - ❒ Back/spine pain
   - ❒ Overactive bladder
   - ❒ Joint pain/arthritis Location of injection:_____
   - ❒ None of the above

   Name of injection/infusion: _____

   Date of last injection/infusion: _____

   Frequency of injection/infusion:_____
3. Are you currently under the care of a pain management doctor or clinic and/or do you require ongoing use of opioid or narcotic medication to control pain? ❒ Yes ❒ No
4. In the past 24 months, have you had, been treated for, diagnosed or advised by a member of the medical profession with:
   - ❒ Psoriatic arthritis
   - ❒ Mental/nervous condition or major depression
   - ❒ Crohn's disease
   - ❒ Atrial fibrillation or other heart rhythm disorder
   - ❒ Epilepsy or seizures
   - ❒ Ulcerative colitis
   - ❒ Blood disorder (excluding mild anemia) Diagnosis/Condition:_____
   - ❒ None of the above

   Type of treatment:_____

   Date of last treatment:_____

   Frequency of treatment: _____
5. Have you been or has a member of the medical profession recommended that you be hospitalized, confined to a nursing facility or assisted living facility, or received home health care within the last 60 days? ❒ Yes ❒ No
6. Have you been hospitalized or in the emergency room two or more times within the past 12 months? ❒ Yes ❒ No

Question details (include question number 1 - 6)

Have you taken any medication in the last 12 months, including injections or infusions? ❒ Yes ❒ No

If "Yes," please provide the following information:

Medication name	Dosage	Quantity taken each time	Frequency taken	Diagnosis/Condition	Start date

Do you have a primary care physician? ❒ Yes ❒ No

Have you seen a specialist in the past 24 months? ❒ Yes ❒ No

If "Yes," please provide the following information:

Primary care physician name	Reason seen	Date of last visit	Phone number	City/state

Physician name	Specialty	Condition	Date of last visit	Phone number	City/state

Part E: Payment options

Method of payment:	Frequency of payment:			
❒ Automatic bank withdrawal	❒ Monthly	❒ Quarterly	❒ Semi-annually	❒ Annually
❒ Credit/Debit card	❒ Monthly	❒ Quarterly	❒ Semi-annually	❒ Annually

Part F: Notices

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 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 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 it will otherwise be substantially equivalent to your coverage before the date of the 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 it 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).

Part G: Application agreement

I hereby apply to Medico Insurance Company (the Company) for a **Medicare Supplement insurance policy**. I understand that the policy will be issued in reliance upon information obtained from any or all of the following sources: (i) answers provided on this Application, (ii) information from authorized third-parties, (iii) the Company's policy records related to me, and (iv) health information obtained during the underwriting process. This application will become a part of any policy to which this form is attached. I have read, or had read to me, the complete application.

I have read and agree:

- **No insurance exists unless and until coverage is approved by the Company, the first premium is paid, and a policy is delivered.**
- Between the time I signed the application and the time the policy becomes effective, I must tell the Company if my health changes in a way that could affect my answers to the previous health questions.
- The information furnished is complete, true, and correctly recorded to the best of my knowledge.
- If requested, I will complete a recorded telephone call with a Company representative as part of the underwriting process.
- No portion of the premium will be paid, during the period the policy is in force, by or on behalf of a third party (not to include an immediate family member), either directly, through wage adjustments, or other means of reimbursement.

I have received the Notice of Privacy Practices and the Outline of Coverage for the policy.

I have received a link to the Medicare Supplement Buyers Guide, "A Guide to Health Insurance for People With Medicare," on the Company website at wellabe.com/products.

CAUTION: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind your policy if the misrepresentation was material to our acceptance of the risk.

NOTICE: 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.

Part G: Application agreement (continued)

I acknowledge that in states where it is required, the producer made the necessary inquiries concerning my insurance needs and proposed a program of insurance that is suitable for my needs. I am applying for this Medicare Supplement insurance policy.

X _____

Applicant's signature | Date (MM/DD/YYYY)

Part H: Producer's section

Have you personally sold any other health insurance policies to the proposed insured that are still in force OR sold any policies no longer in force in the past 5 years? ❒ Yes ❒ No

If "Yes," please list policies:

Policy type and number	In force?
	❒ Yes ❒ No
	❒ Yes ❒ No

Is the insurance applied for intended to replace any medical or health insurance coverage? ❒ Yes ❒ No

Producer's certification: I certify the information in this application was provided by the applicant and correctly recorded. I have no information to add that could affect the acceptance or rejection of the risk. Any intention to replace coverage is reflected in the application. I have provided the applicant a link to the Medicare Supplement Buyers Guide at wellabe.com/products.

TIFFANY JACKSON | **7975WHZ6**

Producer's printed name | Producer's number

X _____

Producer's signature | Date (MM/DD/YYYY)

HIPAA Authorization

I authorize any physician, hospital, pharmacy, pharmacy benefit manager, health insurance plan, or any other entity that possesses any diagnosis, treatment, prescription, or other medical information about me to furnish such health information to Medico Insurance Company, Medico Corp Life Insurance Company, and/or Medico Life and Health Insurance Company and the entities with which it contracts to administer insurance applications (collectively the "Company"), and their agents and representatives, for the purpose of evaluating my eligibility for insurance. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization overrides any restrictions that I may have in place with any entity regarding the release of my medical information. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for two years from this date and may be revoked by sending written notice to the Company.

Non-health information is all other information. It may be about employment, other insurance owned, or motor vehicle, consumer, or credit reports. It may also be information used to confirm questions and answers on the application for insurance.

I authorize disclosure of this information to the Company by any of the following sources: doctors, medical practitioners, hospitals, clinics, or other medical or medically related facilities or professionals; the Company's legal representatives or agents; insurers or reinsurers; health plans; consumer reporting agencies; public records; employers; Pharmacy Benefit Manager (PBM); or the Medical Information Bureau (MIB).

I authorize the Company or it's reinsurers to make a brief report of my personal health information to the MIB.

I understand:

- I can refuse to sign this Authorization. If I refuse, the Company will not be able to consider my application(s).
- I can revoke this Authorization at any time, except to the extent that the Company has acted in reliance upon it or other law that gives the Company the right to contest a claim under the policy/certificate or the policy/certificate itself.
- Revoking this Authorization means the Company will not be able to consider my application(s). Requests to revoke must be in writing and sent to: Medico Insurance Company and/or Medico Life and Health Insurance Company, P.O. Box 10386, Des Moines, Iowa 50306-0386 and/or Medico Corp Life Insurance Company, P.O. Box 10482, Des Moines, Iowa 50306-0482.
- Subject to state and federal laws, information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.
- I (or my authorized personal representative) am entitled to and will be sent a copy of this Authorization.
- This Authorization expires 24 months from the date I sign it.
- I may request to be interviewed in connection with the preparation of a consumer report and, upon written request, receive a copy of the report.

I agree that a copy of this Authorization is as valid as the original.

Your name (Please print) Date

X

Your signature

Spouse's name (If applying, please print) Date

X

Your signature

Authorization to Disclose Information (MIB)

I authorize Medico Insurance Company, Medico Corp Life Insurance Company, and/or Medico Life and Health Insurance Company (the "Company") to disclose health and non-health information that they may obtain about me to the Medical Information Bureau (MIB). The purpose of the disclosure is fraud prevention.

I understand that I do not have to authorize this disclosure to MIB. Issuance of coverage will not be conditioned on me signing this authorization. ❒ **Yes** ❒ **No**

I understand that, subject to state and Federal laws, information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that I have the right to revoke this authorization at any time except to the extent that the Company has acted upon this authorization. I further understand that if I revoke this authorization I must do so in writing and must send my written request to: Medico Insurance Company and/or Medico Life and Health Insurance Company, P.O. Box 10386, Des Moines, Iowa 50306-0386 and/or Medico Corp Life Insurance Company, P.O. Box 10482, Des Moines, Iowa 50306-0482.

I understand that this authorization will expire 24 months from the date I sign it.

I acknowledge that I, or my authorized personal representative, am entitled to and have received a copy of this form.

Your name (Please print) Date

X

Your signature

Spouse's name (If applying, please print) Date

X

Your signature

If you are signing as a personal representative for an individual to be insured, read and sign below

I hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

Personal representative (Please print)

X

Personal representative signature

Person(s) to be insured (Please print):

1.

2.

My relationship to applicant(s) (Please print):

1.

2.

Medico® Insurance Company
A Wellabe® Company
601 Sixth Ave., Des Moines, IA 50309
P.O. Box 10386, Des Moines, IA 50306
www.wellabe.com
Phone (toll-free): 800-228-6080

Notice to Applicant Regarding Replacement of Medicare Supplement or Medicare Advantage

Save this notice! It may be important to you in the future.

According to your application or information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Medico Insurance Company. Your new policy will provide 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 the 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 ISSUER OR 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 prescription 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.

TIFFANY JACKSON 2160 W11TH AVE STE D, EUGENE OR 97402

Signature of producer

Typed name and address of issuer or producer

Applicant's signature

Date