# Cigna Application Packet

Thank you for your interest in applying for the Cigna 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 Cigna. 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)<br>Download Policy Outline (.pdf)<br>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.

# APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE
## Cigna Health and Life Insurance Company

PO Box 559015, Austin, TX 78755-9015 • (866) 459-4272

Application is for: ☐ New business ☐ Reinstatement

Requested Medicare Supplement effective date* _____ Phone verification case # _____

**note: if no effective date is requested, we will assign the 1st day of the month following the date of this application*

**Section I.** Applicant Information

| First name | MI | Last name | Age | Date of birth (MM/DD/YYYY) | State of birth |
|---|---|---|---|---|---|
| | | | | | |

**Resident street address** *(no PO Box)* _____

**City** _____ State _____ ZIP _____

**Mailing address** *(if different from above)* _____

**City** _____ State _____ ZIP _____

**Phone** (_____) _____ **Email address** _____

| Social Security No. (XXX-XX-XXXX) | Medicare card no. | Sex (M/F) | Household discount* |
|---|---|---|---|
| | | | ☐ Yes ☐ No |

**Have you used tobacco within the last 12 months?** ☐ Yes ☐ No **Rate class:** ☐ Preferred ☐ Standard

**If another member of your household is applying for or currently has a Medicare Supplement plan with Cigna Health and Life Insurance Company or an affiliated company, you may qualify for a Household Discount; see the Outline of Coverage for details. Please provide the name and Social Security Number (SSN) of the individual(s) living at your current address.*

**Spouse/household member name**

| First name | MI | Last name | Spouse/household member SSN (XXX-XX-XXXX) |
|---|---|---|---|
| | | | |
| | | | |

**Section II.** Coverage Applied for

**Check plan selected:** ☐ Plan A ☐ Plan F ☐ Plan High-Deductible F ☐ Plan G ☐ Plan N

**Section III.** Billing

**Method** *(select one of the following)*:
- ☐ Bank draft *(complete the Electronic Funds Transfer Agreement)*
- ☐ Direct bill

**Mode** *(select one of the following)*:
- ☐ Monthly *(not available with* Direct bill*)*
- ☐ Quarterly
- ☐ Semi-annually
- ☐ Annually

**Section IV.** Billing Totals

**Initial premium**: ☐ Draft bank account ☐ Check enclosed *(payable to* **Cigna Health and Life Insurance Company***)*

Modal premium *(if household discount, then multiply modal premium by 0.93)* $_____

Total modal premium *(with discount(s) if applicable)* $_____

Total premium with application $_____

## **Section V.** Open Enrollment / Guaranteed Issue Questions (MUST BE COMPLETED)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for Guaranteed Issue of a Medicare Supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS *(mark* **YES** *or* **NO** *below with an "X")*.

| To the best of your knowledge: | YES | NO |
|---|---|---|
| 1. a. Did you turn age 65 in the last six (6) months? | ☐ | ☐ |
| b. Did you enroll in Medicare Part B in the last six (6) months? | ☐ | ☐ |
| If YES, what is the effective date? _____ | | |
| 2. Are you covered for medical assistance through the state Medicaid program? (Note to Applicant: if you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.) | ☐ | ☐ |
| 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. 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 the* END *date blank*. | | |
| START _____ END _____ | | |
| a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? | ☐ | ☐ |
| b. Was this your first time in this type of Medicare plan? | ☐ | ☐ |
| c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? | ☐ | ☐ |
| 4. Do you have another Medicare Supplement policy in force? | ☐ | ☐ |
| a. If so, with what company and what type plan do you have? _____ | | |
| _____ | | |
| b. If so, do you intend to replace your current Medicare Supplement policy with this policy? | ☐ | ☐ |
| **If existing Medicare Supplement coverage is not to be replaced, this policy cannot be issued.** | | |
| 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 and what kind of policy? _____ | | |
| _____ | | |
| b. What are your dates of coverage under the other policy? *(If you are still covered under the other policy, leave the* END *date blank.)* START _____ END _____ | | |

## **Section VI.** Medicare

| | YES | NO |
|---|---|---|
| 1. Do you now have Medicare Parts A and B? | ☐ | ☐ |
| If YES, give effective date of Part B _____ | | |
| 2. If Medicare Parts A and B are to be effective at a future date, provide the date both Medicare Parts A and B will be effective _____ | | |

**NOTE**: **Medicare effective date is always the 1st day of the month. You must have both Medicare Parts A and B on the effective date of the policy. If not, coverage cannot be issued.**

## **Section VII.** Medical Questions

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

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

**PART A. MEDICAL QUESTIONS** - If the answer to any question in Part A is YES, you are not eligible for coverage. If you answered NO to all questions in this Section, please continue to Part B.

| | | YES | NO |
|---|---|---|---|
| 1. | Are you currently confined, scheduled for admission, or in the last two (2) years have you been confined to a nursing facility or assisted living facility? | ☐ | ☐ |
| 2. | Do you currently receive home health care services or, in the last two (2) years, have you received home health care services for more than three (3) separate periods of care? | ☐ | ☐ |
| 3. | Do you currently have a terminal illness or are you currently in the hospital, pending hospital admission, or have you been hospitalized more than two (2) times in the last two (2) years? | ☐ | ☐ |
| 4. | Do you currently receive assistance bathing, transferring, toileting, eating, dressing, or are you bedridden; or have you been advised by a medical professional to use the assistance of a wheelchair, walker, or motorized mobility aid? | ☐ | ☐ |
| 5. | Do you have now or in the last two (2) years have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for the following conditions: | | |
| | a. internal cancer, leukemia, malignant melanoma, Hodgkin's disease, or lymphoma? | ☐ | ☐ |
| | b. angina, atherosclerosis, arteriosclerosis, peripheral vascular disease, heart attack, irregular heartbeat, atrial fibrillation, cardiomyopathy, congestive heart failure, angioplasty, stent placement, carotid artery disease, coronary artery disease (CAD), heart valve surgery, coronary bypass, cardiac pacemaker, implantable or subcutaneous defibrillator? (You should answer NO if your only treatment is with maintenance medication.) | ☐ | ☐ |
| | c. Parkinson's disease, myasthenia gravis, cerebral palsy, muscular dystrophy, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's disease)? | ☐ | ☐ |
| | d. Paget's disease, rheumatoid arthritis, disabling arthritis, systemic lupus, osteoporosis with fractures, or paralysis? | ☐ | ☐ |
| | e. chronic kidney disease, Addison's disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, pancreatitis, or any condition requiring an organ transplant? | ☐ | ☐ |
| | f. diabetes with hypertension requiring three (3) or more hypertension medications to control or diabetes requiring more than 50 units of insulin daily to control? | ☐ | ☐ |
| | g. diabetes with: neuropathy, retinopathy, vascular disease, or tobacco use? | ☐ | ☐ |
| | h. chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), emphysema, chronic bronchitis, or any other chronic lung or respiratory disorder requiring the use of oxygen? | ☐ | ☐ |
| | i. major depression, bipolar disorder, schizophrenia, or a paranoid disorder? | ☐ | ☐ |
| | j. dementia, senility, Alzheimer's disease, or organic brain disorder? | ☐ | ☐ |
| | k. unrepaired aneurysm, hemophilia, anemia requiring repeated blood transfusions, or any other blood disorder? | ☐ | ☐ |
| | l. hepatitis (other than hepatitis A), alcohol or drug abuse, cirrhosis of the liver, or other liver disease? | ☐ | ☐ |
| | m. stroke or transient ischemic attack (TIA)? | ☐ | ☐ |
| 6. | Do you have now or at any time have you been treated for or advised by a medical professional to have treatment for amputation caused by disease or organ transplant other than corneas? | ☐ | ☐ |
| 7. | Have medical tests, treatment, therapy, or surgery been advised but not performed or is any surgery anticipated? (This excludes mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only.) | ☐ | ☐ |
| 8. | Have you ever been diagnosed with or received treatment from a physician or an appropriately-licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection? | ☐ | ☐ |

## **Section VII.** Medical Questions *(cont'd.)*

**PART B. HEIGHT/WEIGHT AND MEDICATIONS** - The answers to questions in Part B are subject to the Company's Underwriting review. Please provide complete details as requested.

9. Height *(ft.-in.)* _____ Weight *(lbs.)* _____

10. Please list any prescription medications taken or prescribed in the past two (2) years.

| Medication | Dates taken | Condition taken for |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

AGENT NOTES - Please provide any other information that you believe may assist in our Underwriting determination:

_____

_____

_____

_____

## **Section VIII.** Important Statements for Applicant to Read

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.
- 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 the suspension.
- If you are eligible for and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted 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 reinstituted 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).

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

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

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

**Telephone number** (_____)_____ **Best time to call** _____

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

**Applicant's printed name** _____

**Signature of Applicant** _____ **Date** _____

## **Section IX.** Agent(s) Certification

Agent(s) shall list any health insurance policies sold to the Applicant.

1. List any other health policies or coverages sold to the Applicant which are still in force *(if this does not apply, state "NONE")*.

   _____

   _____

2. List any other health policies or coverages sold to the Applicant in the past five (5) years which are no longer in force *(if this does not apply, state "NONE")*. _____

   _____

| | YES | NO |
|---|---|---|
| 3. Have you submitted any applications or have knowledge of any applications submitted for this Applicant that have been declined? ..... If YES, provide details below. | ☐ | ☐ |
| 4. Have you reviewed the application for correctness and omissions? ..... | ☐ | ☐ |

5. I certify that I have provided the Applicant with the following documents:

   a. Application packet *(phone sales only)*
   b. *Guide to Health Insurance for People with Medicare*
   c. Outline of Medicare Supplement Coverage
   d. MIB Notice
   e. other _____

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

   ☐ In person _____ date
   ☐ Mail _____ date
   ☐ Email _____ date
   ☐ Fax _____ date
   ☐ other *(explain)* _____ _____ date

| | YES | NO |
|---|---|---|
| 6. Was the application completed by you in the Applicant's physical presence? ..... | ☐ | ☐ |
| 7. Was the application completed by you over the phone? ..... | ☐ | ☐ |
| 8. Do you have knowledge or reason to believe the replacement of existing insurance may be involved? ..... If YES, give name of Company, reason, and termination date | ☐ | ☐ |

_____

_____

_____

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

| Printed name of licensed Agent | Signature of licensed Agent | Writing number | Percentage |
|---|---|---|---|
| Tiffany Jackson | | CB09582 | 100% |
| Printed name of 2nd licensed Agent | Signature of 2nd licensed Agent | Writing number | Percentage |
| | | | |

**CIGNA HEALTH AND LIFE INSURANCE COMPANY**
PO Box 559015, Austin, Texas 78755-9015 • 866-459-4272

# MEDICARE SUPPLEMENT SUPPLEMENTARY APPLICATION

### Definitions of Eligible Person for Guaranteed Issue and Creditable Coverage

An eligible person is an individual described in any of the following paragraphs:

1) The individual is enrolled under an employee welfare benefit plan that provides health benefits which supplement the benefits under Medicare and the plan terminates *or* the plan ceases to provide supplemental health benefits to the individual *or* the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates *or* the plan ceases to provide all health benefits to the individual because the individual leaves the plan;

2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare and any of the following circumstances apply *or* the individual is 65 years of age or older and is enrolled with a Program of All-inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with the provider if such individual were enrolled in a Medicare Advantage plan:
   A) The certification of the organization or plan has been terminated;
   B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
   C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;
   D) The individual demonstrates, in accordance with guidelines established by the Secretary, that:
      i) the organization offering the plan substantially violated a material provision of the organization's contract under 42 U.S.C. Chapter 7, Subchapter XVIII, Part D, in relation to the individual including the failure to provide an individual on a timely basis medically-necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards; or
      ii) the organization or agent or other entity acting on the organization's behalf materially misrepresented the plan's provisions in marketing the plan to the individual; or
   E) The individual meets other exceptional conditions as the Secretary may provide;

3) The individual is enrolled with an entity listed in subparagraphs A - D of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph 2 of this subsection:
   A) an eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost);
   B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
   C) an organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
   D) an organization under a Medicare Select policy;

4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:
   A) of the insolvency of the issuer or bankruptcy of the non-issuer organization or of other involuntary termination of coverage or enrollment under the policy;
   B) the issuer of the policy substantially violated a material provision of the policy; or
   C) the issuer or an agent or other entity acting on the issuer's behalf materially misrepresented the policy's provisions in marketing the policy to the individual;

5) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls for the first time with: any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy and the subsequent enrollment is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which the individual is permitted to terminate the subsequent enrollment under section 1851(e) of the Social Security Act);

6) The individual, upon first becoming enrolled in Medicare Part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under Part C of Medicare or with a PACE provider under section 1894 of the Social Security Act and disenrolls from the plan or program no later than 12 months after the effective date of enrollment;

7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (c)(4) of this section;

8) The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid); or

9) The individual meets the following requirements:
   A) the individual was enrolled in both the federal Medicare program and the Texas Health Insurance Pool on December 31, 2013; and
   B) the individual's Pool coverage terminated on or after December 31, 2013.

If any of the definitions apply to you, please complete an Application for Medicare Supplement Insurance and submit evidence of the date of termination or disenrollment. Application must be made for coverage no later than 63 days of termination or disenrollment.

The following is a definition of Creditable Coverage:
Creditable Coverage means (a) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); (b) a group health benefit plan provided by a health insurance carrier or an HMO; (c) an individual health insurance policy or evidence of coverage; (d) Part A or Part B of Title XVIII of the Social Security Act; (e) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (f) Chapter 55 of Title 10 (CHAMPUS); (g) a medical care program of the Indian Health Service or of a tribal organization; (h) a state health benefits risk pool; (i) a health plan offered under Chapter 89 of Title 5 (Federal Employees Health Benefits Program); (j) a public health plan (as defined in federal regulation); (k) a health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)); or (l) short-term, limited duration insurance.

I acknowledge receipt of this Supplementary Application.

_____ _____

**Signature of Applicant** **Date**

# PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

CIGNA HEALTH AND LIFE INSURANCE COMPANY • PO BOX 559015 • AUSTIN, TX 78755-9015

| **Proposed Insured's name** | | **Policy number (if available)** |
|---|---|---|
| **Financial institution name and telephone number** | | |
| **Financial institution address** | | |
| **9-digit routing number** | **Account number** | **Requested withdrawal date (1st - 28th)** |

Withdraw payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of account: ☐ Personal checking account ☐ Personal savings account ☐ Corporate/business checking

Name of employer group _____

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

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ Change in existing coverage

**For checking account**: Please tape a VOIDED check in this box.

**For savings account**: Please attach a letter from the bank stating the account and routing number of your savings account.


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

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

**Name of Payor (if other than Insured)** **Payor's address**

**Print name of Depositor (as it appears on account)** **Signature of Depositor** **Date**

# MIB, Inc., Pre-Notice

## CIGNA HEALTH AND LIFE INSURANCE COMPANY

PO Box 559015, Austin, Texas 78755-9015 • 866-459-4272

Information regarding your insurability will be treated as confidential. Cigna Health and Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Cigna Health and Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

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

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

1. The Company, as used in this authorization, shall mean Cigna Health and Life Insurance Company.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB, Inc., or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information. However, MIB, Inc., information will only be shared with the Company's underwriting staff and Medical Director.
3. I authorize the Company to make a brief report of my protected health information to MIB, Inc.
4. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 26580, Austin, Texas 78755-0580.
6. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
7. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
8. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
9. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

_____

**Applicant's name**

**Name of Applicant's personal representative, if applicable**

**Applicant's Social Security Number**

**Relationship of personal representative to the Applicant**

**Signature of Applicant** **Date**

**Signature of personal representative** **Date**

**Signature of Company's Agent** **Date**

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

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

1. I hereby authorize the use and disclosure of all my health information, including but not limited to my personal and medical information contained in the Company's records ("Protected Health Information") to American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, and their affiliates ("Company") as described below.
2. I authorize the Company to use the Protected Health Information contained in the Company's records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.
3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.
4. I understand that I may revoke this Authorization at any time, except to the extent that action has been taken by the Company in reliance on this Authorization, by sending a written revocation to the Company's Privacy Steward at PO Box 26580, Austin, Texas 78755-0580.
5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing this Authorization.
6. I understand that if the person or entity that receives my Protected Health Information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this Authorization is as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this Authorization. This Authorization will expire twenty-four (24) months from the date it is signed.

If you are the representative of a Consumer, describe the scope of your authority to act on the Consumer's behalf:

_____

_____ _____

**Consumer's Name** **Name of Consumer's Personal Representative, if applicable**

_____ _____

**Signature of Consumer** **Date** **Relationship of Personal Representative to the Consumer**

_____ _____

**Signature of Company's Agent** **Date** **Signature of Personal Representative** **Date**

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

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

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

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

## CIGNA HEALTH AND LIFE INSURANCE COMPANY

PO Box 559015, Austin, Texas 78755-9015 • 866-459-4272

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

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Cigna Health and Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

**STATEMENT TO APPLICANT BY ISSUER, AGENT, OR BROKER**

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

- ☐ additional benefits
- ☐ no change in benefits, but lower premiums
- ☐ fewer benefits and lower premiums
- ☐ 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) _____

**NOTE:**

1. If the Issuer of the Medicare Supplement policy being applied for does not or is otherwise prohibited from imposing pre-existing condition limitations, please skip to note 2 below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy.
3. 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.

I call your attention to the following for your consideration: If you still wish to terminate your present policy and replace it with new coverage, be certain to answer truthfully and completely all questions on the application concerning your medical and health history. Failure to include all material medical information on the application may provide a basis for the issuer to deny any future claims and to refund your premium as though the policy had never been in force. After the application has been completed and before you sign it, read and review it carefully to be certain 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.**

_____ _____

**Agent's signature** **Applicant's signature**

Tiffany Jackson - PO Box 26540, Eugene, OR 97402 _____

**Type or print name and address of Agent/Broker** **Date**

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

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**Agent's signature** **Applicant's signature**

Tiffany Jackson - PO Box 26540, Eugene, OR 97402 _____

**Type or print name and address of Agent/Broker** **Date**