

Thank you for your interest in applying for the Health Net Medicare Supplement plan!

This application needs to be reviewed and signed by an Agent before it can be submitted to Health Net. You may email, fax or mail it in to CDA Insurance:

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

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf)
Download Policy Outline (.pdf)

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



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HEALTH NET HEALTH PLAN OF OREGON, INC.
MEDICARE SUPPLEMENT COVERAGE APPLICATION

Please follow these application instructions:

Complete your application, provide any supporting information requested, then sign and date it where indicated.
If your spouse or Registered Domestic Partner is applying to be insured, please complete a separate application.
If your application is approved, the contract will become effective on the first of the month following the date that Health Net Health Plan of Oregon, Inc. (Health Net of Oregon) receives your completed application and premium payment.

Upon acceptance by Health Net of Oregon, this application becomes part of your contract.

I. Check the Health Net Medicare Supplement Plan for which you are applying:

- Plan A, Plan F, Plan F with high deductible, Plan K, Plan M

II. Your Personal Information:

Form with fields for Last name, First name, Initial, Birth date, Sex, Residence address street, City, State, ZIP, Home phone, PO Box, Work phone, Social Security Number, Requested start date, Email address.

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card
- OR -
Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.



SAMPLE ONLY

Name:
Medicare Claim Number Sex
Is Entitled To Effective Date
HOSPITAL (Part A)
MEDICAL (Part B)

Applicant, please go to the next page

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III. Existing insurance information

Note that 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 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).

IV. Current health plan information

Under certain circumstances, we cannot deny you enrollment under this policy. In general, this applies when you have recently terminated coverage under a prior policy. To qualify for a Health Net of Oregon Medicare supplement policy, your prior coverage and manner of termination must meet certain requirements. You must also enroll under the Health Net of Oregon plan (and provide proof of termination of the previous plan) within 63 days of that termination.

To determine if you qualify, please answer the following questions to the best of your knowledge:

Did you turn age 65 in the last six months? Yes No

Did you enroll in Medicare Part B in the last six months? Yes No

If "Yes," what was the effective date? ____/____/_____
(MM / DD / YYYY)

Are you covered for medical assistance through the state Medicaid program? Yes No

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. If "Yes,"

(a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes No

(b) Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium? Yes No

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IV. Current health plan information (continued)

If 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), fill in your start and end dates below. If you are still covered under this plan, leave "End" section blank.

Start ____/____/____ End ____/____/____
(MM / DD / YYYY) (MM / DD / YYYY)

If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes No

Was this your first time in this type of Medicare plan? Yes No

Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes No

Do you have another Medicare supplement policy in force? Yes No

If so, with what company, and what plan do you have? _____

If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No

Have you had coverage under any other health insurance within the past 63 days? Yes No
(For example, an employer, union, or individual plan.)

If so, with what company and what kind of policy? _____

What are your dates of coverage under the other policy?

Start ____/____/____ End ____/____/____
(MM / DD / YYYY) (MM / DD / YYYY)

If you are still covered under the other policy, leave "End" section blank.

Are you covered for medical assistance through the state Medicare program as (1) a Specified Low Income Medicare Beneficiary (SLMB), (2) a Qualified Medicare Beneficiary (QMB), or (3) for other Medicaid medical benefits?

Yes No

V. Health Statement Requirement/Medicare Supplement Open Enrollment and Guaranteed Issue Periods

If you are in a Medicare Supplement Open Enrollment Period (OEP) or think you qualify for guaranteed issuance of a Medicare Supplement plan, please check the appropriate OEP or Guaranteed Issue Period below.

If you check one or more of the boxes below, you do NOT need to complete Section VI, the "Current health statement" portion of this application.

Please attach any supporting documents related to your OEP or Guaranteed Issue Period.

You are age 65 or older, have Medicare Part A and are newly enrolled in Medicare Part B, or you already have Medicare because you are disabled and have just turned 65.

You are under age 65 and newly entitled to Medicare Part B because of disability.

You enrolled in a Medicare Advantage or PACE Provider Plan upon first becoming eligible for benefits under Medicare Part A at 65 years of age, and then you disenrolled from the Medicare Advantage or PACE Provider Plan within 12 months of the effective date of enrollment.

You disenrolled from a Medicare Supplement Plan to enroll for the first time in a Medicare Select or Medicare Advantage Plan, and then voluntarily disenrolled within 12 months of coverage.

You enrolled in a Medicare Advantage Plan, but coverage was terminated because the Plan terminated its Medicare Advantage contract, or the Plan discontinued offering coverage in your service area, or you no longer reside in the Medicare Advantage service area.

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V. Health Statement Requirement/Medicare Supplement Open Enrollment and Guaranteed Issue Periods (continued)

- You are enrolled in Medicare Part B, and have received a notice of termination or have been terminated from an employer-sponsored health plan, employer-sponsored retiree health plan (including coverage under COBRA), or are no longer eligible for employer-sponsored health plan coverage due to the divorce or death of a spouse.
- You are enrolled in Medicare Part B and enrolled in a Medicare Select Plan, but you can no longer retain the coverage because you moved outside the plan’s service area.
- You enrolled in a Medicare Supplement Plan but coverage stopped because the company filed bankruptcy or insolvency, or the company involuntarily terminated coverage, or the company violated a material provision of the Plan, or the company, or an agent acting on its behalf, materially misrepresented a provision of the plan.
- You are enrolled in a Medicare Advantage Plan but stopped coverage because the company, or an agent acting on its behalf, materially misrepresented a provision of the plan.

If you checked any of the boxes above, do not complete the health statement that follows. Go to page 6. Complete Section VII, “Payment options.” Read, sign and date Section VIII, “Conditional authorization to use and disclose Protected Health Information” section.

If you have not checked any of these boxes, you must complete Section VI, “Current health statement.”

NOTE: If you are transferring from one Health Net of Oregon Medicare Supplement plan to another Health Net of Oregon Supplement plan, you must complete the health statement below and on the next two pages.

If you are unsure if you should complete the health statement, please call **1-800-709-4193 (TTY 1-800-929-9955)** for help from a Health Net Sales Representative.

VI. Current health statement

Genetic Information and Non-discrimination Act of 2008 (GINA) compliance statement

This insurance application is not a request for genetic information. In answering these questions, you should not include any genetic information. That is, please do not include family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic disease for which you believe you may be at risk.

Answer the following health questions to the best of your knowledge. If you need more space for additional information, please attach a separate sheet.

Current height:	Current weight:
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Medications: List all medications that you are currently taking.

Medication name	Name/address/telephone of prescriber	Date prescribed

Condition	Yes	No	Date of last treatment
Alcohol/chemical/drug abuse/habit	<input type="checkbox"/>	<input type="checkbox"/>	
Liver condition/hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Knee/shoulder/hip/other joints	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes/sugar in urine	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach disorders/ulcer/acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder/urinary tract	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney/kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	
Reproductive system disorder/infertility	<input type="checkbox"/>	<input type="checkbox"/>	
Prostate/elevated PSA/prostatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Tumors	<input type="checkbox"/>	<input type="checkbox"/>	
AIDS/ARC/HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	
Lupus/chronic muscle pain/muscle injury or disease, or fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological condition/disease/injury	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke/paralysis/seizures	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure (If "Yes," please record last reading.): _____	<input type="checkbox"/>	<input type="checkbox"/>	
Heart/chest pain/angina	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine/gland/hormone system	<input type="checkbox"/>	<input type="checkbox"/>	
Disease or injury of eye/cataract/glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic ear/nose/throat/tonsil condition/disease/disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema/asthma/chronic lung disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	

Additional health questions

Have you had any medical advice, diagnosis, care or treatment – including prescribed medications – recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement not listed above? Yes No

Have you had chronic cough, fatigue, diarrhea or enlarged glands? Yes No

Have you been advised to have or contemplated having an operation or medical procedure not yet performed? Yes No

Have you been scheduled to see a health care provider? Yes No

Have you taken any prescription medication on a regular basis? Yes No

VII. Payment options

Initial payment:

You will be billed for your initial premium upon acceptance.

Future payment (check box):

Mail-in premium payment Automatic Bank Draft/Premium payment

Health Net of Oregon may change or amend this policy upon prior approval from the Oregon Insurance Division by giving the subscriber thirty (30) days’ notice before the change is effective.

VIII. Certification of completion and correctness

I affirm that the answers given in this application are complete and correct. I have provided these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that if this application contains any material misstatements or omissions, the insurance carrier may, within the first two years of coverage, deny coverage, modify or cancel the contract, or take other legal action. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes this incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by the insurance carrier. If approved, coverage will be in force as of the effective date determined by the carrier. The carrier may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

Conditional authorization to use and disclose Protected Health Information

Note: All applicants must sign and date the following authorization.

To any physician; health care provider, including OHSU; hospital, including OHSU; insurance or reinsurance company; the Medical Information Bureau, Inc. (MIB), or other insurance information exchange:

I authorize you to give Health Net Health Plan of Oregon, Inc. or its representatives any medical record information (including alcohol, chemical dependency, mental treatment, or HIV treatment) you have about me. Such information may be used for processing application for coverage, for prior authorizing services or processing claims for benefits, or for purposes of health care provider credentialing, quality assurance, utilization review, case management, peer review, and audit. A photocopy of this authorization is as valid as the original. I understand that I may receive a copy of this authorization upon request.

This authorization takes effect on the date signed, and it remains in effect as follows:

- For information used to process this application – 30 months.
- For information used for all the other reasons listed above – as long as coverage is in effect or until the completion of processing any claim, whichever is longer.

Printed name: _____

Date: _____

Applicant’s signature: _____

(MM / DD / YYYY)

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INSURANCE PRODUCER USE ONLY

I certify that the information supplied by the applicant has been truly and accurately recorded and that I have made no representation about benefits, conditions, or limitations of the contract except through written material furnished by Health Net of Oregon. I have provided the applicant with a notice regarding replacement of Medicare supplement coverage if applicable.

Sales Rep name (please print): _____

Phone: (_____) _____

Sales Rep signature: _____

Insurance Producer name (please print): _____

Phone: (_____)

Producer ID #: _____

Email address: _____

FMO/GA/Agency name: _____

Insurance Producer signature: _____

Date: ____/____/____
(MM / DD / YYYY)



Health Net®

Health Net Health Plan of Oregon, Inc.
13221 SW 68th Pkwy., Ste. 200
Tigard, OR 97223

To speak to a Health Net Sales Representative,
please call **1-800-709-4193 (TTY 1-800-929-9955)**.

www.healthnet.com

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HEALTH NET HEALTH PLAN OF OREGON, INC.

2012 MEDICARE SUPPLEMENT ROUTINE VISION OPTIONAL BENEFIT INDIVIDUAL APPLICATION

ROUTINE VISION OPTIONAL BENEFIT

Monthly Premium: \$5

Benefits: Routine eye exam and routine eyewear

In order to apply for the Routine Vision Optional Benefit, you must apply for or be enrolled in a Health Net Health Plan of Oregon, Inc. (Health Net of Oregon) Medicare Supplement plan.

PLEASE PRINT

Last name:		First name:		MI:	Birth date: / /
Residential Street Address:			City:	State:	ZIP:
Mailing Address (if different from above):			City:	State:	ZIP:
Home phone: ()	Work phone: ()	Email address:			
Medicare # <i>(from red, white, & blue Medicare card)</i> :		Health Net member/subscriber Reference # (if applicable):			

Health Net of Oregon will notify you of the effective date of your Routine Vision Optional Benefit coverage.

The premium for the Routine Vision Optional Benefit is in addition to the Health Net of Oregon Medicare Supplement monthly plan premium. Premiums for the Routine Vision Optional Benefit will be added to your Medicare Supplement plan billing and set up on the same premium payment mode (i.e., check or automatic bank draft) as your Medicare Supplement plan.

I understand that to be eligible for the Routine Vision Optional Benefit, I must remain a member of a Health Net of Oregon Medicare Supplement plan. If I disenroll from my Medicare Supplement plan or my Medicare Supplement plan otherwise terminates, I will be automatically disenrolled from the Routine Vision Optional Benefit. If I discontinue payment of the Routine Vision Optional Benefit, my membership in this optional benefit will be terminated, and I will only be enrolled in the Health Net of Oregon Medicare Supplement plan. I may cancel the Routine Vision Optional Benefit at any time by providing written notification to Health Net of Oregon. Enrollment in the Routine Vision Optional Benefit will cease the first of the month after receipt of the written notification. However, once disenrolled from the Routine Vision Optional Benefit, re-enrollment cannot occur until the following calendar year.

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Please refer to the 2012 Optional Benefit Guide: Routine Vision Optional Benefit or to your Routine Vision Optional Benefit Schedule for additional information on covered benefits and eligibility.

Please complete the following:

I am applying for or currently enrolled in a Health Net of Oregon Medicare Supplement plan and wish to enroll in the Routine Vision Optional Benefit for an additional monthly premium of \$5.

I understand that my signature on this application means that I have read and understand the contents of this application.

Printed name of applicant: _____

Signature of applicant: _____ Date: __ __/__ __/_____
(M M/ D D / Y Y Y Y)

Signature of Health Net representative (*if applicable*):

_____ Date: __ __/__ __/_____
(M M/ D D / Y Y Y Y)

After you have completed this form, please mail it to:

**Health Net Health Plan of Oregon, Inc.
Attn: Medicare Supplement Plans
13221 SW 68th Pkwy., Ste. 200
Tigard, OR 97223**

Thank you for choosing Health Net of Oregon. If you have any questions about applying for a Health Net Medicare Supplement plan or for the Routine Vision Optional Benefit, please contact a Health Net Sales Representative at **1-800-709-4193** (TTY/TDD **1-800-929-9955**) Monday through Friday, 8:00 a.m. to 6:00 p.m., except holidays.

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