

Questions? Call us at HealthInsuranceWashington.com

1-800 762 8309

Tips for completing the application:

1. Please read everything carefully and answer all questions honestly. This document becomes part of your health insurance contract.

Payment:

The payment options are monthly bank draft or direct bill.

Monthly Bank Draft:

Please complete Authorization section carefully and attach a voided check.

Direct Bill:

Simply check the Direct Bill, and you are done.

Final check list before mailing:

- All sections completed?
- Copy of Insurance Card or Certificate of Credible Coverage
- Proof of Residency (Valid Washington Drivers License or ID card, Voter registration card or current utility bill in your name, including address
- Signed and Dated
- Voided check if selecting the automated monthly withdrawal

Send Completed Application to:

Health Insurance Washington
PO Box 26540
Eugene, Oregon 97402

KPS Washington Application

PLAN CHOICE: <input type="checkbox"/> A <input type="checkbox"/> E <input type="checkbox"/> F

PLEASE PRINT – Answer all questions completely and accurately to ensure timely processing.

Name (Last, First, Middle)							Birth Date			
Address (Street, City, State, Zip)										
Telephone			<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Single <input type="checkbox"/> Married				
MEDICARE CLAIM NUMBER	Please, copy the numbers shown as "MEDICARE CLAIM NUMBER" on the Medicare Health Insurance card issued you by the Social Security Administration.									
Enter effective date of "Hospital (Part A)" coverage shown on your Medicare Health Insurance card.						Month	Day	Year		
Enter effective date of "Medical (Part B)" coverage shown on your Medicare Health Insurance card.						Month	Day	Year		

PLEASE READ THE FOLLOWING INFORMATION BEFORE COMPLETING THIS FORM

- **If you intend to terminate existing Medicare supplement insurance and replace it with a contract to be issued by KPS Health Plans**, please complete the enclosed Notice To Applicant Regarding Replacement of Medicare Supplement Health Care Coverage. Retain one copy for your records and return a completed/signed copy to KPS Health Plans.
- You do not need more than one Medicare supplement contract.
- If you purchase this contract, 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 contract.
- If, after purchasing this contract, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement contract 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 contract (or, if that is no longer available, a substantially equivalent contract) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (continued)

- If you are eligible for, and have enrolled in a Medicare supplement contract 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 contract 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 contract under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement contract (or, if that is no longer available, a substantially equivalent contract) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract 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).

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 contract, or that you had certain rights to buy such a contract, 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. (Mark YES or NO below with an "X")

To the best of your knowledge:

1. (a) Did you turn age 65 in the last six (6) months?

YES NO

(b) Did you enroll in Medicare Part B in the last six (6) months?

YES NO

(c) If yes, what is the effective date? _____

2. Are you covered for 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.)

YES NO

If Yes: (a) Will Medicaid pay your premiums for this Medicare supplement contract?

YES NO

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

YES NO

(continued)

3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, please leave "END" blank.

START _____ END _____

- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement contract?

YES NO

- (c) Was this your first time in this type of Medicare plan?

YES NO

- (d) Did you drop a Medicare supplement contract to enroll in the Medicare plan?

YES NO

4. (a) Do you have another Medicare supplement contract in force?

YES NO

- (b) If so, with what company and what plan do you have?

- (c) If so, do you intend to replace your current Medicare supplement contract with this contract?

YES NO

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

YES NO

- (a) If so, with what company and what kind of contract?

- (b) What are your dates of coverage under the other contract? If you are still covered under this plan, please leave "END" blank.

START _____ END _____

AUTHORIZATION:

I authorize any physician, hospital or other provider of service to disclose to KPS Health Plans any medical information that may be requested. I understand that such information will be kept confidential, except as may be necessary to administer the provisions of my contract. I understand 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 a true copy of this application will be attached to my contract when it is issued.

I hereby authorize the Centers for Medicare and Medicaid Services (CMS) to release to KPS Health Plans any information from Title XVIII (Medicare) that is required to process my claims in conjunction with Medicare, if applicable. This authorization is ongoing for as long as I am or will be eligible for Medicare and remain enrolled in this plan.

(continued)

By my signature below, I acknowledge that I have received a copy of the following (check all that apply):

- Guide to Health Insurance for People with Medicare Notice of Replacement Coverage
 Outline of Coverage

I, the undersigned, have read and personally completed all of the requested information on this form. (If not, please attach a letter of explanation.)

Signature of Applicant _____ Date _____

Please enclose a check or money order for your initial monthly payment with this application. Use either the postage-paid envelope provided or mail to:

**KPS HEALTH PLANS
P.O. BOX 339
BREMERTON, WA 98337**

Your coverage will begin the first of the month following approval of this application OR the first of _____ (month).

(You may request a later effective date up to 90 days from the date of this application.)

AGENT INFORMATION:

If your application is being made through an agent, he or she must complete the following; and, if appropriate, the notice of replacement coverage included with this application. All information must be completed or the application will be returned.

1. List any other medical or health insurance contracts sold to the applicant:

2. List contracts that are still in force:

3. List contracts sold in the past five years that are no longer in force:

AGENT VERIFICATION:

FOR AGENT USE ONLY

The following **MUST** be completed **AFTER** the applicant has completed the application.

To the best of my knowledge, the answers on this application are complete and accurate.

Agent Name - as licensed Dann Loewenthal	Agency Name CDA Insurance LLC	Agent No. 5357		
Mailing Address PO Box 26540	City Eugene	State OR	Zip 97402	Telephone No. 541.284.2993
Agent Signature				Date