

Thank you for your interest in applying for the Asuris Northwest Health Medicare Supplement plan!

This application needs to be reviewed and signed by an Agent before it can be submitted to Asuris Northwest Health. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: [dann@lowinsure.com](mailto:dann@lowinsure.com)
- Mail: CDA Insurance LLC  
2160 W 11<sup>th</sup> Ave  
Eugene, Oregon 97402

Other Important Information
Download Medicare's <a href="#">Choosing a Medigap Policy Guide</a> (.pdf)
Download <a href="#">Policy Outline</a> (.pdf)

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.



Asuris Northwest Health  
528 East Spokane Falls Boulevard  
Suite 301  
Spokane, WA 99202  
Mail form to: PO Box 1106, MS-LB1  
Lewiston, ID 83501

## Asuris Medicare Supplement (Medigap) Application

- You do not need more than one Medicare Supplement (Medigap) 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 (Medigap) policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement (Medigap) 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 (Medigap) 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 (Medigap) 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.
- If you are eligible for, and have enrolled in a Medicare Supplement (Medigap) 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 (Medigap) 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 (Medigap) policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement (Medigap) 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 (Medigap) 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 (Medigap) insurance and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and specified low-income Medicare beneficiary (SLMB).

## INSTRUCTIONS FOR COMPLETING YOUR APPLICATION

Thank you for selecting Asuris Northwest Health for your Medicare Supplement (Medigap) Coverage. You must be age 65 or older and have both Medicare Part A and Part B to apply for these plans.

**To assure prompt processing of your application, please be sure to:**

1. Answer each required question completely **using ink**.
2. Copy the information from your Medicare Identification Card into Section 2 of this application.
3. Sign and date the statements in Section 9 of this application. If you choose our automatic bank withdrawal, complete Section 6.
4. If you need assistance completing this application, please contact our Sales Department at 1-866-704-2708 or contact your independent producer.

## SECTION 1 - PLAN SELECTION

Choose **ONE** of the four standard plans:

- Pledge Plan A     Pledge Plan C  
 Pledge Plan F     Pledge Plan K

## SECTION 2 - ENROLLMENT INFORMATION

Applicant Last Name		First Name, MI		Gender	Age
Height	Weight	Birthdate	Social Security Number		
Medicare Insurance Number			Medicare Effective Dates (from your Medicare card):		
			PART A (Hospital) _____		
			PART B (Physician) _____		

### WASHINGTON RESIDENCE ADDRESS

To be eligible to apply for our Medicare Supplement (Medigap) plans, you must reside in our service area. A photocopy of a valid Washington state driver's license, identification card, or current utility bill with name and address may be requested as proof of residency.

Residence Street Address		
City, State, ZIP Code		
Mailing Address (if different than residence street address)		
E-Mail Address (will not be disclosed outside of the company)		
Home Phone Number	Work Phone Number	County

**SECTION 3 - OTHER COVERAGE 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 (Medigap) 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 (Medigap) 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**  
**(Please mark Yes or No with an "X")**

- A. Did you turn 65 in the last 6 months? .....  Yes  No
- B. Did you enroll in Medicare Part B in the last 6 months? .....  Yes  No

If Yes, what is the effective date \_\_\_\_\_

- C. 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, will Medicaid pay your rates for this Medicare Supplement (Medigap) contract? .....  Yes  No

If Yes, do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? .....  Yes  No

- D. 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)? If yes, fill in your start and end dates below. If you are still covered under this plan, leave "End" blank. ....  Yes  No

If Yes: Start \_\_\_\_\_ End \_\_\_\_\_

- E. Have you recently lost coverage for medical assistance through the state Medicaid program? .....  Yes  No

If Yes, what date did coverage end \_\_\_\_\_

- F. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement (Medigap) contract? .....  Yes  No

- G. Was this your first time in this type of Medicare plan? .....  Yes  No

- H. Did you drop a Medicare Supplement (Medigap) policy to enroll in the Medicare plan? .....  Yes  No

- I. Do you have another Medicare Supplement (Medigap) policy in force? .....  Yes  No

If Yes, with which company and what plan do you have \_\_\_\_\_

If Yes, do you intend to replace your current Medicare Supplement (Medigap) policy with this contract? .....  Yes  No

**(Please complete Section 7 "Notice to Applicant Regarding Replacement of Medicare Supplement (Medigap) Insurance or Medicare Advantage".)**

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

If Yes, with which company \_\_\_\_\_

If Yes, what kind of policy \_\_\_\_\_

If Yes, what are your dates of coverage under the other policy. If you are still covered under this plan, leave "End" blank.

Start \_\_\_\_\_ End \_\_\_\_\_

**Authorization signature required on page 10.**

**SECTION 4 - MEDICARE SUPPLEMENT (MEDIGAP) PROTECTION PERIODS**

	Do I need to complete a Health Statement?			
	A	C	F	K
Applying for plan:				
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.	No	No	No	No
2. Your employer group 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 terminates 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.	No	No	No	No
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 receiving notice of termination or bankruptcy, and no later than 63 days after your coverage terminates.	No	No	No	No
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.	No	No	No	No
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) policy up to 60 days before and no later than 63 days after your Medicare Advantage or PACE program coverage terminates.	No	No	No	No
6. You dropped a Medicare Supplement (Medigap) policy to join a Medicare Advantage plan, Medicare Select plan, 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.	No	No	No	No
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 mislead 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.	No	No	No	No

**SECTION 5 - HEALTH STATEMENT**

- ♦ Are you applying for coverage to start within the six-month period immediately following your enrollment in Medicare Part B or your 65th birthday? (This is your **open enrollment period**.).....  Yes  No
- ♦ If you answered "Yes" to the above question, continue to Section 6. You do not need to answer any more questions in Section 5.
- ♦ If you answered "No" to above question, finish completing Section 5. Answer all of the questions in this section. **An incomplete application will be returned to you.**

*Please Note: Congress has established a six-month open enrollment period for buying Medicare Supplement (Medigap) health insurance. 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.*

Other than the circumstances listed above, there are some exceptions where, completing the following health history questionnaire may not be required. If you would like to verify if one of these exceptions applies to you please see page 4 section 4 otherwise, please complete the following questionnaire:

A. Within the last five years, have you had diagnosis, treatment, or advice relating to any of the following:

	Yes	No		Yes	No
1. Accident, injury, or deformity.....	<input type="checkbox"/>	<input type="checkbox"/>	23. Lung problems, chronic obstructive pulmonary disease, emphysema or oxygen use .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Acquired Immune Deficiency Syndrome (AIDS) or related disease....	<input type="checkbox"/>	<input type="checkbox"/>	24. Mental anxiety, emotional condition, or depression .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Alcoholism or drug dependency.....	<input type="checkbox"/>	<input type="checkbox"/>	25. Muscular Disorders, Dystrophies.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Anemia, blood disease, or leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Neurological disease or Parkinson's.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Arthritis or Rheumatoid Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	27. Neuritis, chronic or recurrent numbness/tingling.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Asthma or chronic bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	28. Obesity (overweight).....	<input type="checkbox"/>	<input type="checkbox"/>
7. Back trouble (recurrent or chronic).....	<input type="checkbox"/>	<input type="checkbox"/>	29. Prostate or male disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Cancer or tumor.....	<input type="checkbox"/>	<input type="checkbox"/>	30. Rectal disorder, hemorrhoids, or bleeding .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Confusion or Alzheimer's.....	<input type="checkbox"/>	<input type="checkbox"/>	31. Sciatica or chronic pain .....	<input type="checkbox"/>	<input type="checkbox"/>
10. Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	32. Skin condition or disease, melanoma.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Dizziness or headaches (frequent).....	<input type="checkbox"/>	<input type="checkbox"/>	33. Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Epilepsy or convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	34. Stomach disorders, frequent or chronic heartburn.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Ear, nose, or throat disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	35. Thyroid or glandular.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Eye disorder, glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	36. Ulcer (stomach or duodenal).....	<input type="checkbox"/>	<input type="checkbox"/>
15. Female disorders, fibroids, or excessive or irregular bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	37. Varicose veins, phlebitis, or blood clots.....	<input type="checkbox"/>	<input type="checkbox"/>
16. Gallbladder.....	<input type="checkbox"/>	<input type="checkbox"/>	38. Any other condition or disease not listed.....	<input type="checkbox"/>	<input type="checkbox"/>
17. Heart or circulatory.....	<input type="checkbox"/>	<input type="checkbox"/>	above (list below)		
18. High or low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>			
19. Intestines, bowel, or colon.....	<input type="checkbox"/>	<input type="checkbox"/>			
20. Joint problems, including knee and other.....	<input type="checkbox"/>	<input type="checkbox"/>			
21. Kidney or bladder.....	<input type="checkbox"/>	<input type="checkbox"/>			
22. Liver disorder or hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>			

**SECTION 5 - HEALTH STATEMENT (continued)**

Please explain below any items that you checked "Yes" on the previous page.

Question Number	Year	Duration	Name and Nature of Injury, Disease, or Condition	Was Recovery Complete?	Name and Address of Physician

B. Have you been advised to have an operation that was not performed?.....  Yes  No  
 If "yes", please give full details, including name and address of physician \_\_\_\_\_

C. Have you been hospitalized in the last 5 years or are you currently hospitalized or in an extended care facility?.....  Yes  No  
 If "yes", please explain below (use an extra sheet of paper if necessary).

Date of Hospitalization	Disease, Injury, or Condition	Name of Operation Performed, if any	Name and Address of Physician

D. Are you planning to be hospitalized within the next 6 months?.....  Yes  No  
 If "yes", please explain \_\_\_\_\_

E. Have you taken any prescription medications within the past 12 months?.....  Yes  No  
 If "yes", please explain below (use an extra sheet of paper if necessary).

Medication	Prescribing Physician	Medical Condition	Still Taking?



**SECTION 7 - NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT (MEDIGAP) INSURANCE OR MEDICARE ADVANTAGE**

Please review this section if you indicated in Section 3 of the application that you intend to terminate existing Medicare Supplement (Medigap) coverage or Medicare Advantage insurance and replace it with a policy to be issued by Asuris Northwest Health. 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 purchase of this Medicare Supplement (Medigap) coverage is a wise decision, you should terminate your present Medicare Supplement (Medigap) 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, PRODUCER (AGENT)**

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement (Medigap) policy will not duplicate your existing Medicare Supplement (Medigap) coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement (Medigap) 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 rates
- Fewer benefits and lower rates
- 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) \_\_\_\_\_

State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

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 rates 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 you want to keep it.

\_\_\_\_\_  
Producer's Signature\*

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

EFEGG JEE  
\_\_\_\_\_  
Producer's Asuris Appointment Number

\_\_\_\_\_  
Applicant's Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Medicare Insurance Number

*\*Producer signature not required if you do not have a Producer*

**SECTION 8 - INSURANCE PRODUCER (AGENT) CERTIFICATION**

If you have a producer, that producer may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Asuris Northwest Health. Incentives may be based on any of several factors, including the products you buy, your producer's volume of business with Asuris Northwest Health, and the other services your producer provides you. For more information, please contact your producer.

**FOR PRODUCER USE ONLY**

I, (the producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Asuris Northwest Health. I have informed the applicant that the effective date of coverage is assigned only by Asuris Northwest Health and provided the Washington Disclosure Information required.

**I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.**

- 1. List any other medical or health insurance policies sold to the applicant \_\_\_\_\_
- 2. List the policies still in force \_\_\_\_\_
- 3. List the policies sold in the past 5 years that are no longer in force \_\_\_\_\_

Producer Name (please print or type)	Producer Phone Number	Asuris Appointment Number
<i>Öæ } AS[ ^, ^} c@</i>	<i>I FÈ H ÈÎ FH</i>	<i>F EGG J EEE</i>
Producer's Signature (Required)		Date (Required)
X		

**PRODUCER: COLLECT NO PREMIUM WITH APPLICATION**

**SECTION 9 - CERTIFICATION, AUTHORIZATION AND SIGNATURE**

Be sure to sign and date the application below. Signature applies to both "Certification of Completeness and Correctness" and "Authorization for Use and Disclosure of Protected Health Information":

**CERTIFICATION OF COMPLETENESS AND CORRECTNESS**

**IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.** I affirm that the answers given in this application are true, complete, and correct. I am providing these answers as part of the application procedure required by Asuris Northwest Health to enroll in their coverage. I understand that Asuris Northwest Health will rely on each answer in making coverage and rating determinations. If coverage is rescinded for fraud or intentionally misleading statements, Asuris Northwest Health will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium. I will promptly inform Asuris Northwest Health in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Asuris Northwest Health. Asuris Northwest Health may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

**SECTION 9 - CERTIFICATION, AUTHORIZATION AND SIGNATURE (continued)**

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I acknowledge and understand my health plan may request or disclose health information about me from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law.\*

Health information requested or disclosed may be related to treatment or services performed by:

- ♦ a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- ♦ a clinic, hospital, long-term care or other medical facility;
- ♦ any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- ♦ an insurance carrier or health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). A separate authorization will be required for psychotherapy notes.

I understand that if this application contains any material misstatements or omissions, Asuris Northwest Health may deny coverage, modify or cancel coverage and/or take any other legal action available to us by law.

\* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Asuris Northwest Health Consumer Privacy Notice. A copy is available on our Web site at [www.asuris.com](http://www.asuris.com) or by telephone request at 1 (800) 365-3155.

**THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES**

(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of a conversation during a counseling session.)

**SIGNATURE**

Signature of applicant*	Date
<b>X</b>	

\* If signature by a personal representative of the member/enrollee please complete the following:

Personal Representative's Name (please print) \_\_\_\_\_

Relationship to Individual \_\_\_\_\_ (Attach legal documentation if other than parent of a minor child)

If additional health information is required to qualify you for coverage, we may send you a separate authorization form for the purpose of obtaining medical information.

***Do not send payment with your application. We will bill you upon acceptance of your application.***

**FOR OFFICE USE ONLY**
