Providence Health Assurance Application Packet

Thank you for your interest in the Providence Health Assurance Medicare Supplement plan!

This application packet provides you with access to the printable copy of the Enrollment Form and the Outline of Coverage in addition to a link to the Choosing a Medigap Policy Guide.

Should you decide to apply by secure upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to Providence Health Assurance. You may upload/email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) **Online application** – Click here Download Policy Outline (.pdf) Download Application (.pdf)

Our website: https://medicare-oregon.com

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

Providence Health Assurance

2024

Medicare Supplement (Medigap) Application Form

Personal information

FIRST NAME _____ LAST NAME _____ MI _____ DATE OF BIRTH ___/___/___

SOCIAL SECURITY NUMBER _____

PERMANENT RESIDENCE STREET ADDRESS _____ COUNTY _____

MAILING ADDRESS (IF DIFFERENT FROM STREET ADDRESS) _____

GENDER: ☐ Male ☐ Female

CELL PHONE ( ) -

HOME PHONE (IF OTHER THAN CELL PHONE) ( ) -

EMAIL ADDRESS (REQUIRED) _____

By providing your email address, you are agreeing to receive important account information and product offers. Be sure to write all necessary symbols, such as (.) and (@) in the space above.

Oregon Residence Address

To be eligible to apply for our Medicare Supplemental plans, you must reside in our service area. A photocopy of a valid Oregon state driver's license or identification card, and a current utility bill with name and address may be requested as proof of residency.

	YES	NO
In the past 12 months, at any time, have you used cigarettes, cigars, pipe tobacco, chew or snuff?	☐	☐

Medicare information

Please supply the information below from your Medicare card:

NAME _____ MEDICARE NUMBER _____

HOSPITAL (PART A) EFFECTIVE DATE ___/___/___

MEDICAL (PART B) EFFECTIVE DATE ___/___/___

	YES	NO
Are both Medicare Parts A and B coverage active? (or will be active by the plan effective date)	☐	☐

Indicate your Medicare Supplement plan

Which plan do you want to purchase (check one)? ☐ A ☐ G ☐ N

Complete applications received in our office by midnight Pacific Time on the last business day of the month will be eligible for an effective date of the first of the following month, unless otherwise indicated. Your application is subject to review and approval by Providence Health Assurance. Incomplete applications may receive a later effective date. If approved, you will receive an enrollment confirmation notice and your member ID card.

If you would like your policy to start on a later date (the first day of a future month), please indicate the date (MONTH / DAY / YEAR): _____/_____/_____

If you have requested a Future Date, the policy will be effective starting with the date you specify.

Eligibility

You are eligible for these Medicare Supplement plans if you are enrolled in Medicare Parts A and B, and are not duplicating Medicare supplement coverage from another plan (for example, Medicare Advantage). You must also reside in our service area for this Supplement coverage which is defined as all counties in Oregon.

Guaranteed enrollment determination

	YES	NO
Did you turn 65 years old in the last six months?	☐	☐
Will you be turning 65 years old in the next six months?	☐	☐
Did you enroll in Medicare Part B within the last six months? **If YES**, what is your effective date for Medicare Part B? _____/_____/_____	☐	☐

If you answered **YES** to any of the questions above, you are guaranteed enrollment in the Medicare Supplement plan you indicated. Based on this, please skip the Medical History and Conditions section and go to the Prior and Current Coverage section.

Guaranteed enrollment means that for six months immediately following enrollment in Medicare Part B medical care coverage, individuals cannot be denied insurance due to health conditions.

If any of the following scenarios apply to you, skip to the "Prior and Current Coverage" section on Page 7.

☐ Beginning 30 days prior to your birthday, and for 30 days after your birthday, you wish to transfer from your 1990 standard Medigap plan to a 2010 standard plan of equal or lesser benefits (for example, from a 1990 standard Plan A to a 2010 standard Plan A).

☐ Your employer group health plan coverage ends.

☐ You joined a Medicare Advantage or PACE program when you were first eligible for Medicare Part A (and you're enrolled in Medicare Part B). Within the first year of joining, you want to switch to Original Medicare.

☐ You dropped a Medigap policy to join a Medicare Advantage plan, Medicare Select plan, or PACE program for the first time and now you want to leave. You have been in the plan for less than a year. Note: A health statement is not required if you enroll in the same Medigap policy (with the same company) that you had previously.

☐ You lost medical assistance through the state Medicaid program.

☐ Your Medicare managed care plan or PACE program coverage ends because the plan is leaving the Medicare program, the plan stops giving care in your area, or you move out of the plan's service area.

☐ Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage ends through no fault of your own.

☐ You enrolled in a Medicare Part D plan during your initial enrollment period and were enrolled under a Medigap policy that covers outpatient prescription medications. Please enclose proof of enrollment in Medicare Part D.

☐ You leave a Medicare Advantage plan or drop a Medigap plan because the company or its representatives haven't followed the rules or misled you.

Medical history and conditions

Within the past two years, have you been treated for, or been advised by a physician to have treatment for any of the following conditions?

	YES	NO
Diabetes:	☐	☐
Type 1	☐	☐
Type 2	☐	☐
Angina, heart attack or heart surgery	☐	☐
Atherosclerosis or blockage of veins/arteries	☐	☐
Stroke or Transient Ischemic Attack (TIA)	☐	☐
Heart rhythm abnormalities or a pacemaker	☐	☐
Chronic lung disease (emphysema, COPD, etc.)	☐	☐
Cancer (other than skin cancer)	☐	☐
Anemia, hemophilia, leukemia or other blood disease?	☐	☐
Cirrhosis of the liver	☐	☐
Hepatitis C	☐	☐
Amputation due to disease	☐	☐
Rheumatoid arthritis	☐	☐
Chronic back or neck pain	☐	☐
Paraplegia, quadriplegia or hemiplegia	☐	☐
Bipolar or manic depressive	☐	☐
Schizophrenia	☐	☐
Macular degeneration	☐	☐
Amyotrophic Lateral Sclerosis (ALS)	☐	☐
Alzheimer's disease or dementia	☐	☐
Multiple Sclerosis (MS)	☐	☐

Parkinson's disease	☐	☐
Systemic Lupus Erythematosus (SLE)	☐	☐
AIDS/HIV positive	☐	☐
Have kidney insufficiency or end-stage renal kidney disease	☐	☐

Facility care

	YES	NO
Been diagnosed with kidney disease that may require dialysis	☐	☐
Currently receive dialysis	☐	☐
Been admitted to a hospital within the past 90 days	☐	☐
Moved into a nursing home or getting home health care	☐	☐
Enrolled in a hospice program	☐	☐
Plan to be admitted to a hospital or nursing home in the next 6 months	☐	☐
Use a wheelchair or walker	☐	☐
Use oxygen or a nebulizer in the past 6 months	☐	☐

Providers

	YES	NO
Do you have a primary care physician?	☐	☐
If YES, have you seen them in the last year?	☐	☐
Have you seen a dentist for an exam in the last year?	☐	☐
Have you had an eye exam in the last year?	☐	☐

Tell us about your living situation. Do you/have you:

☐ Live alone ☐ Live with a family member ☐ Live in an assisted living facility

Other _____

	YES	NO
Within the past two years, has a medical professional recommended or discussed as a treatment option either a surgical procedure or a transplant that has **NOT** been completed?	☐	☐

How many days per week do you use the following:

	0	1	2	3	4	5	6	7
Tobacco use:	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol use:	☐	☐	☐	☐	☐	☐	☐	☐
Recreational drug use:	☐	☐	☐	☐	☐	☐	☐	☐

Activities of daily living

Do you need help with any of the following activities:

	YES	NO
Bathing	☐	☐
Dressing	☐	☐
Eating	☐	☐
Getting in/out of bed/chair	☐	☐
Walking	☐	☐
Using the telephone	☐	☐
Doing light housework	☐	☐
Doing heavy housework	☐	☐
Preparing meals	☐	☐
Shopping	☐	☐
Managing finances	☐	☐
Managing medications	☐	☐

	YES	NO
Have you been injured because of a fall in the past year?	☐	☐
Do you do some form of regular exercise/physical activity? How many days per week (circle one): 1 / 2 / 3 / 4 / 5 / 6 / 7	☐	☐

How long do you do the activity generally (check one):

☐ 15 – 30 minutes ☐ 30 minutes – 1 hour ☐ More than 1 hour

Prior and current coverage

Medicaid coverage information	YES	NO
Are you covered for medical assistance through the state Medicaid program?	☐	☐
If YES, will Medicaid pay your rates for this Medicare supplement policy?	☐	☐
If YES, do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?	☐	☐
Have you recently lost coverage for medical assistance through the state Medicaid program?	☐	☐

Medicare insurance plans	YES	NO
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)? If yes, fill in your start and end dates below. If you are still covered under this plan, leave "End" blank.	☐	☐

If NO, skip to question A.

If YES: Start : ____/____/____ End: ____/____/____

If YES, with which company? _____

If YES, what plan do you have? _____

If YES, answer questions A and B below:

	YES	NO
If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	☐	☐
Was this your first time on this type of Medicare plan?	☐	☐
Did you voluntarily disenroll from a Medicare Supplement (Medigap) policy to enroll in the Medicare plan?	☐	☐

	YES	NO
A. Do you have another Medicare Supplement policy in force?	☐	☐

If NO, skip to question B.

If YES, with which company? _____

If YES, what plan do you have? _____

If YES, what is the effective date of your current policy? _____

If YES, do you intend to replace your current Medicare Supplement policy with this policy? ☐ YES ☐ NO

(Note: In order to cancel your current policy, you will need to request cancellation with your current carrier.)

If you answered YES to any of the above questions, please carefully review the section "Notice to applicant regarding replacement of Medicare Supplement (Medigap) insurance or Medicare Advantage" and consult your insurance Agent/Broker if you have one.

Group or individual insurance coverage

	YES	NO
B. Have you had coverage under any other health insurance within the past 63 days? (For example, through an employer, union or individual plan.)	☐	☐

If NO, skip to next section.

If YES, with which company? _____

If YES, what kind of policy? _____

If YES, do you intend to replace your current policy with this policy? ☐ YES ☐ NO

(Note: In order to cancel your current policy, you will need to request cancellation with your current carrier.)

If YES, what are your dates of coverage under the other policy? If you are still covered under this plan, leave "End" blank.

Start: ____/____/____ End: ____/____/____

Are you currently enrolled in a medical plan and wish to cancel that coverage? ☐ YES ☐ NO

If YES, confirm your requested coverage end date: ____/____/____

Paying your plan premiums

You can pay your monthly plan premium by mail each month or through Electronic Funds Transfer (EFT).

Please select a premium payment option:

☐ Get a monthly bill.

☐ Pay using Electronic Funds Transfer (EFT) – If selecting EFT, please fill out the information at the end of the application.

Household discount (if application is approved)

A household discount of up to 20% off your monthly premium may be available if you (1) are married or live with a domestic partner and reside at the same physical address, or (2) have resided with at least one, but no more than three other adults 18 years of age or older, in the last 12 months at the same physical address. The household discount is not available to those living in a one-person household, or in an assisted living facility.

FIRST NAME _____ LAST NAME _____ MI ____ DATE OF BIRTH ____/____/____

RELATIONSHIP _____

SIGNATURE OF OTHER HOUSEHOLDER _____ DATE ____/____/____

Providence may validate householder eligibility and may request additional documentation. If you are deemed ineligible for the household discount after the effective date of your coverage, your premium will be adjusted back to your original effective date.

Please review the following information about Medicare Supplement policies

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 coverage.

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 reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of 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).

Premium payments will not be accepted from any provider or facility offering health care services; or entities that receive 25 percent or more of their funding from providers or facilities, unless from a private, not-for-profit foundation that provides such payments on a charitable basis and does not base contributions on the policyholder's health status, enrollment in a particular health insurance plan, or use of any particular health care services or facilities; or as otherwise required by law.

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.

NOTE: 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 Form.

Authorization and verification of application information

I declare the answers on this Application Form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this Application Form becomes a part of the insurance contract and that if the answers are incomplete, incorrect or untrue, Providence Health Assurance may have the right to rescind my coverage, adjust my premium or reduce my benefits.

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent

insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.

I understand coverage, if provided, will not take effect until issued by Providence Health Assurance, the actual premium is not determined until coverage is issued and that this Application Form and payment of the initial premium does not guarantee coverage will be provided.

I understand that if my application is not submitted during an open enrollment or guaranteed issue period, Providence Health Assurance has the right to reject my application and any premiums paid will be refunded.

I acknowledge receipt of the currently available Outline of Coverage and the document "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" published by the Centers for Medicare & Medicaid Services.

I understand that I must be enrolled in Medicare Part A and Part B to be eligible for Medigap coverage and if Medicare Part A and/or Part B terminate for any reason, my Medigap policy will automatically terminate.

I understand that each Providence Health Assurance Medicare Supplement plan includes a six-month waiting period for pre-existing conditions. Credit toward the waiting period will be given day for day for prior coverage.

Authorization for use and release of protected health information

I understand that the following parties may need to collect information on me in regard to the proposed coverage: Providence Health Assurance and its reinsurers, any insurance support organization, any consumer reporting agency and all persons authorized to represent these organizations for this purpose.

Any and all individually identifiable health information, including but not limited to medical records, reports, pharmaceutical records, diagnostic testing and lab work results may be disclosed to or by Providence Health Assurance. This medical or health information may include information on the diagnosis and treatment of mental illness and 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.

Those parties who may need to collect information may disclose information to the following: Other insurers to whom I've applied or may apply; reinsurers, pharmacy benefit managers, physicians, hospitals, clinics or other medically related facilities; health care clearinghouses; or persons who perform business, professional or insurance tasks for them. They may disclose information as allowed or required by law.

I understand that this authorization is needed for the purpose of gathering information for making eligibility and underwriting determinations. Unless revoked earlier, this authorization will be valid for 12 months after the date signed.

I understand I can revoke this authorization any time by contacting Providence Customer Service.* I also understand that my revocation won't affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation. To revoke this authorization, please send a written statement to Providence Medicare Supplement Enrollment Department at PO Box 14590, Salem, OR 97309 and state that you are revoking this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, but if I don't, I may not be eligible for enrollment. I understand there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

***NOTE: PLEASE KEEP A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS**

To revoke this authorization, please send a written statement to the following address and state that you are revoking this authorization:

Providence Medicare Supplement
Enrollment Department
PO Box 14590
Salem, OR 97309

If the Application Form is being submitted through an Agent or Broker

I understand an agent or broker discussing Plan options with me is appointed by Providence Health Assurance, and may be compensated based on my enrollment in a Plan.

I understand that an agent or broker cannot change or waive any terms or requirements related to this Application Form and its contents, underwriting, premium or coverage and cannot grant approval.

APPLICANT PRINTED NAME (REQUIRED): _____

APPLICANT SIGNATURE (REQUIRED): _____

DATE (REQUIRED): ____/____/____

NOTE: If you are signing as the legal representative (e.g., POA, Guardian, Conservator, etc.) for the applicant, please send a complete copy of the appropriate legal documentation and check this box. ☐

I understand that I must be enrolled in Medicare Part A and Part B to be eligible for Medigap coverage and if Medicare Part A and/or Part B terminate for any reason, my Medigap policy will automatically terminate.

Notice to applicant regarding replacement of Medicare Supplement (Medigap) insurance or Medicare Advantage

Please review this section if you indicated on page 7 of the application that you intend to terminate existing Medicare Supplement coverage or Medicare Advantage insurance, and replace it with a policy to be issued by Providence Health Assurance. Your new policy allows a 30-day "free look" period. If you decide within 30 days to cancel your policy, you will not incur a cost or penalty.

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 purchase of this Medicare Supplement policy is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage plan. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

For Agent/Broker Use Only Please

Agent/Broker must complete the following information and include the notice of replacement coverage, if appropriate, with this Application Form. All information must be complete or the Application Form will be returned.

1. List any other health insurance policies that will be enforced by the time the new plan begins:

_____

_____

2. List policies issued in the past 5 years which are no longer in force (please indicate N/A if none or not applicable):

_____

_____

Statement to applicant by issuer, agent, 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 coverage or, if applicable, Medicare Advantage coverage, because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ☐ Additional benefits
- ☐ No change in benefits, but lower rates
- ☐ Fewer benefits and lower rates
- ☐ 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) _____

State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

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.

APPLICANT OR PERSONAL REPRESENTATIVE'S SIGNATURE

DATE OF APPLICANT OR PERSONAL REPRESENTATIVE'S SIGNATURE

APPLICANT'S NAME (PLEASE PRINT)

AGENT NAME (PLEASE PRINT)

TIFFANY	JACKSON	R
FIRST NAME	LAST NAME	MI

	14254716	/ /
AGENT SIGNATURE (REQUIRED)	AGENT ID (REQUIRED)	TODAY'S DATE (REQUIRED)

TIFFANY@LOWINSURE.COM	(541) 434 - 9613
AGENT EMAIL ADDRESS	AGENT PHONE NUMBER

Enrollment Department
PO Box 14590
Salem, OR 97309

EFT Authorization (complete only if Electronic Funds Transfer is requested)

1. EFT payments will be deducted by the 10th of the month.

2. If your application is approved by the 25th of the month prior to your effective date, your premium deduction will begin in your first month.

3. If your application is processed after that date, two months of premium will be deducted in your second month of coverage if authorized by you.

If more than one month's premium is due for the first draft, do you authorize Providence to pull the full amount from your account?

☐ YES ☐ NO

If NO, you are not eligible for EFT right away. You can enroll in EFT and provide your bank information at a later time.

I (or we, if this is a joint account) authorize Providence to charge my/our bank account for monthly premiums for the below named individual. I also authorize my bank to honor these monthly charges. This authority remains in effect until I revoke it in writing and provide notice to Providence.

Please attach a copy of a voided check or preprinted deposit slip showing your savings account number.

FINANCIAL INSTITUTION OR BANK	
TRANSIT/ROUTING NUMBER	
☐☐☐☐☐☐☐☐☐	
ACCOUNT NUMBER	
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	
CHECK ONE: ☐ Checking Account ☐ Savings Account	
ACCOUNT HOLDER'S NAME (PLEASE PRINT)	
ACCOUNT HOLDER'S SIGNATURE	DATE ___/___/___