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.

PACIFICSOURCE MEDICARE ADVANTAGE PLAN DOCUMENTS:

Benefit Summaries
MyCare Rx 40 HMO | MyCare Choice 30 HMO-POS | Essentials Choice 3 HMO-POS |
Essentials Choice Rx 14 HMO-POS | Essentials Rx 6 HMO | Essentials Choice Rx 36 HMO-POS
Explorer Rx 4 PPO | Explorer 6 PPO | Essentials Rx 41 HMO

Application
Available 10-15-2025 please email if you would like one to be sent out.

Links
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.

Portland area, Oregon

Clackamas, Multnomah, and Washington Counties, Oregon

PacificSource Dual Care Alliance (HMO D-SNP) is available in these Oregon counties: Clackamas, Multnomah, and Washington.

Section 1 – All fields in this section are required (unless marked optional)

Select your plan:

☐	**$0/mo**	MyCare™ Rx 40 (HMO)
☐	**$15/mo**	MyCare™ Choice 30 (HMO-POS)
☐	**$0/mo***	PacificSource Dual Care Alliance (HMO D-SNP)

*If you have full Medicaid benefits and Medicare, you will pay $0 for your premium and $0 for your Medicare-covered services. Your costs may vary if your Medicaid eligibility category and/or the level of Extra Help you receive changes.

First name _____ Last name _____

Middle initial (Optional) _____ Birth date _____

Sex ☐ Male ☐ Female **Requested effective date** _____

List your primary care provider (PCP, clinic, or health center) _____

Permanent residence (PO Box not allowed):

Street address _____

City _____ County _____ State _____ ZIP _____

Phone _____ Email _____

Mailing address, if different from your permanent address:

Street address _____

City _____ State _____ ZIP _____

Your Medicare information: **Medicare number** _____

Please read and answer these important questions:

1. **Are you a current PacificSource member?** ☐ Yes ☐ No
2. **Are you enrolled in your state Medicaid program?** ☐ Yes ☐ No **Medicaid number** _____
3. **Will you have, or have you had, other medical and/or prescription drug coverage in addition to your Medicare coverage and PacificSource Medicare?** (For example, other private insurance, TRICARE, federal employee health benefits or VA benefits, or a State Pharmaceutical Assistance Program) ☐ Yes ☐ No

   If "Yes," please include: Effective date _____ Termination date _____

   Subscriber name _____ Insurance company _____

   Group name _____ ID number _____ Group number _____
4. **Are you a resident in a long-term care facility, such as a nursing home?** ☐ Yes ☐ No **If "Yes," provide:**

   Name of institution _____ Phone number of institution _____

   Institution address (number and street) _____

For broker use only:

Broker name TIFFANY JACKON

Broker ID PM 00173 **Date received by broker** _____

IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in PacificSource Medicare.
- By joining this Medicare Advantage plan or Medicare Prescription Drug plan, I acknowledge that PacificSource Medicare will share my information with Medicare, which 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 on page 6.) Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one Part D plan at a time, and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- I understand that when my PacificSource Medicare coverage begins, I must get all of my medical and prescription drug benefits from PacificSource Medicare. Benefits and services allowed by PacificSource Medicare and contained in my PacificSource Medicare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor PacificSource Medicare 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 (as described above), 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** _____

If you're the authorized representative of the enrollee, please sign above and fill out these fields:

Name _____ Address _____

Phone number _____ Relationship to enrollee _____

If you're an individual helping an enrollee fill out this form, please fill out these fields and sign below:

Name _____ National Producer Number (agents/brokers) _____

Relationship to enrollee: ☐ Agent ☐ Broker ☐ SHIP counselor ☐ Authorized representative
☐ Other (third party) ☐ Self ☐ I choose not to answer

Signature _____

Section 2 – All fields in this section are optional

Select if you want us to send you information in a language other than English.

☐ Spanish ☐ Other _____

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact PacificSource Medicare at **888-863-3637,** TTY: 711 (we accept all relay calls) if you need information in an accessible format other than what's listed above. Our office hours are October 1 – March 31: 8:00 a.m. – 8:00 p.m., seven days a week; April 1 – September 30: 8:00 a.m. – 8:00 p.m., Monday – Friday.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage (your member handbook)
☐ Formulary (the list of covered drugs)
☐ Pharmacy Directory (the list of in-network pharmacies)
☐ Provider Directory (the list of in-network providers)

Email address _____

Section 3 – Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) with one of the options below. **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 (IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay PacificSource Medicare the Part D IRMAA.

☐ **Monthly bill**

☐ **Automatic deduction from your Social Security or RRB benefit**

I get monthly benefits from ☐ Social Security ☐ RRB

☐ **Automatic deduction from your checking account each month. Please include a voided check or provide the following:**

Account holder name _____

Bank routing number _____

Bank account number _____

Account type: ☐ Checking ☐ Savings

Automatic deductions are made on the 5th day of every month. Deductions include any outstanding balance on your account. If the deduction falls on a weekend or holiday, the deduction will occur the next business day. Please provide a voided check (deposit slips not accepted). You can stop deductions from your account by notifying us at the phone number or address on page 1 at least 30 days prior to the deduction date.

☐ **Credit card**

Once you're enrolled, we'll send you information about setting up credit card payments.

Section 4 – Confirm your eligibility to enroll (please check all that apply)

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period, from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am enrolling during the annual enrollment period (October 15 – December 7).
- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage open enrollment period.
- ☐ I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on (insert date) _____
- ☐ I was recently released from incarceration. I was released on (insert date) _____
- ☐ I recently returned to the United States after living outside of the U.S. I returned to the U.S. on (insert date) _____
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums), or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) _____
- ☐ I recently left a PACE program on (insert date) _____
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____
- ☐ I am leaving employer or union coverage on (insert date) _____
- ☐ I belong to a State Pharmaceutical Assistance Program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____
- ☐ I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a federal, state, or local government entity. One of the other statements here applies to me, but I was unable to make my enrollment request because of the disaster.

  Specify FEMA declaration _____

If none of these statements applies to you or you're not sure, please contact PacificSource Medicare at **888-863-3637,** TTY: 711 to see if you are eligible to enroll. We are open October 1 – March 31: 8:00 a.m. – 8:00 p.m., seven days a week; April 1 – September 30: 8:00 a.m. – 8:00 p.m., Monday – Friday.

PacificSource Community Health Plans is an HMO, HMO D-SNP, and PPO plan with a Medicare contract and a contract with Oregon Health Plan (Medicaid). Enrollment in PacificSource Medicare depends on contract renewal.

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 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 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

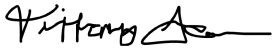
The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face or telephonic appointment sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). 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**
☐ **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.