



**Please return signed applications via one of the following methods:**

**EMAIL:** [secure email link](#) (Ctrl+Click)  
[tiffany@lowinsure.com](mailto:tiffany@lowinsure.com)

**FAX:** [1-541-284-2994](tel:1-541-284-2994)

**MAIL:** [CDA Insurance LLC](#)  
[P.O. Box 26540](#)  
[Eugene, OR 97402](#)

**OFFICE:** [CDA Insurance LLC](#)  
[2160 W 11<sup>th</sup> Ave Ste D](#)  
[Eugene, OR 97402](#)

**CONTACT:** Tiffany Jackson, independent agent, with any questions or concerns, or if you prefer an electronic application.  
Email: [tiffany@lowinsure.com](mailto:tiffany@lowinsure.com) or phone: [1-541-434-9613](tel:1-541-434-9613)

**DOCUMENTS:** The 'Outline of Coverage' and Medicare's 'Choosing a Medigap' book are located under each company heading.

- [www.medicare-oregon.com](http://www.medicare-oregon.com)
- [www.medicare-washington.com](http://www.medicare-washington.com)
- [www.medicare-idaho.com](http://www.medicare-idaho.com)
- [www.medicare-texas.net](http://www.medicare-texas.net)

**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.

# APPLICATION for MEDICARE SUPPLEMENT INSURANCE

Medco Containment Life Insurance Company

One Express Way, Saint Louis, Missouri 63121 • 866-459-4272 • [www.Cigna.com](http://www.Cigna.com)

Phone Verification (PV) Hotline 866-825-4822 • FaxApp Submission 877-704-8186



Application is for:  New business  Reinstatement

Phone verification case #(s) \_\_\_\_\_

- › If you complete this application with another Applicant, you are consenting to the other Applicant viewing the protected health information that you provided on this application.
- › If only one Applicant, complete Applicant A questions.

## A. Personal information

### APPLICANT A

Name (First MI Last)

Age

Date of birth (MM/DD/YYYY)

Gender

Male  Female

Resident address (Street, City, State ZIP)

Phone

Mailing address (if different from resident address)

Social Security no. (XXX-XX-XXXX)

Email address (optional) By providing your email address, you agree to receive marketing content electronically.

### APPLICANT B

Name (First MI Last)

Age

Date of birth (MM/DD/YYYY)

Gender

Male  Female

Resident address (Street, City, State ZIP) – OR check box  if same as Applicant A

Phone

Mailing address (if different from resident address)

Social Security no. (XXX-XX-XXXX)

Email address (optional) By providing your email address, you agree to receive marketing content electronically.

Household Discount (see Outline of Coverage for details)

APPLICANT A      APPLICANT B  
YES      NO      YES      NO

Do you live with someone that has a Medicare Supplement policy with Medco Containment Life Insurance Company and is 18 years or older (11% Household Discount)? .....

If you answered YES, please provide member information if other than Applicant A or Applicant B.

Name (First MI Last)

Social Security no. (XXX-XX-XXXX)

## B. Please provide your Medicare information (as shown on your Medicare card)

### APPLICANT A

Medicare number \_\_\_\_\_

### APPLICANT B

Medicare number \_\_\_\_\_

Hospital (Part A) coverage starts (MM/DD/YYYY) \_\_\_\_\_

Hospital (Part A) coverage starts (MM/DD/YYYY) \_\_\_\_\_

Medical (Part B) coverage starts (MM/DD/YYYY) \_\_\_\_\_

Medical (Part B) coverage starts (MM/DD/YYYY) \_\_\_\_\_

Medicare Part A is hospital insurance. Medicare Part B is medical insurance. You must have both Medicare Parts A and B on your requested Medicare Supplement effective date for coverage to be issued.

## C. Select a plan and effective date

APPLICANT A Check plan selected:  Plan A  Plan F\*  Plan HDF\*  Plan G  Plan N

APPLICANT B Check plan selected:  Plan A  Plan F\*  Plan HDF\*  Plan G  Plan N

Requested Medicare Supplement effective date (MM/DD/YYYY) A \_\_\_\_\_ B \_\_\_\_\_  
(if no effective date is requested, we will assign the 1<sup>st</sup> day of the month following the date of this application)

\*Plans F and HDF are only available if you are first Medicare-eligible before 2020.

## D. Are you eligible for Guaranteed Acceptance (Open Enrollment or Guaranteed Issue)?

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 (mark YES or NO below with an "X").

To the best of your knowledge:

Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the **Outline of Coverage?** .....

APPLICANT A	APPLICANT B
YES	NO

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1. a. Did you turn age 65 in the last six (6) months? .....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

b. Did you enroll in Medicare Part B in the last six (6) months? .....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

If YES, what is the effective date? (MM/DD/YYYY) A \_\_\_\_\_ B \_\_\_\_\_

2. Are you covered for medical assistance through the state Medicaid program? (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.) .....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

If YES,

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

a. will Medicaid pay your premiums for this Medicare Supplement policy? .....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

b. do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? .....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

3. 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)? .....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

If YES,

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

a. fill in your START and END dates below (if you are still covered under this plan, leave the END date blank).

A START \_\_\_\_\_ END \_\_\_\_\_

B 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? .....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

c. was this your first time in this type of Medicare plan? .....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

d. did you drop a Medicare Supplement policy to enroll in the Medicare plan? .....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

4. a. Do you have another Medicare Supplement policy in force? .....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Note: if you are applying on or during the 30 days before or after your birthday and replacing your current Medicare Supplement plan with a plan that has the same or lesser benefits, you qualify for guaranteed acceptance.

b. If so, with what company and what type plan do you have?

A \_\_\_\_\_

B \_\_\_\_\_

c. If so, do you intend to replace your current Medicare Supplement policy with this policy? .....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

If existing Medicare Supplement coverage is not to be replaced, this policy cannot be issued.

## D. Are you eligible for Guaranteed Acceptance (Open Enrollment or Guaranteed Issue)? (cont'd.)

	APPLICANT A	APPLICANT B
	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)? .....	<input type="checkbox"/>	<input type="checkbox"/>
a. If so, with what company and what kind of policy?	_____	
A _____	_____	
B _____	_____	
b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave the END date blank.)		
A START _____ END _____	_____	
B START _____ END _____	_____	
6. Have you lost or are you losing Medicaid (as described in Title XIX of the Social Security Act) or Tricare (as described in Title XVIII of the Social Security Act) coverage which qualifies you for guaranteed acceptance? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you eligible for Medicare due to a disability and moved to Oregon from a state that does not permit Medicare Supplement plans to be offered to those under age 65? (You must enroll within 63 days of establishing Oregon residency.) .....	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

## E. Complete medical questions (Statement of Health)

**IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEED ISSUE (BASED ON YOUR ANSWERS IN SECTION(S) B & D), DO NOT ANSWER THE QUESTIONS IN THIS SECTION.**

It is important that you provide truthful and accurate answers to the questions in this section as your answers form the basis of our determination of your eligibility for this coverage. Failure to provide complete and accurate information, if it is determined to be material to our assessment, may result in future denial of benefits and/or rescission of this coverage.

### PART A. MEDICAL QUESTIONS – If the answer to any question in Part A is YES, you are not eligible for coverage.

	APPLICANT A	APPLICANT B
	YES	NO
1. Are you confined, scheduled for admission, or in the last two (2) years have you been confined to a nursing facility or assisted living facility? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you receive home health care services; or in the last two (2) years, have you received home health care services for more than three (3) separate periods of care? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a terminal illness; are you in the hospital, pending hospital admission, or have you been hospitalized more than two (2) times in the last two (2) years? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you receive assistance bathing, transferring, toileting, eating, dressing, or are you bedridden; have you been advised by a medical professional to use the assistance of a wheelchair, walker, or motorized mobility aid? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Within the past six (6) months, have you been treated for or advised by a medical professional to have treatment for diabetes with hypertension that required three (3) or more hypertension medications to control or diabetes requiring more than 50 units of insulin daily to control? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Within the past two (2) years, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following: • heart attack, congestive heart failure, coronary bypass, angioplasty, atherosclerosis or arteriosclerosis, peripheral vascular disease, carotid artery disease, coronary artery disease (CAD), angina, cardiomyopathy, stent placement, heart valve surgery, atrial fibrillation, irregular heartbeat, cardiac pacemaker, transient ischemic attack (TIA) or stroke? (You should answer NO if your only treatment has been less than three concurrent cardiovascular medications and your treatment has not altered in the last two (2) years (e.g., change in medications or dosage increases)).	<input type="checkbox"/>	<input type="checkbox"/>

## E. Complete medical questions (Statement of Health) (cont'd)

	APPLICANT A YES <input type="checkbox"/> NO <input type="checkbox"/>	APPLICANT B YES <input type="checkbox"/> NO <input type="checkbox"/>
7. At any time, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following: .....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
• muscular dystrophy, multiple sclerosis, or amyotrophic lateral sclerosis (Lou Gehrig's disease)?	<input type="checkbox"/>	<input type="checkbox"/>
• Paget's disease, rheumatoid arthritis, disabling arthritis, osteoporosis with fractures, or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>
• chronic kidney disease, Addison's disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, cirrhosis of the liver or any condition requiring an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
• bipolar disorder, schizophrenia, a paranoid disorder, severe depression, or treatment for depression with medication for two (2) or more years?	<input type="checkbox"/>	<input type="checkbox"/>
• organic brain disorder?	<input type="checkbox"/>	<input type="checkbox"/>
• unrepaired aneurysm, hemophilia, or any other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
• any heart disease requiring a permanent, implantable cardiac defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>
• chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), emphysema, chronic bronchitis or other chronic lung or respiratory disorder not listed that requires the permanent use of oxygen?	<input type="checkbox"/>	<input type="checkbox"/>
• diabetes with neuropathy, diabetes with retinopathy, or diabetes with vascular disease?	<input type="checkbox"/>	<input type="checkbox"/>
• cerebral palsy, myasthenia gravis, systemic lupus, Parkinson's disease?	<input type="checkbox"/>	<input type="checkbox"/>
• hepatitis other than hepatitis A or other liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
• dementia, senility or Alzheimer's disease?	<input type="checkbox"/>	<input type="checkbox"/>
• PSA levels greater than 6.0	<input type="checkbox"/>	<input type="checkbox"/>
8. Within the past two (2) years, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following: .....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
• any cancer, excluding skin cancer (except malignant melanoma)?	<input type="checkbox"/>	<input type="checkbox"/>
• anemia requiring repeated blood transfusions?	<input type="checkbox"/>	<input type="checkbox"/>
• alcohol or drug abuse (including counseling)?	<input type="checkbox"/>	<input type="checkbox"/>
• pancreatitis?	<input type="checkbox"/>	<input type="checkbox"/>
• seizure?	<input type="checkbox"/>	<input type="checkbox"/>
9. At any time, have you been treated for or advised by a medical professional to have treatment for an amputation caused by disease or for an organ transplant (other than corneas)? .....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
10. Have medical tests, treatment, therapy, or surgery been advised but not performed or is any surgery anticipated? (This excludes mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only.) .....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
11. Have you ever been diagnosed with or received medical advice or treatment from a physician or an appropriately-licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection? .....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

If you answered NO to all questions in this Section, please continue to Part B. >>>

## E. Complete medical questions (cont'd.)

**PART B. MEDICAL QUESTIONS AND MEDICATIONS** – The answers to questions in Part B are subject to the Company's underwriting review and may result in a decline. Please provide complete details as requested.

APPLICANT A      APPLICANT B  
YES    NO      YES    NO

12. Have you used tobacco within the last 12 months?.....

13. **APPLICANT A** Height (ft.-in.) \_\_\_\_\_ Weight (lbs.) \_\_\_\_\_

**APPLICANT B** Height (ft.-in.) \_\_\_\_\_ Weight (lbs.) \_\_\_\_\_

14. Please list any prescription medications taken or prescribed in the past two (2) years (attach a separate sheet if needed).

14. Please list any prescription medications taken or prescribed in the past two (2) years (attach a separate sheet if needed).

## F. Important statements for Applicant to read

- You do not need more than one Medicare Supplement 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 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, 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 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 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 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 reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement 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 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).

"Newly Eligible" for Medicare means:

- a. Individuals who become eligible for Medicare before 1/1/2020 based on disability or end-stage renal disease (ESRD), "OR;"
- b. By reason of attaining age 65 before 1/1/2020 and are currently enrolled in Medicare Part A and Part B; and
- c. Individuals who become eligible for Medicare due to age, disability or end-stage renal (ESRD) disease on or after 1/1/2020.

As an alternative to court action, any matter in dispute between me and the Company may be subject to binding arbitration governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association. Any decision reached by arbitration shall be binding upon both myself and the Company and may be entered as a judgment in any court of proper jurisdiction. By signing this application, I acknowledge that I am giving up the right to a trial in court, both with and without a jury.

I hereby apply to Medco Containment Life Insurance Company for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) no agent has the authority to waive the answer to any questions on the application; (2) no insurance will be effective until (a) a policy has been issued by the Company and (b) the initial premium has been paid; and (3) I have received the Outline of Medicare Supplement Coverage for the policy applied for and the required *Guide to Health Insurance for People with Medicare*.

**CAUTION:** Please review your answers to the questions on the application. It is important to the issuance of this policy that all questions are answered correctly and truthfully.

**WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to civil or criminal penalties if intentional and material to the risk.

A recorded telephone interview may be used as part of the underwriting on your application for insurance.

**APPLICANT A** Telephone number \_\_\_\_\_ Best time to call \_\_\_\_\_

**APPLICANT B** Telephone number \_\_\_\_\_ Best time to call \_\_\_\_\_

I understand that the Medicare Supplement policy applied for will not cover loss due to Pre-Existing Condition(s) unless the expense for that loss is incurred more than six (6) months after the effective date of coverage. This provision does not apply if, as of the date of application, you had a Continuous Period of Creditable Coverage which did not expire more than 63 days ago and such coverage, while in force, lasted for at least six (6) months. If, as of the date of application, you had less than six (6) months prior Creditable Coverage, the Pre-Existing Conditions limitation will be reduced by the aggregate amount of Creditable Coverage. If this policy is replacing another Medicare Supplement policy, credit will be given for any portion of the waiting period that has been satisfied. This provision does not apply if you are applying for and are issued this policy under Guaranteed Issue status.

**APPLICANT A** Signature \_\_\_\_\_ Date \_\_\_\_\_

**APPLICANT B** Signature \_\_\_\_\_ Date \_\_\_\_\_

## G. Determine your rate class

A B

**Preferred** If you're eligible for Open Enrollment/Guaranteed Issue or answered NO to section E, question 12.  
  **Standard** If you answered YES to section E, question 12 (tobacco use).

Your eligibility for coverage and final rate class is subject to underwriting review.

## H. Choose your method of payment

### APPLICANT A

**Method** (select one of the following):

Bank draft (complete the *Electronic Funds Transfer Agreement*)  
 Direct bill (enclose check payable to **Medco Containment Life Insurance Company**; do not send cash)  
 List bill Group name \_\_\_\_\_ Group number \_\_\_\_\_

**Mode:**  Monthly (bank draft or list bill only)  Quarterly  Semi-annually  Annually

**Premium** (see rate chart in *Outline of Coverage*) \$\_\_\_\_\_

If you answered YES to Section A, Household Discount, multiply premium by 0.89.

### APPLICANT B

**Method** (select one of the following):

Bank draft (complete the *Electronic Funds Transfer Agreement*)  
 Direct bill (enclose check payable to **Medco Containment Life Insurance Company**; do not send cash)  
 List bill Group name \_\_\_\_\_ Group number \_\_\_\_\_

**Mode:**  Monthly (bank draft or list bill only)  Quarterly  Semi-annually  Annually

**Premium** (see rate chart in *Outline of Coverage*) \$\_\_\_\_\_

If you answered YES to Section A, Household Discount, multiply premium by 0.89.

## I. Agent use only

Please answer all questions:

1. I certify that I have provided the Applicant(s) with the following documents:

a. Application packet (phone sales only) b. *Guide to Health Insurance for People with Medicare*  
c. Outline of Medicare Supplement Coverage d. Other \_\_\_\_\_

I further certify that I have delivered the documents to the Applicant(s) (check all that apply; must select at least one):

Date \_\_\_\_\_  In person  Mail  Email  Fax  Other (explain) \_\_\_\_\_

2. Do you have knowledge or reason to believe the replacement of existing insurance may be involved?

**APPLICANT A:**  YES  NO **APPLICANT B:**  YES  NO

If YES, give name of company, reason, and termination date:

A \_\_\_\_\_

B \_\_\_\_\_

NOTES: Please provide additional information that may assist in processing this application (attach a separate sheet if needed).

I certify that I have interviewed the Applicant(s), asked all of the questions as written on the application, and I have truly and accurately recorded on the application the information supplied to me by the Applicant(s).

Printed name of licensed Agent <b>TIFFANY JACKSON</b>	Signature of licensed Agent	Writing number <b>CB09582</b>	Percentage <b>100</b>
Printed name of 2 <sup>nd</sup> licensed Agent	Signature of 2 <sup>nd</sup> licensed Agent	Writing number	Percentage

All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (domicile in CT), Cigna National Health Insurance Company (domicile in OH), Cigna Insurance Company, American Retirement Life Insurance Company, Loyal American Life Insurance Company, Medco Containment Life Insurance Company, and Provident American Life & Health Insurance Company. The Cigna Healthcare names, logos, and marks are owned by Cigna Intellectual Property, Inc.

# PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

MEDCO CONTAINMENT LIFE INSURANCE COMPANY • One Express Way, Saint Louis, Missouri 63121

<input type="checkbox"/> <b>Joint Account – only one form is needed for Joint Account</b>		<input type="checkbox"/> <b>APPLICANT A only</b>	<input type="checkbox"/> <b>APPLICANT B only</b>
Proposed Insured Name		Policy Number (if available)	
Financial Institution Name and Telephone Number			
9-digit Routing Number	Account Number	Requested Withdrawal Date (1st - 28th)	

Withdraw Payment:  Monthly  Quarterly  Semi-annually  Annually

Type of Account:  Personal Checking Account  Personal Savings Account  Corporate/Business Checking

Name of Employer Group \_\_\_\_\_

Purpose for submitting this Authorization (check appropriate box(es)):

New authorization

Change in checking/savings account

Change in financial institution

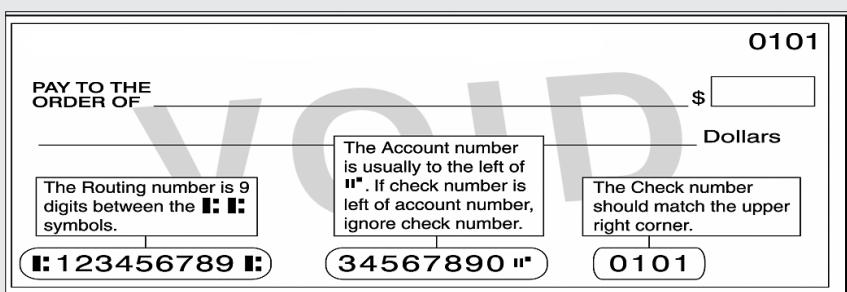
Change in existing coverage

**For checking account:**

Refer to the sections on the sample check.

**For savings account:**

Please verify with your bank the account and routing number of your savings account.



**APPLICANT A OR APPLICANT B INFORMATION FOR FINANCIAL INSTITUTIONS:** As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Medco Containment Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Medco Containment Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Medco Containment Life Insurance Company mistakenly deposits funds into my account, I authorize Cigna Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

**APPLICANT A OR APPLICANT B INFORMATION FOR Medco Containment Life Insurance Company:** It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Medco Containment Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Medco Containment Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Medco Containment Life Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured)

Payor's Address

Print name of Depositor (as it appears on account)

Signature of Depositor

Date

MCLIC-EFT-MULTI

RETURN TO COMPANY

03/24

# PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

MEDCO CONTAINMENT LIFE INSURANCE COMPANY • One Express Way, Saint Louis, Missouri 63121

<input type="checkbox"/> <b>Joint Account – only one form is needed for Joint Account</b>		<input type="checkbox"/> <b>APPLICANT A only</b>	<input type="checkbox"/> <b>APPLICANT B only</b>
Proposed Insured Name		Policy Number (if available)	
Financial Institution Name and Telephone Number			
9-digit Routing Number	Account Number	Requested Withdrawal Date (1st - 28th)	

Withdraw Payment:  Monthly  Quarterly  Semi-annually  Annually

Type of Account:  Personal Checking Account  Personal Savings Account  Corporate/Business Checking

Name of Employer Group \_\_\_\_\_

Purpose for submitting this Authorization (check appropriate box(es)):

New authorization

Change in checking/savings account

Change in financial institution

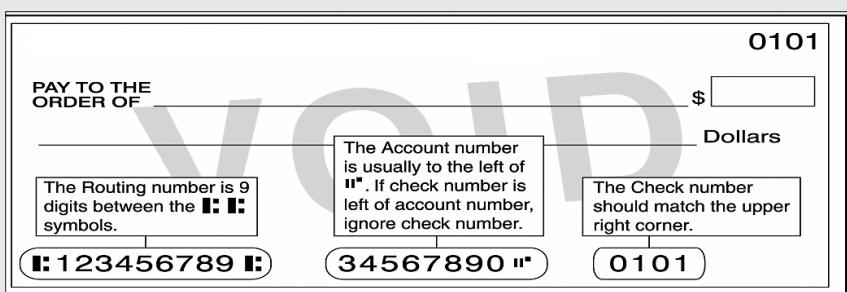
Change in existing coverage

**For checking account:**

Refer to the sections on the sample check.

**For savings account:**

Please verify with your bank the account and routing number of your savings account.



**APPLICANT A OR APPLICANT B INFORMATION FOR FINANCIAL INSTITUTIONS:** As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Medco Containment Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Medco Containment Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Medco Containment Life Insurance Company mistakenly deposits funds into my account, I authorize Cigna Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

**APPLICANT A OR APPLICANT B INFORMATION FOR Medco Containment Life Insurance Company:** It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Medco Containment Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Medco Containment Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Medco Containment Life Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured)

Payor's Address

Print name of Depositor (as it appears on account)

Signature of Depositor

Date

MCLIC-EFT-MULTI

RETURN TO COMPANY

03/24

# AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, Cigna Insurance Company, Medco Containment Life Insurance Company and their affiliates as described below.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information.
3. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
4. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually-transmitted diseases unless otherwise restricted by state law.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 5700, Scranton, PA 18505-5700.
6. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
7. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
8. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
9. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

---

\_\_\_\_\_  
Applicant's Name

\_\_\_\_\_  
Name of Applicant's Personal Representative, if applicable

\_\_\_\_\_  
Applicant's Social Security Number

\_\_\_\_\_  
Relationship of Personal Representative to the Applicant

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Company's Agent

\_\_\_\_\_  
Date

A signed copy of this form will be provided with the policy if issued and any other time upon request.

# AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, Cigna Insurance Company, Medco Containment Life Insurance Company and their affiliates as described below.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information.
3. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
4. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually-transmitted diseases unless otherwise restricted by state law.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 5700, Scranton, PA 18505-5700.
6. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
7. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
8. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
9. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

---

\_\_\_\_\_  
Applicant's Name

\_\_\_\_\_  
Name of Applicant's Personal Representative, if applicable

\_\_\_\_\_  
Applicant's Social Security Number

\_\_\_\_\_  
Relationship of Personal Representative to the Applicant

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Company's Agent

\_\_\_\_\_  
Date

A signed copy of this form will be provided with the policy if issued and any other time upon request.

**AUTHORIZATION FORM FOR DISCLOSURE OF A CONSUMER'S  
PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES  
("Authorization")**

1. I hereby authorize the use and disclosure of all my health information, including but not limited to my personal and medical information contained in the Company's records ("Protected Health Information") to American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, Cigna Insurance Company, Medco Containment Life Insurance Company and their affiliates ("Company") as described below.
2. I authorize the Company to use the Protected Health Information contained in the Company's records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.
3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.
4. I understand that I may revoke this Authorization at any time, except to the extent that action has been taken by the Company in reliance on this Authorization, by sending a written revocation to the Company's Privacy Steward at PO Box 5700, Scranton, PA 18505-5700.
5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing this Authorization.
6. I understand that if the person or entity that receives my Protected Health Information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redislosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this Authorization is as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this Authorization. This Authorization will remain in effect for two (2) years from the day my policy(ies) is terminated or the day I revoke my permission.
8. By providing my telephone number(s) on the attached application for insurance, I consent to receive calls, texts, or autodialed or prerecorded telemarketing messages from Cigna and its affiliates.

---

**APPLICANT A Name**

---

**Name of APPLICANT A Personal Representative, if applicable**

---

**APPLICANT A Social Security Number**

---

**Relationship of Personal Representative to APPLICANT A**

---

**APPLICANT A Signature**

---

**Signature of Personal Representative**

---

**Date**

---

**Date**

---

**APPLICANT B Name**

---

**Name of APPLICANT B Personal Representative, if applicable**

---

**APPLICANT B Social Security Number**

---

**Relationship of Personal Representative to APPLICANT B**

---

**APPLICANT B Signature**

---

**Signature of Personal Representative**

---

**Date**

---

**Date**

---

**Signature of Company's Agent**

---

**Date**

A signed copy of this form will be provided to you.

**Instructions to Agent:** This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the Applicant and by the Agent, and submitted to the Medco Containment Life Insurance Company (MCLIC) with the application.

***A copy of this form must also be left with the Applicant.***

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE  
OR MEDICARE ADVANTAGE**

MEDCO CONTAINMENT LIFE INSURANCE COMPANY

One Express Way, Saint Louis, Missouri 63121 • 866-459-4272

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Medco Containment Life Insurance Company. Your new policy will provide thirty (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 the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement 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, AGENT, OR BROKER**

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement coverage is being purchased for the following reason (check one):

**Applicant A**

- additional benefits
- no change in benefits, but lower premiums
- fewer benefits and lower premiums
- 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) \_\_\_\_\_

**Applicant B**

- additional benefits
- no change in benefits, but lower premiums
- fewer benefits and lower premiums
- 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) \_\_\_\_\_

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 premiums 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.**

**TIFFANY JACKSON**

**Agent/Broker printed name and signature**

**Date**

**Applicant A signature**

**Date**

**Applicant B signature**

**Date**

**Instructions to Agent:** This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the Applicant and by the Agent, and submitted to the Medco Containment Life Insurance Company (MCLIC) with the application.

*A copy of this form must also be left with the Applicant.*

## NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

MEDCO CONTAINMENT LIFE INSURANCE COMPANY

One Express Way, Saint Louis, Missouri 63121 • 866-459-4272

### SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Medco Containment Life Insurance Company. Your new policy will provide thirty (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 the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement 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, AGENT, OR BROKER

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement coverage is being purchased for the following reason (check one):

#### Applicant A

- additional benefits
- no change in benefits, but lower premiums
- fewer benefits and lower premiums
- 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) \_\_\_\_\_

#### Applicant B

- additional benefits
- no change in benefits, but lower premiums
- fewer benefits and lower premiums
- 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) \_\_\_\_\_

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 premiums 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.

**TIFFANY JACKSON**

Agent/Broker printed name and signature

Date

Applicant A signature

Date

Applicant B signature

Date

# DISCRIMINATION IS AGAINST THE LAW

## Medicare Supplement coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card or call 1.866.459.4272 (TTY: Dial 711), and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to [ACAGrievance@Cigna.com](mailto:ACAGrievance@Cigna.com) or by writing to the following address:

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call 1.866.459.4272 (TTY: Dial 711), or send an email to [ACAGrievance@Cigna.com](mailto:ACAGrievance@Cigna.com). You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, DC 20201  
1.800.868.1019, 800.537.7697 (TDD)  
Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>.



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including MedcoContainmentLifeInsuranceCompany. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. ATTENTION: If you speak languages other than English, language assistance services, free of charge are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.866.459.4272 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.866.459.4272 (los usuarios de TTY deben llamar al 711).

## Proficiency of Language Assistance Services

**English** – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.866.459.4272 (TTY: Dial 711).

**Spanish** – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.866.459.4272 (los usuarios de TTY deben llamar al 711).

**Chinese** – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.866.459.4272 (聽障專線：請撥 711)。

**Vietnamese** – XIN LƯU Ý: Quý vị được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.866.459.4272 (TTY: Quay số 711).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.866.459.4272 (TTY: 다이얼 711)번으로 전화해주십시오.

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.866.459.4272 (TTY: I-dial ang 711).

**Russian** – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.866.459.4272 (TTY: 711).

– برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون على ظهر بطاقةكم الشخصية. **Arabic** او اتصل ب 1.866.459.4272 (TTY: اتصل ب 711)

**French Creole** – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.866.459.4272 (TTY: Rele 711).

**French** – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.866.459.4272 (ATS : composez le numéro 711).

**Portuguese** – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.866.459.4272 (Dispositivos TTY: marque 711).

**Polish** – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1.866.459.4272 (TTY: wybierz 711).

**Japanese** – 注意事項:日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.866.459.4272 (TTY: 711)まで、お電話にてご連絡ください。

**Italian** – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.866.459.4272 (utenti TTY: chiamare il numero 711).

**German** – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.866.459.4272 an (TTY: Wählen Sie 711).

– توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.866.459.4272 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره مگری کنید).