Thank you for your interest in applying for the Lifewise Health Plans of Oregon Medicare Supplement plan.

These application need to be reviewed and signed by an Agent before they can be submitted to Lifewise Health Plans of Oregon. You may email, fax or mail it in to CDA Insurance:

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

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

Oregon Medicare Supplement Enrollment Application for Plans A, F, High Deductible F and N

P.O. Box 7709
Bend, OR 97708-7709
1-800-290-1278

You can become a LifeWise Health Plan of Oregon (LifeWise) Medicare Supplement member if you:

- Reside in Oregon,
- Currently have both Medicare Part A and Part B, **and**
- Don't receive Medicaid assistance other than payment of your Medicare Part B premium.

Don't send payment with this application.

Please PRINT, sign and date in blue or black ink. Applications that contain correction fluid or tape will not be accepted.

Important Notes

1. You do not need more than one Medicare Supplement policy. If you currently have a Medicare Supplement policy or Medicare Advantage policy (including a Medicare HMO or PPO), you cannot be enrolled unless you intend to replace your current coverage. Please complete a replacement form. If you purchase this contract, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
2. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. Medicaid is a public aid program for people with low income. It is not the same as Medicare.
3. If, after purchasing this policy, you become entitled to Medicaid, the benefits and premiums under your Medicare Supplement contract 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 re-instituted if requested within 90 days of losing Medicaid eligibility.
4. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) or a "Specified Low-Income Medicare Beneficiary" (SLMB).
5. 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.
6. Except that you must provide information on diseases and disorders for which you have symptoms, please do not provide any information on any part of this application about genetic testing or genetic information, including any decision by an insurance company that is based on a genetic test or on genetic information.

A Your Information

Last Name	First Name	Middle Initial	Social Security Number (required) ☐☐☐-☐☐-☐☐☐☐	
Home Address (cannot be a P.O. Box)	City	County	State OR	ZIP
Mailing Address (if different from above)	City		State	ZIP
Billing Address (if different from both above)	City		State	ZIP
Phone Number ( )		Alternate Phone Number ( )		
Birthdate Month Day Year	Height Ft. In.	Weight / lbs.	Gender ☐ Male ☐ Female	

B Your Policy Selection

Which Medicare Supplement Policy do you want to enroll in? ☐ Plan A ☐ Plan F ☐ Plan F: High Deductible ☐ Plan N
☐ Yes ☐ No Did you receive a copy of the "Outline of Coverage?"
☐ Yes ☐ No Did you receive a copy of Medicare's "Choosing a Medigap Policy" guide?

C When Would You Like Your Policy to Start (Effective Date)

Coverage starts on the first of the month after the date we receive your application if all information is completed and accurate **and** we approve your application.

To request a **later effective date**, write that date here:

______________ / 01 / ______________
Month Year

If you are **replacing** a Medicare Advantage policy, please contact your producer or our team at 1-800-290-1278 for more information.

D Paying for your Medicare Supplement Policy

Select one:

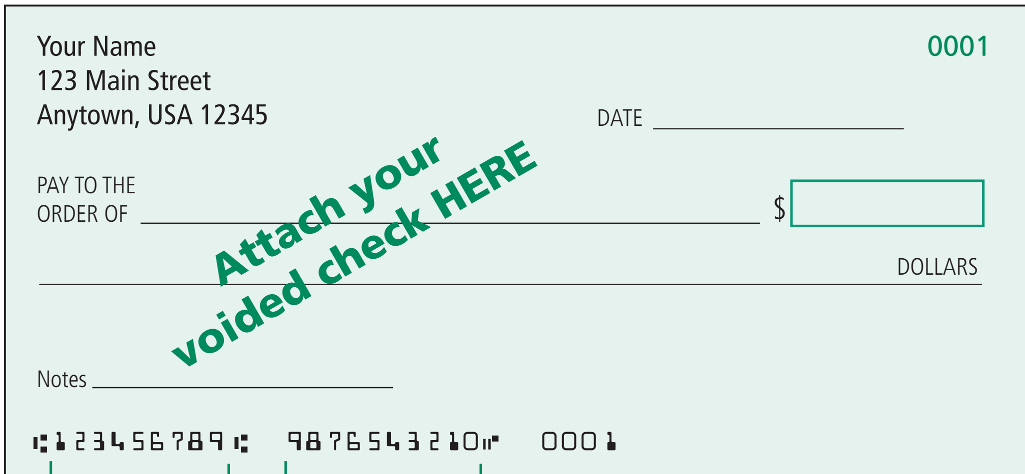
☐ Monthly paper bill by mail (move on to Section E).

☐ Automatic monthly withdrawal (AFT) from your bank account. (Complete all information below.) By choosing the AFT option, you save money. Please see the Outline of Coverage for rates.

> ***Tip***
> You can also pay by credit card after your first month's payment. Call us at 1-800-290-1278 for more information.

I have selected automatic monthly withdrawal and I hereby authorize LifeWise to initiate funds transfer from the bank or financial institution account indicated below. I authorize my financial institution to honor these transfers.

Account Holder's Name (print)		
Financial Institution or Bank Name		
Financial Institution/Bank City	State	ZIP
Bank Routing Number (see picture below)	Account Number (see picture below)	☐ Checking ☐ Savings



Bank Routing Number Account Number

> ***Routing Number***
> We can't set up automatic withdrawals with bank routing numbers that begin with a "5." If your routing number begins with a "5," call your bank to get the correct bank routing number.

Additional Terms and Conditions:

- Funds are transferred on the 3rd business day of each month to pay for that month's coverage. (For example, the deduction on January 3rd pays for coverage in January.)
- I understand that my monthly premiums will be automatically withdrawn from my bank account each month until I notify LifeWise that it should be cancelled. To ensure prompt cancellation, I must notify LifeWise no later than the 20th of the month to be effective for the following month's automatic withdrawal. I have the right to stop payment on a specific bank transfer at least 3 days prior to the next scheduled withdrawal date. I agree to indemnify and hold harmless LifeWise for any claim arising out of transfers or deductions from my account pursuant to this agreement.
- It may take as long as 45 days to set up the funds transfer. I may receive a paper bill to cover the initial month(s) while the transfer is being set up.

Account Holder Signature X ______________________ **Today's Date** ____ / ____ / ____

E Your Health Coverage Information

If you have lost or are losing other health coverage and received a notice saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy or that you had certain rights to buy a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement policies. **Please answer all questions.**

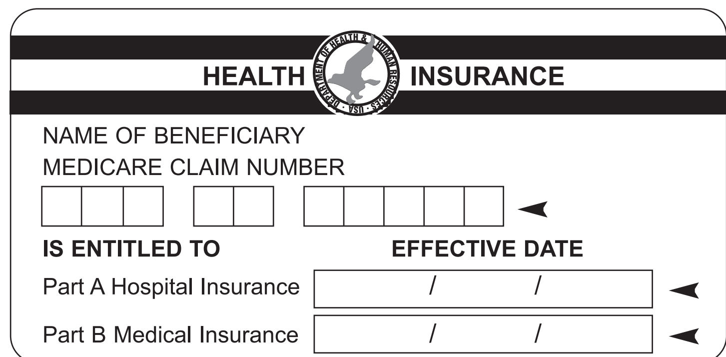
To the best of your knowledge: (Please mark Yes or No below with an "**X.**")

☐Y ☐N **1.** a. Did you turn age 65 in the last 6 months?

☐Y ☐N b. Did you enroll in Medicare Part B in the last 6 months?

c. If **Yes**, what is the effective date? ________ / ________ / ________

You must include a copy of your Medicare card or fill in all boxes to the right. We cannot process your application without this information.



☐Y ☐N **2.** a. Are you covered for any 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.

☐Y ☐N b. If **Yes**, will Medicaid pay your premiums for this Medicare Supplement policy?

☐Y ☐N c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium?

3. a. If you had coverage from any Medicare policy other than original Medicare within the last 63 days (for example, a Medicare Advantage policy, or a Medicare HMO or PPO), fill in your start and end dates below. **If you are still covered under this policy**, leave "End" blank

Start: ________ / ________ / ________ End: ________ / ________ / ________

☐Y ☐N b. If you are still covered under the Medicare policy, do you intend to replace your current coverage with this new Medicare Supplement policy?

☐Y ☐N c. Was this your first time in this type of Medicare policy?

☐Y ☐N d. Did you drop a Medicare Supplement policy to enroll in the Medicare policy?

☐Y ☐N **4.** a. Do you have another Medicare Supplement policy in force?

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

Company: ______________________________ Policy: ___________________________________

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

☐Y ☐N **5.** a. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual policy).

b. If so, with what company and what kind of policy?

Company: ______________________________ Policy: __________________________________

c. What are your dates of coverage under the other policy? **If you are still covered under the same policy**, leave "End" blank.

Start: ________ / ________ / ________ End: ________ / ________ / ________

E Your Health Coverage Information, continued

☐Y ☐N **6.** a. Are you currently enrolled in a Medicare Supplement policy or a policy offered by LifeWise Health Plan of Oregon or a LifeWise affiliate company?

☐Y ☐N b. If **Yes**, do you wish to terminate that coverage? If you answered Yes, complete the statement below:

I, ________________________wish to terminate my ______________________ (policy name) individual medical coverage effective _____/_____/________ (the effective date of this Medicare Supplement policy).

F Do you need to complete "Section G: Your Health Conditions?"

If you can answer "**Yes**" to any of the questions listed below, you **DO NOT** need to complete Section G: Health Conditions. Please submit proof of prior coverage that supports "Yes" answers.

You are applying for coverage during your Open Enrollment period:

☐Y ☐N A. You are applying for coverage prior to or during the 6-month period beginning on the first day of the first month in which you are 65 years of age or older and enrolled for benefits under Medicare Part B OR you are eligible due to disability and you enrolled in Medicare Part B in the last six months.

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

☐Y ☐N B. For Plans A, F and High Deductible F—your Medicare Advantage policy or Program of All-Inclusive Care for the Elderly (PACE) terminated or no longer provided service in your area or you moved out of the service area.

☐Y ☐N C. For Plans A, F and High Deductible F—you were covered by an employer's group health plan that provided health benefits and the plan terminated or no longer provided benefits.

☐Y ☐N D. For Plans A, F and High Deductible F—you were covered by a state Medicaid policy that provided health benefits that supplemented the benefits of Medicare and the policy terminated or stopped providing all supplemental health benefits.

☐Y ☐N E. For Plans A, F and High Deductible F—your Medicare Supplement policy enrollment terminated because the insurer became insolvent or bankrupt.

☐Y ☐N F. For Plans A, F and High Deductible F—your Medicare Supplement insurer violated a material provision of the policy or the agent materially misrepresented the policy's provisions in marketing the policy.

☐Y ☐N G. You terminated your LifeWise Medicare Supplement policy and enrolled in a Medicare Advantage policy then voluntarily disenrolled from that policy within the first 12 months of enrolling. (You may enroll in the LifeWise Medicare Supplement policy you were previously enrolled in, however, if that Medicare Supplement policy is not available, you may enroll in Plans A, F or High Deductible F).

☐Y ☐N H. You joined a Medicare Advantage policy or a PACE program when you were first eligible for Medicare and within the first year of joining that policy, you decide to disenroll. (You may enroll in any of our Medicare Supplement policies).

Please submit proof of prior coverage that supports any "**Yes**" answers for the above questions.

G Your Health Conditions

STOP! You only need to complete this section if you answered "No" to all questions in Section F. If you answered "Yes" to any question in Section F please SKIP this section and move on to Section H.

1. Have you had any of the following conditions or received treatment during the past five years? Please mark (**X**) each condition "Yes" or "No" or the application will be returned.

- ☐Y ☐N **1a.** Alcohol—Dependence or Abuse
- ☐Y ☐N **1b.** Chemical/Drug—Dependence or Abuse
- ☐Y ☐N **1c.** DWI/DUI Violations
- ☐Y ☐N **2a.** Lupus (Not discoid)
- ☐Y ☐N **2b.** Scleroderma
- ☐Y ☐N **2c.** Mixed Connective Tissue
- ☐Y ☐N **3a.** Anemia (Not iron deficiency or controlled pernicious anemia)
- ☐Y ☐N **3b.** Bleeding Disorders (coagulation defect)
- ☐Y ☐N **3c.** Hypercoagulation Disorders
- ☐Y ☐N **3d.** Blood Disorder (Agranulocytosis, TCP, etc)
- ☐Y ☐N **3e.** Leukemia
- ☐Y ☐N **3f.** Aneurysm: brain, aortic
- ☐Y ☐N **3g.** Impaired Circulation
- ☐Y ☐N **3h.** High Cholesterol, Triglycerides
- ☐Y ☐N **3i.** High Blood Pressure: Non-smoker
- ☐Y ☐N **3j.** High Blood Pressure: Smoker
- ☐Y ☐N **3k.** Phlebitis (superficial)
- ☐Y ☐N **3l.** Clots (DVT)/Thrombophlebitis
- ☐Y ☐N **3m.** Raynauds (non-smoker)
- ☐Y ☐N **3n.** Raynauds (smoker)
- ☐Y ☐N **3o.** Peripheral Vascular Disease (PVD)
- ☐Y ☐N **4a.** Congenital Disorder/Birth Defects (mild to moderate)
- ☐Y ☐N **4b.** Congenital Disorder/Birth Defects (severe)
- ☐Y ☐N **5a.** Nasal Malformation/Deviated Septum
- ☐Y ☐N **5b.** Nasal Polyps
- ☐Y ☐N **5c.** Recurrent Sinusitis
- ☐Y ☐N **5d.** Tonsillitis
- ☐Y ☐N **5e.** Crossed Eyes/Strabismus
- ☐Y ☐N **5f.** Detached Retina
- ☐Y ☐N **5g.** Macular: Degeneration (Verteporfin treatment)
- ☐Y ☐N **5h.** Macular: Degeneration (No Verteporfin treatment)
- ☐Y ☐N **5i.** Macular: Tear or Hole
- ☐Y ☐N **5j.** Cataract(s)/Lens Implants
- ☐Y ☐N **5k.** Glaucoma
- ☐Y ☐N **6a.** Swallowing Problems
- ☐Y ☐N **6b.** GERD/Acid Reflux/Hiatal Hernia
- ☐Y ☐N **6c.** Stomach/Intestinal Ulcers
- ☐Y ☐N **6d.** Chronic Abdominal Pain
- ☐Y ☐N **6e.** Gallbladder Disorder/Gallstones
- ☐Y ☐N **6f.** Diverticulitis
- ☐Y ☐N **6g.** Hemorrhoids
- ☐Y ☐N **6h.** Irritable Bowel Syndrome
- ☐Y ☐N **6i.** Ulcerative Colitis
- ☐Y ☐N **6j.** Crohn's Disease
- ☐Y ☐N **6k.** Colitis
- ☐Y ☐N **6l.** Hernia (Inguinal, Umbilical, Femoral, or Scrotal)
- ☐Y ☐N **6m.** Polyps: Gastrointestinal, Rectal
- ☐Y ☐N **6n.** Weight gain or loss of 10 lbs or more within 1 year
- ☐Y ☐N **7a.** Diabetes
- ☐Y ☐N **7b.** Elevated Blood Sugar
- ☐Y ☐N **7c.** Goiter
- ☐Y ☐N **7d.** Thyroid Nodule
- ☐Y ☐N **7e.** Hyperthyroidism
- ☐Y ☐N **7f.** Hypothyroidism
- ☐Y ☐N **7g.** Other Adrenal/Pituitary Condition
- ☐Y ☐N **7h.** Addison's Disease (adrenal insufficiency)
- ☐Y ☐N **7i.** Cushing's Disease (hyperadrenocorticism)
- ☐Y ☐N **8a.** Angina/Chest Pain
- ☐Y ☐N **8b.** Heart Attack
- ☐Y ☐N **8c.** Arterio-Atherosclerosis/Coronary Artery Disease

G Your Health Conditions, continued

1. Have you had any of the following conditions or received treatment during the past five years?

- ☐Y ☐N **8d.** Congestive Heart Failure (includes cardiomyopathy, cardiomegaly)
- ☐Y ☐N **8e.** Heart Murmur
- ☐Y ☐N **8f.** Arrhythmia: controlled
- ☐Y ☐N **8g.** Arrhythmia: severe or not controlled
- ☐Y ☐N **8h.** Pacemaker: post surgery/repair not anticipated, no complications
- ☐Y ☐N **8i.** Pacemaker: pending surgery/repair or with complications
- ☐Y ☐N **8j.** Heart Valve: Stenosis
- ☐Y ☐N **8k.** Heart Valve: Regurgitation or Prolapse: minor
- ☐Y ☐N **8l.** Heart Valve: Regurgitation or Prolapse: moderate/severe
- ☐Y ☐N **8m.** Heart Valve: Infection
- ☐Y ☐N **8n.** Heart Valve: replaced (transplant, artifical valve)
- ☐Y ☐N **9a.** AIDS/AIDS Related Complex/HIV Positive
- ☐Y ☐N **10a.** Bladder: Infections
- ☐Y ☐N **10b.** Bladder: Incontinence (Not stress)/ Retention
- ☐Y ☐N **10c.** Kidney Infections (recovered from single episode)
- ☐Y ☐N **10d.** Kidney Infections (not recovered or recurring)
- ☐Y ☐N **10e.** Kidney Stones
- ☐Y ☐N **10f.** Kidney Failure/Nephritis
- ☐Y ☐N **11a.** Hepatitis A
- ☐Y ☐N **11b.** Hepatitis B
- ☐Y ☐N **11c.** Hepatitis C
- ☐Y ☐N **11d.** Hepatitis Other
- ☐Y ☐N **11e.** Cirrhosis/Liver Failure
- ☐Y ☐N **12a.** Chronic Back or Neck Pain/Strain
- ☐Y ☐N **12b.** Disc Problems: Bulging, Herniated, Slipped, Ruptured
- ☐Y ☐N **12c.** Bone Spurs
- ☐Y ☐N **12d.** Arthritis
- ☐Y ☐N **12e.** Rheumatoid Arthritis
- ☐Y ☐N **12f.** Osteoporosis/Bone Disorder
- ☐Y ☐N **12g.** Fibromyalgia/Myositis
- ☐Y ☐N **12h.** Chronic Fatigue Syndrome
- ☐Y ☐N **12i.** Muscular Dystrophy
- ☐Y ☐N **12j.** Polio Residuals
- ☐Y ☐N **12k.** Bursitis
- ☐Y ☐N **12l.** Gout
- ☐Y ☐N **12m.** Carpal Tunnel Syndrome
- ☐Y ☐N **12n.** Tendonitis/Repetitive Stress Injury
- ☐Y ☐N **12o.** Joint Disorder
- ☐Y ☐N **12p.** Joint Replacement: post revision/future surgery not anticipated
- ☐Y ☐N **12q.** Joint Replacement: surgery/revision pending or completed recently
- ☐Y ☐N **12r.** Joint Dislocation
- ☐Y ☐N **12s.** Foot Disorder/Bunions/Hammertoe
- ☐Y ☐N **12t.** Fractures
- ☐Y ☐N **12u.** Fracture: pathological
- ☐Y ☐N **12v.** Gait Abnormality
- ☐Y ☐N **12w.** Loss of Limb(s)
- ☐Y ☐N **12x.** Loss of Limb(s) due to disease
- ☐Y ☐N **12y.** Chronic Pain/Decreased Range of Motion
- ☐Y ☐N **12z.** Chronic Pain (Narcotic/Injury Pain Management)
- ☐Y ☐N **13a.** Schizophrenia
- ☐Y ☐N **13b.** Bipolar Mood
- ☐Y ☐N **13c.** Psychosis
- ☐Y ☐N **13d.** Depressive Disorder
- ☐Y ☐N **13e.** Anxiety
- ☐Y ☐N **13f.** Attempted Suicide
- ☐Y ☐N **13g.** Anorexia
- ☐Y ☐N **13h.** Bulimia
- ☐Y ☐N **13i.** Attention Deficit Hyperactivity Disorder
- ☐Y ☐N **14a.** Traumatic Brain Injury
- ☐Y ☐N **14b.** Seizures
- ☐Y ☐N **14c.** Cerebral Palsy
- ☐Y ☐N **14d.** Stroke/TIA
- ☐Y ☐N **14e.** Paralysis
- ☐Y ☐N **14f.** Headaches (Recurrent or Migraine)
- ☐Y ☐N **14g.** Multiple Sclerosis

G Your Health Conditions, continued

1. Have you had any of the following conditions or received treatment during the past five years?

- ☐Y ☐N **14h.** Alzheimer's Disease
- ☐Y ☐N **14i.** Huntington's Chorea
- ☐Y ☐N **14j.** Amyotrophic Lateral Sclerosis
- ☐Y ☐N **14k.** Parkinson's Disease/Syndrome
- ☐Y ☐N **14l.** Other progressive neurological disorder
- ☐Y ☐N **14m.** Meningitis/Encephalitis (present, recurring)
- ☐Y ☐N **14n.** Meningitis/Encephalitis (resolved)
- ☐Y ☐N **14o.** Neurodevelopmental/Cognitive/Motor/ Speech Delay (ambulatory: mild to moderate)
- ☐Y ☐N **14p.** Neurodevelopmental/Cognitive/Motor/ Speech Delay (ambulatory: significant)
- ☐Y ☐N **14q.** Neurodevelopmental/Cognitive/Motor/ Speech Delay (profound)
- ☐Y ☐N **15a.** Transplant (excludes corneal)
- ☐Y ☐N **15b.** Critical Organ Cyst/Tumor (present)
- ☐Y ☐N **15c.** Critical Organ Cyst/Tumor (removed)
- ☐Y ☐N **15d.** Cancer: Local
- ☐Y ☐N **15e.** Cancer: Regional
- ☐Y ☐N **15f.** Cancer (Metastastic, Sarcoma, Lymphoma, Myeloma, Hodgkins, Bone)
- ☐Y ☐N **15g.** Cancer Squamous/Basal Cell
- ☐Y ☐N **16a.** Breast Disorder/Fibrocystic Breast Disease/Implant
- ☐Y ☐N **16b.** Abnormal Pap Smear (benign, reactive cellular)
- ☐Y ☐N **16c.** Cervical Dysplasia
- ☐Y ☐N **16d.** Endometrium: Endometriosis/Hyperplasia
- ☐Y ☐N **16e.** Uterine Fibroids
- ☐Y ☐N **16f.** Uterine/ Cervix Polyps
- ☐Y ☐N **16g.** Ovarian: Cyst
- ☐Y ☐N **16h.** Testicular: Cyst/Torsion/Lump
- ☐Y ☐N **16i.** Enlarged Prostate
- ☐Y ☐N **16j.** Prostatitis
- ☐Y ☐N **16k.** Sexual Dysfunction or Impotence
- ☐Y ☐N **17a.** Allergies/Hay Fever (Not mild/seasonal)
- ☐Y ☐N **17b.** Asthma/Reactive Airway Disease (non-status asthmaticus)
- ☐Y ☐N **17c.** Asthma: status asthmaticus
- ☐Y ☐N **17d.** Sleep apnea
- ☐Y ☐N **17e.** Chronic Bronchitis
- ☐Y ☐N **17f.** Pneumonia
- ☐Y ☐N **17g.** Tuberculosis
- ☐Y ☐N **17h.** Pulmonary Embolism (Lung Clot) recovered
- ☐Y ☐N **17i.** Pulmonary Embolism (Lung Clot) present or recurring
- ☐Y ☐N **17j.** Collapsed Lung
- ☐Y ☐N **17k.** Chronic Obstructive Lung Disease
- ☐Y ☐N **18a.** Genital Herpes
- ☐Y ☐N **18b.** Human Pap. Virus (HPV/Genital Warts)
- ☐Y ☐N **18c.** Other Sexually Transmitted Diseases
- ☐Y ☐N **19a.** Severe: Burns/Scars
- ☐Y ☐N **19b.** Skin Ulcers

G Your Health Conditions, continued

2. If you have answered "Yes" to ANY of the previous questions in this section or have experienced any other health issues in the past 5 years, complete this question.

   Attach additional sheets if needed. You may wish to submit copies of relevant medical records to expedite the process (at your own expense).

Enter Condition Number: ☐	Condition Name	Dates of Condition (leave "End" date blank if ongoing) Start: ____/____/_____ End: ____/____/_____
Description of Treatment		Number of days in hospital, if applicable (inpatient stays only): ☐ Days (total)
Do you still have this condition? ☐ Yes, my condition persists ☐ No, my condition is resolved. Please describe:		Do you anticipate future care? ☐ Yes. ☐ No, my condition is resolved. Please describe:

Enter Condition Number: ☐	Condition Name	Dates of Condition (leave "End" date blank if ongoing) Start: ____/____/_____ End: ____/____/_____
Description of Treatment		Number of days in hospital, if applicable (inpatient stays only): ☐ Days (total)
Do you still have this condition? ☐ Yes, my condition persists ☐ No, my condition is resolved. Please describe:		Do you anticipate future care? ☐ Yes. ☐ No, my condition is resolved. Please describe:

Enter Condition Number: ☐	Condition Name	Dates of Condition (leave "End" date blank if ongoing) Start: ____/____/_____ End: ____/____/_____
Description of Treatment		Number of days in hospital, if applicable (inpatient stays only): ☐ Days (total)
Do you still have this condition? ☐ Yes, my condition persists ☐ No, my condition is resolved. Please describe:		Do you anticipate future care? ☐ Yes. ☐ No, my condition is resolved. Please describe:

G Your Health Conditions, continued

3. Have you taken medications within the past year?

   ☐ Yes. Please enter your medication information in the table provided below and also answer questions 4 and 5.

   ☐ No. Please move on to questions 4 and 5.

Medication name	Dose—how much medication you take every day	Duration	Diagnosis
	________ **mg** **ml** (circle one) ________ (times per day)		
	________ **mg** **ml** (circle one) ________ (times per day)		
	________ **mg** **ml** (circle one) ________ (times per day)		

4. Has any insurance company refused or restricted any insurance coverage for you?

   ☐ Yes. Explain in the area provided below.

   ☐ No.

____

____

5. Has any other future surgery, diagnostic testing or medical treatment been recommended or discussed for you?

   ☐ Yes. Explain in the area provided below.

   ☐ No.

____

____

H Conditions of Enrollment/Signatures

I, the undersigned, apply for enrollment with LifeWise Health Plan of Oregon (LifeWise). I represent that all statements and answers on this application are complete and true. I understand coverage is available to me due to: (1) my residing in Oregon, and (2) my enrollment in Medicare Parts A and B. I understand and agree that coverage does not begin until LifeWise accepts this application and assigns an effective date of coverage and that receipt of my money (cash, check or money order) does not constitute enrollment under any Medicare Supplement program. I authorize LifeWise, at its option, to pay providers directly for services rendered. I also understand and agree that LifeWise may:

1. Accept this application; or
2. Deny this application, in which case any future premiums submitted will be refunded to, and accepted by me; or
3. Cancel my contract retroactively within the first two years of coverage, if it is found that I have supplied false information, or any material information was omitted by or for me on this application.

I understand that LifeWise may collect, use, and disclose personal information about me as required or permitted by law or to perform routine business functions, such as determining my eligibility for enrollment, credit for waiting periods, and benefits; paying claims; and fulfilling other obligations stated in its contract with me. If LifeWise discloses my personal information for any other reason, LifeWise will first remove any data that can be used to easily identify me or will get my signed authorization.

AUTHORIZATION FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

TYPE OF INFORMATION TO BE DISCLOSED: I authorize: any physician; healthcare provider; hospital; insurance or reinsurance company; or the Medical Information Bureau, Inc. (MIB) to disclose a copy of my personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders and mental illness to LifeWise Health Plan of Oregon or its representative.

PURPOSE OF DISCLOSURE: I understand that personal information will be used for underwriting, evaluating enrollment in the health plan, determining eligibility for benefits and paying claims.

TIMEFRAME OF RELEASE: Unless I revoke it, this release will remain valid for twenty-four (24) months from the date of my signature below.

REVOCATION OF RELEASE: I understand that I may change my mind and revoke this release at any time. I will do this by letting LifeWise know of my decision. Any change will be effective five (5) business days after LifeWise receives my written notice at the address listed on this form. I understand that some or all of this information may already have been used by LifeWise to make decisions, which will not be affected by its revocation.

REDISCLOSURE: LifeWise Health Plan of Oregon may be required to redisclose this information to another party that is not subject to state and federal privacy rules.

EFFECT OF DECLINING TO SIGN THIS AUTHORIZATION: This authorization is a condition of your enrollment in our health plan or your eligibility for benefits. If you decide not to sign this authorization, we may decline to enroll you in our health plan or to give you benefits.

☐ **Yes** ☐ **No** I understand that the Medicare Supplement contract will not pay benefits during the first six months after the effective date for any condition for which I have had treatment, medicine or diagnostic testing within the six months prior to my effective date. I understand that, under certain conditions, this limitation may be shortened or waived. The waiting period may be waived if I apply for this contract within 63 days of leaving other health-care coverage and I provide proof with this application. I have provided such proof.

Signature of Applicant	Today's Date
X	

I Final Checklist

To help us process your application faster, please be sure that you have completed the following:

- ☐ You must be enrolled (or have proof of enrollment) in both Medicare Part A (hospital insurance) and Part B (medical insurance). You also must reside in Oregon.
- ☐ Sign and date the application.
- ☐ Include a copy of the certificate of coverage from your prior insurer if needed.

J Producer Information (if applicable)

If this application is being submitted through a producer, he or she must complete the information below and a Notice of Replacement, if appropriate. If all information is not complete, this application will be returned.

Completion of this section by a producer is required.

1. List any other medical or health insurance policies sold to the applicant. ______________________________

____

2. List policies sold which are still in force. ______________________________

____

3. List policies sold in the past five years which are no longer in force. ______________________________

____

4. ☐ Yes ☐ No: Did you see the applicant at the time this application was executed?

   If the answer is "No," please explain: ____

____

____

____

Producer Name (Please Print)	LifeWise Producer Number	Telephone Number
Dann Loewenthal	5304B	541.434.9613

Street Address	City	State	ZIP
PO Box 26540	Eugene	OR	97402

Producer Signature	Date
X	

FOR COMPANY USE ONLY		
Producer Number	Group Number	Effective Date