IAC Application Packet

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

This application packet provides you with access to a 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 IAC. 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) Download Policy Outline (.pdf) Download Application (.pdf)

Our website: http://www.medicare-texas.net

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

Individual Assurance Company, Life, Health & Accident
Administrative Office: PO Box 3270, Salt Lake City, UT 84110-3270
Application- Medicare Supplement Insurance

☐ New Business ☐ Reinstatement
☐ Coverage Change

Part I – Personal Information

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other _____

Last Name _____ First Name _____ MI _____

Birthdate (mm/dd/yyyy) _____ Social Security Number _____ Age _____ Height __ ft __ in Weight _____ lbs Gender ☐ Male ☐ Female

Medicare ID Number _____

Street Address

_____

City _____ State ____ Zip _____

Best Time to Call (3 hour interval)_____ to _____ Weekend Calls Yes ☐ No ☐

Daytime Phone _____ Evening Phone _____

Cell Phone _____ E-Mail Address _____

Part II – Plan Selection

Plan Applied For:

☐ A ☐ F ☐ G ☐ N

Tobacco Use:

Have you used any tobacco products, including cigarettes, cigars, chewing tobacco or a pipe, in the past 12 months?

☐ Yes ☐ No

Part III – Eligibility

State law allows a 6 month open enrollment period beginning with the first day of the first month in which you are eligible for Medicare. If you are under age 65 and eligible for Medicare, you may apply for and receive Plan A from us. If you are age 650 or older, you may apply for and receive any Medicare Supplement Plan available from us.

Yes	No		
☐	☐	1)	Are you covered under Medicare Part A? a) If YES, what is your Part A effective date? _____/_____/_____ b) If NO, what is your eligibility date? _____/_____/_____
☐	☐	2)	Are you covered under Medicare Part B? a) If YES, what is your Part B effective date? _____/_____/_____ b) If NO, what is your eligibility date? _____/_____/_____
☐	☐	3)	Did you turn 65 in the last 6 months?

Part IV – Medicare & Insurance Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare Supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, 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 this Application. *Please mark "Yes" or "No" below with an "X", to the best of your knowledge.*

PLEASE ANSWER ALL QUESTIONS

Yes No

☐ ☐ 1) Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility).

☐ ☐ 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 the Cost", please answer "NO" to this question.
If "Yes",

☐ ☐ a) Will Medicaid pay your premiums for this Medicare Supplement policy?

☐ ☐ b) 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 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 *"Effective"* and *"Paid-to"* dates below.
If you are still covered under this plan, leave *"Paid to"* blank.

Effective _____/_____/_____ Paid to _____/_____/_____ (mm/dd/yyyy)

☐ ☐ b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? (If "Yes" complete Replacement Notice.)
If so, with what company? _____

Company Address: _____

☐ ☐ c) Was this your first time in this type of Medicare Plan?

☐ ☐ d) Did you drop a Medicare Supplement policy or certificate to enroll in the Medicare Plan?

☐ ☐ 4) a) Do you have another Medicare Supplement policy or certificate in force?
b) If so, with what company? _____

Company Address: _____

What plan do you have? _____

☐ ☐ c) If so, do you intend to replace your current Medicare Supplement policy or certificate with this policy?
(If "Yes" complete Replacement Notice.)

☐ ☐ 5) Have you had coverage under any other health insurance within the past 63 days?
(for example, an employer, union, or individual plan)

a) If so, with what company? _____

What kind of policy? _____

b) What are your dates of coverage under the other policy?

Effective _____/_____/_____ Paid to _____/_____/_____ (mm/dd/yyyy)

Part V – General Information

1) You do not need more than one Medicare Supplement policy or certificate.

2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy or certificate.

4) 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, effective as of the date of termination of Medicaid, if requested within 90 days of losing your 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.

5) If you are eligible for, and have enrolled in a Medicare Supplement policy or certificate 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 or certificate 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 or certificate under these circumstances, and later lose your employer or union based group health plan, your suspended Medicare Supplement policy or certificate or, if that is no longer available, a substantially equivalent policy or certificate, will be reinstituted if requested within 90 days of losing your employer or union based group health plan. If the Medicare Supplement policy or certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy or certificate was suspended, the reinstituted policy or certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

6) 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).

Part VI – Guarantee Issue Eligibility

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

☐ Enrolled under an employee welfare benefit plan that provides health benefits that either: (1) supplements the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits; or (2) is primary to Medicare and the plan terminates, or ceases to provide all health benefits because the individual leaves the plan *(eligible for Plans A or F)*; or

☐ Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual *(eligible for Plans A or F)*; or

☐ Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual *(eligible for Plans A or F)*; or

☐ Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency or other involuntary termination of coverage or enrollment in the policy, substantial violation of a material policy provision, or material misrepresentation *(eligible for Plans A or F)*; or

☐ Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of enrollment *(eligible for the same Plan you terminated with us, or, if that Plan is no longer available, Plans A or F)*; or

☐ Upon *first* becoming eligible for benefits under Part B at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months *(eligible for all plans available from us)*; or

Part VI – Guarantee Issue Eligibility *(continued)*

☐ Enrolled in a Medicare Part D Plan during the initial Part D enrollment period while enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and terminate the Medicare Supplement policy *(eligible for Plans A or F)*.

☐ Enrolled under Medicaid and your coverage terminated because you lost eligibility for benefits *(eligible for Plans A and F).*

Documentation of these events must be submitted with this Application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

Part VII – Household Premium Discount Information

You may be eligible for a policy with a lower premium rate based on your answers to the questions in this section.

1. Do you have a household resident (at least one but no more than three): Yes ❒ No ❒
   a) With whom you have continuously resided for the last 12 months; or
   b) With whom you reside and to whom you are either married or with whom you are in a civil union partnership?
2. If you answered "YES" to question 1 above, please fill out the following information about the household resident:

Name (First/Middle/Last): _____

Relationship to Applicant: _____

Street Address: _____

City/State/Zip _____

Part VIII – Premium Payment & Administration

Initial Premium _____

For _____ Months

Application fee: (+) $25

Total Amount Submitted: **(=)** _____

Requested Effective Date (*if other than Application Date)*

_____ (mm-dd-yyyy)

Select Bank Draft Day _____ (1st -28th)

(must be on or prior to the application effective date)

☐ I authorize Bank Draft Payments

☐ Draft Initial Amount ☐ Draft Immediately ☐ Draft Initial Premium On (Date) _____

RENEWAL: ☐ Direct Bill ☐ Bank Draft (Account Type: ☐ Checking ☐ Savings)

PREMIUM Mode**:** ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Bank Draft

Bank Routing # (9 digits) Bank Account # (do not include check #)

⎮⎮_____⎮⎮ _____

Bank Name: _____

Name(s) of Depositor(s): _____

If paying premium by Bank Draft, please include a voided check. The first draft will occur on the date your application is approved by Individual Assurance Company (unless specified otherwise).

Part IX – Medical Questions

Do not answer health questions 1-17 if you are in an open enrollment or guaranteed issue period. Please see pages 3-4 for an explanation of open enrollment/guaranteed issue period information.

NOTICE TO APPLICANT: Please answer all of the following questions. Please verify the accuracy and completeness of the medical information on this application. Incomplete or false information on this application could jeopardize future claims. If you answer YES to any of the following questions 1-16, you are not eligible for coverage.

1. Are you currently hospitalized, in a nursing home or assisted living facility, or are you bedridden or confined to a wheelchair?

2. Have you been diagnosed with emphysema, chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disorders?

3. Have you been diagnosed with Parkinson's disease, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with fractures, cirrhosis or chronic hepatitis?

4. Have you been diagnosed with Alzheimer's disease, senile dementia, or any other cognitive disorder?

5. Have you been diagnosed with or treated by a physician or licensed medical professional for acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)?

6. Do you have diabetes that has ever required more than 50 units of insulin daily or do you have diabetes in addition to the following: neuropathy, retinopathy, peripheral artery disease, any heart disorder, stroke, transient ischemic attack (TIA), or kidney disease? If you do **not** have diabetes this question should be answered **"NO".**

7. If you have diabetes with high blood pressure, have you taken more than two medications for either condition or have there been any changes in your medications within the past two years? If you do **not** have diabetes this question should be answered **"NO"**.

8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism, drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease?

9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?

10. Within the past two years have you been treated for degenerative bone disease, crippling / disabling or rheumatoid arthritis or have you been advised to have a joint replacement?

11. Have you been advised by a physician that surgery may be required within twelve (12) months for cataracts?

12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?

13. Have you been hospital confined three or more times in the last two years?

14. Have you had an organ transplant or been advised by a physician to have an organ transplant?

15. Have you been diagnosed with or treated for chronic kidney disease, kidney failure, or kidney disease requiring dialysis?

16. Do you have an implanted cardiac defibrillator?

Part IX – Medical Questions *(continued)*

17. Are you taking or have you taken any prescription or over-the-counter medications within the past 24 months? If YES, please list the drug(s) below along with the date prescribed, dosage / frequency and diagnosis/medical condition for **each** medication. Attach a separate sheet if needed. Yes ❒ No ❒

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis / Medical Condition	

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis / Medical Condition	

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis / Medical Condition	

Medication Name (copy off pharmacy label)	
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Dosage and Frequency	
Diagnosis / Medical Condition	

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis / Medical Condition	

PRIMARY CARE PHYSICIAN INFORMATION

Physician’s Name: ____

Telephone Number: ____

Part X – Agreement & Acknowledgement

I wish to apply for Medicare supplement insurance coverage. I acknowledge that I have received or been given access to review: (a) an Outline of Coverage for the coverage applied for, and (b) a "Guide to Health Insurance for People with Medicare."

I HAVE READ AND FULLY UNDERSTAND the questions and my answers on this Application. To the best of my knowledge and belief they are true and complete. I understand the Company may conduct a telephone interview with me regarding the answers. I understand and agree the coverage applied for will not take effect until issued by the Company, and that the agent is not authorized to extend, waive or change any terms, conditions or provisions of the coverage.

Caution: If your answers on this Application are incorrect or untrue, the Company has the right to deny benefits or rescind your coverage.

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signed at (City and State): _____ Date: ☐☐-☐☐-☐☐☐☐

Applicant's Signature: _____ Send Policy to: ☐ Applicant ☐ Producer

Producer's Signature: _____ Producer Number: 2100922

Producer Phone: 800.884.2343

Part XI – Producer Supplement

All questions must be completed.

Yes	No		
☐	☐	1.	Did you meet with the Applicant in person?
☐	☐	2.	Did you complete this Application over the phone?
		3.	State the name and relationship of any other person present when this Application was taken. Name _____ Relationship to Applicant _____
☐	☐	4.	Did you review the Application for correctness and any omissions?
☐	☐	5.	Did the Applicant review the Application for correctness and any omissions?
☐	☐	6.	Are you related to the Proposed Insured? If Yes, provide relationship: _____

Listed below are all other health insurance policies or certificates: (a) sold to the Applicant which are still in force; and (b) sold to the Applicant in the last 5 years which are no longer in force.

Company	Type of Policy	Effective Date	In Force
			❒ Yes ❒ No
			❒ Yes ❒ No
			❒ Yes ❒ No

Producer #1 Name (please print) Producer # Split %

Tiffany Jackson 2100922

Producer #2 Name (please print) Producer # Split %

Health Information Authorization

This Authorization complies with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider that has provided services, treatment or payment to me, or on my behalf, within the past 10 years ("My Providers"), or consumer reporting agency, or the Medical Information Bureau, to disclose my entire medical record and any other protected health information concerning me to Individual Assurance Company, Life, Health & Accident ("IAC") and its agents, employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes and excludes information related to genetic tests or genetic services (except to pay a claim related to such tests or services).

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under this Authorization so that IAC may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; **2)** obtain reinsurance; **3)** administer claims and determine or fulfill their responsibility for coverage and provision of benefits; **4)** administer coverage; and **5)** conduct other legally permissible activities that relate to any coverage I have or have applied for with IAC.

For a period of 120 days from the date of this Authorization I authorize my IAC Producer to receive certain protected health information about me that is related to an adverse underwriting decision or counteroffer for alternative coverage made during the underwriting of my application.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to: **IAC at PO Box 3270, Salt Lake City, Utah 84110-3270, Attention: Privacy Officer.** I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that IAC has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, IAC may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

_____ _____

Name of Applicant (please print) Signature of Applicant or Personal Representative

_____ _____

Date of Birth Date

_____

Description of Personal Representative's Authority or Relationship to Applicant (if applicable)

I-HHA (14-MS) (Return to Company)

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

INDIVIDUAL ASSURANCE COMPANY, LIFE, HEALTH & ACCIDENT
Medicare Supplement Administrative Office: P. O. Box 3270, Salt Lake City, UT 84110-3270

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 Individual Assurance Company, Life, Health & Accident. 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 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 AGENT: 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 policy is being purchased for the following reason (check one):

❒ Additional benefits.
❒ No change in benefits, but lower premiums
❒ Fewer benefits and lower premiums.
❒ Change in benefits (Gaining additional benefit(s), but losing some existing benefit(s)).
❒ My plan has outpatient 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 premium 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 that you want to keep it.

_____ Tiffany Jackson, PO Box 26540, Eugene, OR 97402
Signature of Agent, Broker or Other Representative Agent's Printed Name and Address

The above "Notice to Applicant" was delivered to me on:

_____ _____
Applicant's Signature Date

IRN-2015

Leave with Applicant

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❒ Additional benefits.
❒ No change in benefits, but lower premiums
❒ Fewer benefits and lower premiums.
❒ Change in benefits (Gaining additional benefit(s), but losing some existing benefit(s)).
❒ My plan has outpatient 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 premium 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.

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Signature of Agent, Broker or Other Representative — Agent's Printed Name and Address

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_____ _____
Applicant's Signature — Date

IRN-2015

Return to Company