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

CONTACT: **Tiffany Jackson**, independent agent, with any questions or concerns.
Email: tiffany@lowinsure.com or phone: 1-541-434-9613

If using the Annual Enrollment Period, please return between October 15th and December 7th for a January 1st effective date.

All other enrollments will be processed for the first of the month following receipt of the application. A valid Enrollment Period is required by CMS.

AETNA MEDICARE ADVANTAGE PLAN DOCUMENTS:

Benefit Summaries:

- Application download: Available 10-15-2025
- Provider Search
- Star ratings HMO Star ratings PPO
- Pharmacy search
- Formulary search

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.

2026 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM

(KLAMATH COUNTY)

ATRIO HEALTH PLANS

Section 1: All fields on this page are required (unless marked optional)

SELECT THE PLAN YOU WANT TO JOIN:

Medical & Prescription Drug Plan options:	Medical Plan only (no prescription drug):
☐ **ATRIO Choice Rx (PPO):** $26 / mo. (H6743-001)	☐ **ATRIO Freedom Rx (PPO):** $0 / mo. (H6743-031)
☐ **ATRIO Prime Rx (PPO):** $139 / mo. (H6743-030)	

First Name:_____ **Last Name:**_____ **Middle Initial:** _____ *(Optional)*

Birth Date:_____ *(MM / DD / YYYY)* **Sex:** ☐ M ☐ F **Home Phone Number:**_____

Cell Phone Number:_____ **Email:**_____

Please know that by providing your email address, you are agreeing to receive email notifications from us, and by providing your cell phone number, you are agreeing to receive text message notifications from us, as applicable. We will always give you the opportunity to opt-out of future communications.

Permanent Physical Address:(Do NOT enter a PO Box)

Street Address:_____ **Apt. #:** _____

City:_____ **County:**_____ **State:**_____ **Zip Code:** _____

Mailing Address: (If different from your permanent residence address (PO Box allowed)):

Street Address: _____ **Apt. #:** _____

City:_____ **County:**_____ **State:**_____ **Zip Code:** _____

Your Medicare information

Please take out your red, white, and blue Medicare card to complete this section.
Fill out this information as it appears on your Medicare card –OR –attach a copy of your Medicare card from your letter from Social Security or the Railroad Retirement Board

Medicare Number: _____
(Example: 1234-123-1234)

Hospital (Part A) Effective Date:_____

Medical (Part B) Effective Date: _____

You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug Plan.

2026 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM
(KLAMATH COUNTY)

ATRIO HEALTH PLANS

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), credit card, over the phone or on our website each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DO NOT pay ATRIO Health Plans the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Even if you have Extra Help now you may need to reapply for recertification. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover. If you don't Select a payment option, you will receive a bill/invoice each month.

Please select a payment option and follow any further instructions for full set-up:

- ☐ Receive a bill/invoice monthly
- ☐ Automatic Electronic Funds Transfer (EFT) from your bank account –for EFT, visit atriohp.com to sign up on our premium portal
- ☐ Credit Card –for credit card payment, visit atriohp.com to sign up on our premium portal
- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get my benefits from: ☐ Social Security ☐ Railroad Retirement Board

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction or approves deductions to begin after the enrollment effective date, we will send you a bill for your monthly premiums.)

IMPORTANT: Read and Sign Below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in this plan. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it
- By joining this Medicare Advantage Plan, I acknowledge that ATRIO Health Plans will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below)
- I understand that I can be enrolled in only one MA or Part D plan at a time –and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans)

2026 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM

(KLAMATH COUNTY)

ATRIO HEALTH PLANS

- I understand that when my ATRIO coverage begins, I must get all of my medical and prescription drug benefits (If I selected a plan with prescription drug coverage) from ATRIO. Benefits and services provided by ATRIO and contained in my ATRIO "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor ATRIO will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative, this signature certifies that:
  1. This person is authorized under State law to complete this enrollment, and
  2. Documentation of this authority is available upon request by Medicare

Signature:_____ **Today's Date:** _____

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. Agents, brokers, SHIP counselors, family members or other third parties? Helping an enrollee fill out this form.

Name: _____ Signature:_____

Relationship to Enrollee: ☐ Agent ☐ Broker ☐ SHIP counselor ☐ Authorized representative

National Producer Number (Agents/ Brokers only): _____

Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

Do you have other prescription drug or medical coverage (like group, VA, TRICARE) in addition to this plan? ☐ Yes ☐ No

If yes, please list your other coverage and your ID number for this coverage:

Name of other coverage:	Member number for this coverage:	Group number for this coverage:
_____	_____	_____

2026 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM

(KLAMATH COUNTY)

ATRIO HEALTH PLANS

SECTION 2: A few questions to help us manage your plan (optional). Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

List your Primary Care Physician (PCP), clinic or health center:_____

Select one if you prefer plan information in another language or an accessible format:

- ☐ Spanish
- ☐ Braille
- ☐ Large Print
- ☐ Audio CD
- ☐ Data CD

Please contact ATRIO at 1-877-672-8620 (TTY 711) if you need information in an accessible format other than what is listed above. Our office hours are daily, 8:00 a.m. to 8:00 p.m. local time.

Do you or your spouse work? ☐ YES ☐ NO

2026 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM

(KLAMATH COUNTY)

ATRIO HEALTH PLANS

SECTION 3: For licensed sales representative / agency use only

Staff member/ Agent/ Broker must complete:

Name (if assisted in enrollment): TIFFANY JACKONS

Initial receipt date:

Writing ID #: 14254716

Proposed effective date of coverage:

- [x] AEP (Oct 15 –Dec 7)
- [ ] ICEP (MA enrollees)
- [ ] IEP (MA-PD enrollees)
- [ ] IEP (MA-PD enrollees eligible for 2ndIEP)
- [ ] OEP (Jan 1 –March 31)
- [ ] OEP (newly eligible)
- [ ] OEPI
- [ ] SEP (Chronic)
- [ ] SEP (Dual LIS change of status)
- [ ] SEP (Dual LIS maintaining)
- [ ] SEP (Loss of EGHP coverage)
- [ ] SEP (Change in residence)
- [ ] SEP (SEP reason):_____

_____ _____

Licensed Sales Representative Signature *(optional)* Date

Mail or fax this completed form to:
ATRIO Health Plans
338 Jericho Turnpike #135
Syosset, NY 11791
Fax: (602) 975-4071

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Scope of Sales Appointment Confirmation Form

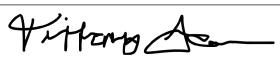
The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face or telephonic appointment sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

(Refer to page 2 for product type descriptions)

	Stand-alone Medicare Prescription Drug Plans (Part D)		**Hospital Indemnity Products**
initial X	**Medicare Advantage Plans (Part C) and Cost Plans**		**Medicare Supplement (Medigap) Products**
	Dental/Vision/Hearing Products		

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Signature Date:
If you are the authorized representative, please sign above and print below:	
Representative's Name:	Your Relationship to the Beneficiary:
To be completed by Agent:	
Agent Name: Tiffany Jackson	Agent Phone: 541-434-9613
Beneficiary Name:	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature: 	
Plan(s) the agent represented during this meeting:	Date Appointment Completed:
[Plan Use Only:]	
Agent, if the form was not signed by the beneficiary 48 hours prior to the appointment, provide explanation why SOA was not documented prior to meeting:	

The Scope of Appointment is subject to CMS record retention requirements, and is valid for 12 months after the date of beneficiary's signature date or the date of the beneficiary's initial request for information.