Thank you for your interest in applying for the ODS Senior Select Medicare Supplement plan.

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

- Fax: 1.888.632.5470 or 1.541.284.2994
- Email: dann@lowinsure.com
- Mail: CDA Insurance LLC
2160 W 11th Ave
Eugene, Oregon 97402

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

Individual Medicare Supplement Application

503.243.3973 ◆ 877.277.7073 ◆ www.odscompanies.com

Please mail your completed application to:
ODS ◆ Attn: Individual Underwriting ◆ 601 S.W. Second Ave. ◆ Portland, OR 97204-3156

THIS APPLICATION MUST BE COMPLETED AND SIGNED IN BLACK or BLUE INK.

All enrollment questions must be answered legibly and to the best of your knowledge.
If your application is incomplete or unsigned, it will be returned to you and your effective date may be delayed.

Enrollment Information

Social Security No.	Sex	Date of Birth	Age

OREGON RESIDENCE ADDRESS

Last Name	First Name	Middle Initial
Residence Street Address		P.O. Box (if applicable)
City	State	ZIP Code
Home Telephone No.	Work Telephone No.	County

BILLING ADDRESS *(complete only if billing should be sent to an address other than the address listed above)*

Name (c/o)	Relationship to Applicant		
Address	City	State	ZIP Code

Health Insurance Social Security Act

Please copy the information from your Medicare Identification Card into the area below and attach a copy of your Medicare Identification Card or the letter of verification from the Social Security Administration or Railroad Retirement Board. This information is REQUIRED to process your application.

Name of Beneficiary: ______________________

Claim No.: ______________________

Gender: ______________________

Is Entitled to:	Effective Date:
Hospital Insurance	______________
Medical Insurance	______________

Hospital insurance represents Part A. Medical insurance represents Part B.

Please attach a copy of your Medicare card.

Medicare Supplement Plan Choice

❑ Plan A	❑ Plan C	❑ Plan F	❑ Plan F with $2,000 deductible

Requested future effective date: 1st of **month:** ______________ **year:** ______________

Dental Plan Choice

Please check a box to elect or decline dental coverage. If you do not check a box below, the "one-time only" ODS SeniorSelect Dental Plan open enrollment period will end and you will not be able to add the ODS SeniorSelect Dental Plan in the future.

❑ Yes, please enroll me in the ODS SeniorSelect Dental Plan. I have read the ODS SeniorSelect Dental Plan Benefit Summary and premium sheet, and understand the coverage available to me.

❑ No, I do not want the ODS Senior Select Dental plan. I understand that by declining the dental coverage available to me, the "one-time only" period to choose the dental plan will expire and I will not be able to enroll in the ODS SeniorSelect Dental Plan at a later date.

Insurance products provided by ODS Health Plan, Inc. and Oregon Dental Service

Statements

It is an eligibility requirement at the time of enrollment that the applicant is an Oregon resident.

You do not need more than one Medicare supplement policy. If you currently have a Medicare supplement policy, you cannot be enrolled unless you intend to replace your current coverage.

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, deferring 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 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.

Counseling services may be available 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).

Please answer each of the questions to the best of your knowledge:

1. (a) Did you turn age 65 in the last six months? ❑ Yes ❑ No
   (b) Did you enroll in Medicare Part B in the last six months? ❑ Yes ❑ No
   (c) If yes, what is the effective date? ________________

2. Are you covered for medical assistance through the state Medicaid program? ❑ Yes ❑ No
   (NOTICE 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,
   (a) Will Medicaid pay your premiums for this Medicare supplement policy? ❑ Yes ❑ No
   (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ❑ Yes ❑ No

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, 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 policy? ❑ Yes ❑ No
   (c) Was this your first time in this type of Medicare plan? ❑ Yes ❑ No
   (d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? ❑ Yes ❑ No

4. (a) Do you have another Medicare supplement policy in force? ❑ Yes ❑ No
   (b) If so, with what company, and what plan do you have (optional for direct mailers)? ________________
   (c) If so, do you intend to replace your current Medicare supplement policy with this policy? ❑ 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 policy? ________________
   (b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave **END** blank. START: ____/____/____ END: ____/____/____

If you are replacing current Medicare supplement coverage, please complete the enclosed "Notice to Applicant Regarding Replacement of Medicare Supplement Coverage" form.

Protected Enrollment Periods

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.**

You are applying for coverage within 63 days from the date your previous Medicare coverage ended and:

1. Your Medicare Advantage plan, or Program of All-Inclusive Care for the Elderly (PACE) terminates or no longer provides service in your area or you move out of the service area. ❑ Yes ❑ No
2. You were covered by an employer's group health plan or a state Medicaid plan as described in Title XIX of the Social Security Act that provides health benefits and the plan terminates your benefits or no longer provides benefits. ❑ Yes ❑ No
3. Your Medicare Supplement policy and enrollment terminates because the insurer becomes insolvent or bankrupt. ❑ Yes ❑ No
4. Your Medicare Supplement insurer has violated a material provision of the policy or the agent materially misrepresented the plan's provisions in marketing the plan. ❑ Yes ❑ No
5. You terminated your Medicare supplement policy and enrolled in a Medicare Advantage plan and voluntarily disenrolled from that plan within the first 12 months of enrolling. You may re-enroll in the same Medicare Supplement policy you had previously if available from the same issuer; however, if that Medicare Supplement policy is not available, you may enroll in plans A, C, F or F High Deductible from us. ❑ Yes ❑ No
6. You joined a Medicare Advantage plan or a PACE program when you were first eligible for Medicare. Within the first year of joining that plan, if you decide to disenroll, you may enroll in any of our Medicare Supplement plans. ❑ Yes ❑ No

For Agent Use Only

Agents must list any other medical or health insurance policies sold to the applicant.

List policies sold that are still in force: ____________________

List such policies sold in the past five years that are no longer in force: ____________________

Insurance History

If you have had prior health coverage and you are applying within 63 days of prior coverage termination, you may be eligible for credit toward any pre-existing condition period. PLEASE COMPLETE THE FOLLOWING:

Insurance Co.	Policy No./ID No.	Kind of Policy *(Medicare, HMO, Group, etc.)*

Employer Name	Effective Date	Termination Date

List Any Coverage Before This *(if above coverage was in force less than six months)*

Prior Dental Coverage Credit

If you answered **YES** to elect enrollment in the ODS Senior Select Dental plan:
Do you have 12 months of prior dental insurance with no more than a 90-day break in coverage? ❑ Yes ❑ No

If yes, please provide the following:

1. Name of individual enrolled in prior plan: ____________________

OR

2. Carrier name: ____________________

   Carrier phone number: ____________________

   Effective: ___/___/___ Termed: ___/___/___

3. Copy of prior dental plan ID card, front and back.

Open Enrollment Qualifiers and Underwriting

1. Are you applying for coverage within the six-month period beginning with the first day of the month you are enrolled for benefits under Medicare Part B regardless of your age? You must also have Medicare Part A to enroll. *(This refers to your open enrollment period.)* ❑ Yes ❑ No

2. Are you applying within any of the protected enrollment periods shown on page 3? *(Attach a copy of supporting documentation — such as a letter from your previous insurance company, certificate of coverage, etc.)* ❑ Yes ❑ No

If you answered **"yes"** to either (or both) of the questions above, please continue onto page 5 for signature and page 6 for billing information. You do not need to answer any additional questions in this section.

If you answered **"no"** to both questions, you **must** answer all questions in the Health History section and acceptance is based on underwriting approval. If your application is incomplete, ODS will return it to you.

Health History

1. Please check each condition **YES** or **NO** to indicate if you have any of the following conditions or have received treatment for any of these conditions during the past FIVE years.

a. Height: _____________ Weight: _____________
b. Alcoholism ❑ Yes ❑ No
c. Arthritis, back or spinal disorder, knee or hip problem ❑ Yes ❑ No
d. Diabetes ❑ Yes ❑ No
e. Disorder of the stomach, intestines or liver ❑ Yes ❑ No
f. Cancer, tumor, leukemia ❑ Yes ❑ No
g. Chronic lung disease ❑ Yes ❑ No
h. Disorder of the eyes or ears ❑ Yes ❑ No
i. Disease related to the immune system (including AIDS, ARC or lupus) ❑ Yes ❑ No
j. Paralysis, stroke, neurological problem ❑ Yes ❑ No
k. High blood pressure, heart disease, vein or artery disease, angina, irregular heart function, heart attack ❑ Yes ❑ No
l. Nervous or emotional condition, depression ❑ Yes ❑ No
m. Thyroid problem ❑ Yes ❑ No
n. Urinary problem, disorder of kidneys, bladder or prostate ❑ Yes ❑ No
o. Do you have any other condition, injury, ailment or symptom not mentioned in items b. through n.? (If yes, list below.) ________________________________ ❑ Yes ❑ No

If you answered YES to any of the conditions above please provide the additional information requested below:

CONDITION LETTER	EXACT DIAGNOSIS, TYPE OF TREATMENT OR SURGERY (PLEASE PROVIDE AS MUCH DETAIL AS POSSIBLE.)	DATE OF ONSET	DATE OF MOST RECENT TREATMENT: MONTH/DAY/YEAR

2. Are you taking prescription drugs? ❑ Yes ❑ No
If yes, please list the name and dose of the medication, and why you take the medication: ______________________

3. Has any future surgery, diagnostic testing or medical treatment been recommended? ❑ Yes ❑ No
If yes, please explain. Give ailment, date and the type of treatment recommended: ______________________

4. Have you been hospitalized or had surgery in the past FIVE years? ❑ Yes ❑ No
If yes, for what condition(s)? ______________________

Attach additional pages if necessary. I have attached _____ page(s).

For Agent Use Only

I, (the agent) have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the policy except through written material furnished by ODS. I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

Agent Name *(print or type)* Dann Loewenthal

Agency Name CDA Insurance LLC | Telephone No. 541.434.9613

Street Address 2160 W 11th Ave., Suite D | City Eugene | State OR | ZIP 97402

Agent's Signature *(required)* | Date

AGENT: COLLECT PREMIUM WITH APPLICATION

Authorization

Be sure to sign and date the application below. Signature applies to "Certification of Completeness and Correctness," "Authorization for Release of Information" and "Applicant's Statement":

CERTIFICATION OF COMPLETION AND CORRECTNESS

I affirm that the answers given in this application are complete and correct. I am providing these answers as part of the application procedure required by ODS to enroll in their insurance coverage. I understand that if this application contains any material misstatements or omissions, ODS may, within the first two years of coverage, deny coverage, modify or cancel the policy, and/or take any other legal action available to it by law. I will promptly inform ODS in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. ODS 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.

AUTHORIZATION FOR RELEASE OF INFORMATION

To any physician; healthcare provider; hospital; insurance or reinsurance company; the Medical Information Bureau, Inc. (MIB) or other insurance information exchange:

I authorize you to give medical information (including alcohol, chemical dependency, mental treatment or HIV treatment) you have about me to ODS or its representatives. This authorization takes effect on the date shown below. This authorization shall be valid for 30 months from the date following my signature below. A photocopy of this authorization is as valid as the original.

APPLICANT'S STATEMENT

I understand that if this application contains material misstatements or omissions, ODS may do any or all of the following:

- Deny coverage for any condition I did not disclose, as well as for any related condition;
- Cancel the policy as though it were never effective;
- Deny benefits under the "pre-existing" clause of the policy, if applicable;
- Take any other legal action available to it by law.

I understand that my agent is not authorized to make any statements about the benefits, conditions or limitations of the policy except through written materials furnished by ODS. If my agent completed any answers on my behalf, I have reread all answers and verified that they are true and complete. I understand that only ODS can determine whether to issue a policy to me, and that my agent has no authority to do so.

I am enrolled in Medicare. I understand that I am applying for ODS Medicare supplement coverage. My signature below also acknowledges that I have received the ODS SeniorSelect packet.

I understand that during a guaranteed issue period, my effective date will be the first day of the month following receipt of my application or other requested future effective date. If I am applying for coverage during a non-guaranteed issued period, my effective date will be the first day of the month following Underwriting approval, and I will be notified in writing within 60 days of receipt of my application. I further understand that each ODS SeniorSelect Medicare supplement plan includes a 6 month waiting period for pre-existing conditions. Credit toward the waiting period will be given day for day for prior coverage.

I understand, upon acceptance, that this application becomes part of the policy.

Signature of Applicant | Date

Billing Information

Please indicate your preferred billing option:

❑ **AUTO PAY BY MONTHLY ELECTRONIC FUNDS TRANSFER** *(EFT)*
- Attach a check for one month's premium and attach a voided check from the account to be drafted. Complete the form below.
  * FUNDS WILL TRANSFER ON OR AROUND THE FIFTH CALENDAR DAY OF EACH MONTH.

❑ **MONTHLY BILLING STATEMENT**
- Attach one month's premium. You will receive a bill every month thereafter. A $5.00 monthly administrative fee is required with this payment method per mailed billing statement.

❑ **QUARTERLY BILLING STATEMENT** *(Every three months.)*
- Attach a check for three months' premium. A $5.00 quarterly administrative fee is required with this payment method per mailed billing statement.

* A CHECK OR MONEY ORDER MUST ACCOMPANY THIS FORM IF YOU DO NOT SELECT AUTO PAY AND INCLUDE BANKING INFORMATION AND AUTHORIZATION BELOW.

Billing Worksheet

Billing Option		MONTHLY Option	QUARTERLY Option
Medicare supplement plan monthly premium		$____________	$____________
Dental plan monthly premium	+	$____________	$____________
Total due to ODS	=	$____________	$____________
		(If monthly EFT was chosen, please attach a voided check and fill out the section below.)	*(Multiply times three; do not fill out section below.)*

Authorization Agreement for Electronic Deduction

Instructions:

1. Complete and sign below as Account Holder if you have chosen Auto Pay monthly **ELECTRONIC FUNDS TRANSFER** payments.
2. **Attach a "VOID" sample of your check, in addition to a check for your first month's premium amount.**
3. Submit the completed application and appropriate documents with your application.

Name of Applicant: ____________________ Social Security Number: ________________

I authorize ODS to charge my checking account for monthly insurance premiums for the above named individual. I also authorize my bank named here to honor these monthly charges. This authority will remain in effect until I give my bank a reasonable chance to act upon it. I can stop payment by notifying my bank before my account has been charged.

Name of Bank: ________________________________

Signature of Account Holder: ____________________ Date: ________________

You may be billed for the premium payment necessary to begin electronic deductions. If you wish to cancel your bank deductions, we must receive written notice 15 days before the next deduction date.

***** Sending in a check does not guarantee coverage unless you are enrolling during a guaranteed issue period. During this period, the coverage effective date will be the first day of the month following receipt of the application **(provided that the application is received by the 20th of the previous month). A future effective date, to be no more than 60 days from the application signature date, may be requested.** If your application is incomplete or unsigned, it may be returned to you and your effective date of coverage may be delayed. If you are applying for coverage during a non-guaranteed issue period, your first month or quarterly premium amount will not be credited to your account until your application for individual Medicare supplement insurance coverage has been approved by ODS Underwriting. You will be notified in writing of your application status no later than 60 days from receipt. If your application is approved, the coverage effective date will be the first day of the month following approval. If your application is not approved, you will be notified in writing and your check will be returned to you.

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