

Thank you for your interest in applying for the KPS Health Plans Medicare Supplement plan!

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

- Fax: 1.541.284.2994
- Email: dann@lowinsure.com
- Mail: CDA Insurance LLC
2160 W 11th Ave
Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf)
Download Policy Outline (.pdf)

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

P.O. BOX 339 | BREMERTON, WA 98337

PLAN CHOICE **PLAN A (2010 STANDARDIZED)** **PLAN F (2010 STANDARDIZED)**

SECTION 1

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
Social Security Number (required):			
MEDICARE CLAIM NUMBER Please, copy the numbers shown as "MEDICARE CLAIM NUMBER" on the Medicare Health Insurance card issued to 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

- You must be enrolled in the KPS Medicare Supplement Plan you have chosen for a period of three (3) consecutive months before KPS will provide benefits for any condition for which you received medical advice, treatment, medicine, or diagnostic testing during the three (3) month period immediately preceding your KPS Medicare Supplement contract effective date. This waiting period will be waived if KPS receives your application within six (6) months of you turning age 65 or your enrollment in Medicare Part B; or it will be reduced to the extent you had prior coverage under another Medicare supplement plan or other more comprehensive coverage, and you did not have a break in coverage of more than 63 days. Please provide proof of prior coverage with this application.
- If you intend to terminate existing Medicare supplement or Medicare Advantage 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 Insurance or Medicare Advantage." Retain one copy for your records and return a completed/signed copy to KPS.
- 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 you become eligible for Medicaid after purchasing this contract, 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.
- 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).

SECTION 2

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. (MARK YES OR NO WITH AN "X")

1.	(a) Did you turn age 65 in the last six (6) months?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	(b) Did you enroll in Medicare Part B in the last six (6) months?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	If yes, what is the effective date?		
2.	Are you covered for medical assistance through the state Medicaid program? <i>(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.)</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	(a) Will Medicaid pay your premiums for this Medicare supplement contract?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	(b) Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.	(a) Have you had coverage from any Medicare plan other than original Medicare within the past 63 days? <i>(For example, a Medicare Advantage plan, or a Medicare HMO or PPO)</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	If yes, what are your start and end dates? <i>If you are still covered under this plan, please leave "END" blank.</i>	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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	(c) Was this your first time in this type of Medicare plan?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	(d) Did you drop a Medicare supplement contract to enroll in the Medicare plan?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4.	(a) Do you have another Medicare supplement contract in force?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	If yes, with what company and what plan do you have?	Company:	
		Plan:	
	(b) If yes, do you intend to replace your current Medicare supplement contract with this contract?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5.	Have you had coverage under any other health insurance within the past 63 days? <i>(For example, an employer, union or individual plan.)</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	(a) If yes, with what company and what kind of contract?:		
	(b) What are your dates of coverage under the other contract? <i>If you are still covered under this plan, please leave "END" blank.</i>	Start:	End:

HEALTH STATEMENT REQUIREMENTS

If you are 65 years of age or older, and you are applying for a Medicare supplement plan for the first time more than six (6) months since you first enrolled in Medicare Part B you must complete the health statement. In compliance with Washington State law, the health statement must be completed either by you or on your behalf by a relative, legal guardian, or physician.

Completion of a health statement is **not required** if:

1. You are 65 years of age or older and applying within six (6) months of your first enrollment under Medicare Part B; **or**
2. You are transferring from another Medicare Supplement Plan A to the KPS Medicare Supplement Plan A (2010 Standardized); **or**
3. You are transferring from a Medicare Supplement plan other than Plan A to a KPS Medicare Supplement Plan; **or**
4. You are transferring from more comprehensive coverage to a KPS Medicare Supplement Plan.

If any of these circumstances (1-4) apply to you, please skip the health statement on the next page and continue to page 5 to complete the rest of this application. If none of these circumstances (1-4) apply to you, please complete the health statement that follows.

HEALTH STATEMENT Please indicate whether or not you have been diagnosed with any of the following conditions within the last five (5) years.
Each condition must be checked "Yes" or "No."

Condition	Please provide details of any conditions marked "Yes."		Surgery	Name & Address of Hospital or Physician
	Year Diagnosed	Name of Disease or Injury		
1. Aids or HIV Positive	<input type="checkbox"/> YES <input type="checkbox"/> NO			
2. Arthritis	<input type="checkbox"/> YES <input type="checkbox"/> NO			
3. Alcoholism/Chemical Dependency	<input type="checkbox"/> YES <input type="checkbox"/> NO			
4. Dementia (e.g., Alzheimer's)	<input type="checkbox"/> YES <input type="checkbox"/> NO			
5. Back Conditions	<input type="checkbox"/> YES <input type="checkbox"/> NO			
6. Cancer, Leukemia	<input type="checkbox"/> YES <input type="checkbox"/> NO			
7. Cataracts	<input type="checkbox"/> YES <input type="checkbox"/> NO			
8. Vein or Artery Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO			
9. Heart Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO			
10. High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO			
11. Intestinal Conditions (e.g., stomach bowel)	<input type="checkbox"/> YES <input type="checkbox"/> NO			

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Continued from page 3

HEALTH STATEMENT Please indicate whether or not you have been diagnosed with any of the following conditions within the last five (5) years. Each condition must be checked "Yes" or "No."

Condition	Please provide details of any conditions marked "Yes."			Name & Address of Hospital or Physician
	Year Diagnosed	Name of Disease or Injury	Surgery	
12. Kidney/Bladder Conditions	<input type="checkbox"/> YES <input type="checkbox"/> NO			
13. Liver Conditions	<input type="checkbox"/> YES <input type="checkbox"/> NO			
14. Parkinson's Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO			
15. Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO			
16. Emphysema/Lung Disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO			
17. Gall Bladder Conditions	<input type="checkbox"/> YES <input type="checkbox"/> NO			
18. Glaucoma	<input type="checkbox"/> YES <input type="checkbox"/> NO			
19. Prostate Disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO			
20. Mental Health Conditions (e.g., depression)	<input type="checkbox"/> YES <input type="checkbox"/> NO			
21. Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO			
22. Conditions Requiring Hospitalization or Surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO			

PLEASE LIST ANY PRESCRIPTION DRUGS YOU ARE TAKING

Name of Drug	Reason Taken

If you have 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 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.

SECTION 4

ACKNOWLEDGEMENTS:**Please read and initial each of the following statements:**

- I am applying for enrollment with KPS Health Plans.
- I represent that all statements and answers on this application and health questionnaire (if applicable) are complete and true to the best of my ability and knowledge.
- 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 coverage is available to me based on the following:
 - My residence in Washington State
 - My enrollment in Medicare Parts A and B
 - My eligibility for Medicare due to age (65 or over)
- I understand that a true copy of this application will be attached to my contract when it is issued.
- I have received a copy of the following **(check all that apply)**:
 - Guide to Health Insurance for People with Medicare
 - Notice to Applicant Regarding Replacement of Medicare Supplement Insurance
 - Outline of Coverage
- I understand and agree that coverage does not begin until KPS notifies me of my coverage effective date.
- I authorize any physician, hospital, or other provider of service to disclose to KPS any medical information that may be requested and understand that such information will be kept confidential, except as may be necessary to administer the provisions of my contract.
- I authorize the Centers for Medicare and Medicaid Services (CMS) to release to KPS 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.
- I understand that KPS will not pay benefits during the first three (3) months after my effective date for any condition for which medical advice was given or treatment was recommended by or received from a physician within three months before the effective date of coverage.
- I understand that this waiting period will be waived if KPS receives my application within six (6) months of my turning age 65 or enrolling in Medicare Part B; or it will be reduced to the extent I had prior coverage under another Medicare supplement plan or other more comprehensive coverage with no break in coverage of more than 63 days, and I provide proof of that coverage with this application.
- I 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 _____

