

Thank you for your interest in applying for the Woodmen of the World Medicare Supplement plan!

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

- Fax: 1.541.284.2994
- Email: [dann@lowinsure.com](mailto:dann@lowinsure.com)
- Mail: CDA Insurance LLC  
2160 W 11<sup>th</sup> Ave  
Eugene, Oregon 97402

Other Important Information
Download Medicare's <a href="#">Choosing a Medigap Policy Guide</a> (.pdf)
Download <a href="#">Policy Outline</a> (.pdf)

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

**Producer Name** \_\_\_\_\_ **Agent Writing Number or Social Security Number** \_\_\_\_\_ **Commission Share** \_\_\_\_\_ **Commission Code**- Required only if you are not appointed or licensed or are changing brokerage firms \_\_\_\_\_



Dann Loewenthal

0 | 3 | 0 | 1 | 6 | 7 | 2 | | | | | | | | | | % | | |

| | | | | | | | | | | | | | | | % | | |

**Preferred Method of Communication (Select one)**

Phone    Fax    Email   Contact info: \_\_\_\_\_

**Note:** Producers must be under the same commission code to share or split commissions.

**Application Submission Checklist – Woodmen of the World Medicare Supplement Coverage**

- Provide Applicant with the Guide to Health Insurance for People with Medicare
- Provide Applicant with the Outline of Coverage
  - Calculate the premium based on age at application date
- Complete the Calculate Your Premium form (T02\_636) to determine rate

**Application (complete in full)**

**Sections A & B: Plan and Applicant Information**

- Select plan
- Enter Requested Effective Date
- Indicate where the certificate is to be mailed



**Section C: Medicare Information**

- Include applicant’s Medicare claim number on the application. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent must provide this number by calling 1-877-617-5587 once it is received. If not already covered by Medicare, indicate “eligibility” and “enrollment” dates.

**Section D: Previous or Existing Coverage Information**

- Please complete ALL questions in full

**For Sections E and F – Refer to the Open Enrollment/Guaranteed Issue worksheet (T00\_631) to help identify eligibility.**

**Section E: Please answer all of the following questions**

- If either Applicant A or B answered “YES” to question 5 OR BOTH questions 6 and 7 in Section E, they can skip to Section H

**Sections F & G: Health/Medication Information**

- Do NOT answer if applicant is in an open enrollment or guaranteed issue period

**Section H: Agreement and Authorization**

- Make sure applicant(s) sign and date the application

**Section J: To be Completed by Producer**

- Make sure producer(s) sign and date the application

**Complete the Method of Payment form (T02\_637) and return with the completed application**

- Use premium determined by the **Calculate Your Premium form (T02\_636)**
- The full modal premium is collected at the time of application

**Complete Replacement Notice (T02\_24\_OR) and leave a copy with the applicant (if applicable)**

**Provide Applicant with Premium Receipt signed by agent (if applicable), and provide Applicant with Notice of Information Practices (T02\_638)**

**Note:** An interviewer may call to verify/confirm the information provided on the application. This form is required if splitting commissions.

## Open Enrollment and Guaranteed Issue Worksheet

**If any of the following situations apply, applicant is in an open enrollment or guaranteed issue period:** (Situations may vary by state and coverage may be limited. Please refer to the Underwriting Guide for more information.)

### **ELIGIBILITY FOR OPEN ENROLLMENT**

#### **Applicant is:**

- at least 64 ½ years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

**Note: Coverage cannot be effective until your Medicare coverage is effective.**

### **ELIGIBILITY FOR GUARANTEED ISSUE**

**Evidence of eligibility is required for the following situations.**

#### **Applicant:**



- is in the original Medicare plan, has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays, and that coverage is ending
- is in the original Medicare plan, has a Medicare Select policy/certificate, and moves out of the Select plan's service area
- loses coverage due to their Medicare supplement insurance company's insolvency or at no fault of the applicant
- the applicant leaves their Medicare supplement plan because the company has not followed rules, or has misled the applicant

*Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.*

#### **Applicant was enrolled in a Medicare Advantage (MA) plan, and:**

- the plan is leaving the Medicare program or stops service in the applicant's area, or the applicant moves out of the plan's service area (applicant must switch back to original Medicare)
- the applicant leaves the plan because the company has not followed rules, or has misled the applicant

*Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.*

- the applicant decided to switch to original Medicare within the first year of joining a MA plan when first eligible for Medicare Part A at age 65

*Applicant has the right to buy any Medicare supplement plan that is sold in the applicant's state by any insurance company.*

- after dropping their Medicare supplement policy/certificate to join a MA plan for the first time, has been on the MA plan less than one year and wants to switch back

*Applicant has the right to obtain their Medicare supplement policy/certificate back if that carrier still sells it or, if not available, buy any Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.*

#### **Acceptable Evidence of Eligibility:**

- a. Copy of the applicant's MA plan's termination notice
- b. Copy of the letter the applicant sent to his/her MA plan requesting disenrollment
- c. Signed statement that the applicant has requested to be disenrolled from his/her MA plan
- d. Certification of group coverage
- e. Copy of the termination letter from employer or group carrier
- f. Image of insurance ID card (ONLY allowed if your MA plan is being terminated)



# Height and Weight Chart

## Eligibility

Find your height in the left-hand column and look across the row to find your weight. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time.

	<b>Decline</b>	<b>Standard</b>	<b>Decline</b>
Height	Weight	Weight	Weight
4' 2"	< 54	54 – 145	146 +
4' 3"	< 56	56 – 151	152 +
4' 4"	< 58	58 – 157	158 +
4' 5"	< 60	60 – 163	164 +
4' 6"	< 63	63 – 170	171 +
4' 7"	< 65	65 – 176	177 +
4' 8"	< 67	67 – 182	183 +
4' 9"	< 70	70 – 189	190 +
4' 10"	< 72	72 – 196	197 +
4' 11"	< 75	75 – 202	203 +
5' 0"	< 77	77 – 209	210 +
5' 1"	< 80	80 – 216	217 +
5' 2"	< 83	83 – 224	225 +
5' 3"	< 85	85 – 231	232 +
5' 4"	< 88	88 – 238	239 +
5' 5"	< 91	91 – 246	247 +
5' 6"	< 93	93 – 254	255 +
5' 7"	< 96	96 – 261	262 +
5' 8"	< 99	99 – 269	270 +
5' 9"	< 102	102 – 277	278 +
5' 10"	< 105	105 – 285	286 +
5' 11"	< 108	108 – 293	294 +
6' 0"	< 111	111 – 302	303 +
6' 1"	< 114	114 – 310	311 +
6' 2"	< 117	117 – 319	320 +
6' 3"	< 121	121 – 328	329 +
6' 4"	< 124	124 – 336	337 +
6' 5"	< 127	127 – 345	346 +
6' 6"	< 130	130 – 354	355 +
6' 7"	< 134	134 – 363	364 +
6' 8"	< 137	137 – 373	374 +
6' 9"	< 140	140 – 382	383 +
6' 10"	< 144	144 – 392	393 +
6' 11"	< 147	147 – 401	402 +
7' 0"	< 151	151 – 411	412 +
7' 1"	< 155	155 – 421	422 +
7' 2"	< 158	158 – 431	432 +
7' 3"	< 162	162 – 441	442 +
7' 4"	< 166	166 – 451	452 +

Medicare supplement insurance is underwritten by

**WOODMEN OF THE WORLD**

Administrative Office

P.O. Box 2397

Omaha, Nebraska 68103-2397





## B. Applicant Information (continued)

### Applicant A

Height Ft <input type="text"/> <input type="text"/> In <input type="text"/> <input type="text"/>	Weight Lbs <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Have you used tobacco in any form in the past 12 months? ..... <input type="checkbox"/> Y <input type="checkbox"/> N	

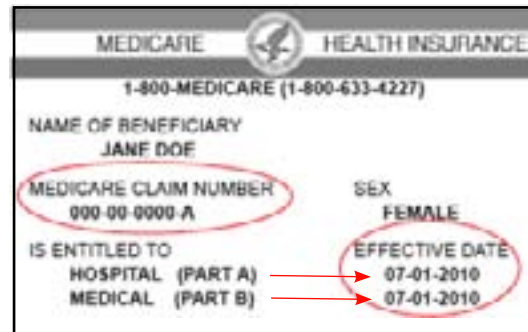
### Applicant B

Height Ft <input type="text"/> <input type="text"/> In <input type="text"/> <input type="text"/>	Weight Lbs <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Have you used tobacco in any form in the past 12 months? ..... <input type="checkbox"/> Y <input type="checkbox"/> N	



## C. Medicare Information

Please reference your Medicare card to complete this section.



### Applicant A

Medicare Claim Number
Medicare Part A Effective Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
Medicare Part B Effective Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>

### Applicant B

Medicare Claim Number
Medicare Part A Effective Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
Medicare Part B Effective Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>

## D. Previous or Existing Coverage Information

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 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 your application.** PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge and Belief:

	Applicant A	Applicant B
1. 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.) <b>If "YES," answer the following about this existing coverage:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(a) Will Medicaid pay your premiums for this Medicare supplement certificate?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

### Please answer questions regarding another Medicare supplement or Select plan:

2. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If "YES," answer the following about this existing coverage:</b>		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this certificate?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Indicate planned termination or disenrollment date.....	Applicant A <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
(c) With what company, and what plan do you have?		

Applicant A	Applicant B
Name of Company	Name of Company
Plan	Plan

### Please answer questions regarding Medicare plan coverage (other than Medicare supplement):

	Applicant A	Applicant B
3. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO).....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If "YES," answer the following about this previous or existing coverage:</b>		
(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.....	Applicant A START <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B START <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
	Applicant A END <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B END <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement Certificate?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(c) Planned date of termination/disenrollment?.....	Applicant A <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
(d) Was this your first time in this type of Medicare plan?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(f) Did you drop a union group or employer health plan to enroll in this Medicare plan?..	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N



T02-2014

- (g) Please indicate reason for termination/disenrollment:
- Your Medicare Advantage plan is leaving the Medicare program.....
  - Your Medicare Advantage organization stopped offering Medicare Advantage plans.....
  - Your Medicare Advantage organization stopped offering coverage in the area in which you live.....
  - You moved out of the geographic service area of your Medicare Advantage plan.....
  - You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan.....
  - Other: \_\_\_\_\_

Check box(s) below if applicable

Applicant A	Applicant B
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Applicant A

Applicant B

**Please answer questions regarding other health insurance:**

4. Have you had coverage under any other health insurance within the past 63 days?.....  
(For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.)

Applicant A	Applicant B
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

**If "YES," answer the following about this previous or existing coverage:**

- (a) What are your dates of coverage under the other policy/certificate?

If you are still covered under this plan, leave "END" blank..... Applicant A START / /   
END / /

Applicant B START / /   
END / /

- (b) Planned date of termination/disenrollment?..... Applicant A / /   
Applicant B / /

- (c) With what company and what kind of policy/certificate? (List below.)

Applicant A	Applicant B
Name of Company	Name of Company
Policy/Certificate type	Policy/Certificate type

**E. Please answer all of the following questions:**

To the Best of Your Knowledge and Belief:

5. Are you applying during a guaranteed issue period?.....  
(NOTE: Refer to the guaranteed issue worksheet to help identify if you are eligible. If the answer above is "YES," attach proof of eligibility.)
6. Did you turn age 65 in the last six months?.....
7. Did you enroll in Medicare Part B in the last six months?.....

Applicant A	Applicant B
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

If "YES," indicate your effective date..... Applicant A / /   
Applicant B / /

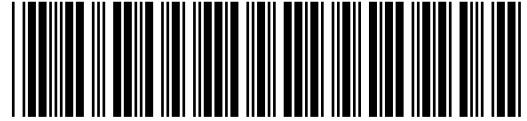


**IF EITHER YOU OR APPLICANT B ANSWERED "YES" TO QUESTION 5 OR BOTH QUESTIONS 6 AND 7 IN SECTION E, SKIP SECTIONS F & G AND GO TO SECTION H.**



**If you are applying during an open enrollment or guaranteed issue period:  
SKIP SECTIONS F & G and GO TO SECTION H.**

**F. Health Information**



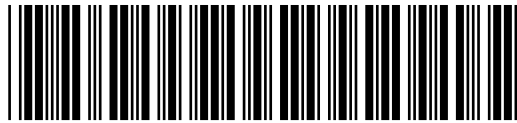
For all plans, answer questions 8-16.

(If "YES" is answered to any of the following questions 8-16, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
8. Are you currently confined to a wheelchair or any motorized mobility device?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
9. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility where you receive skilled nursing care, or receiving any occupational or physical therapy? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
10. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing or any surgery that has not been performed? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
11. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alzheimer's Disease, dementia or any other cognitive disorder? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Parkinson's Disease, Multiple Sclerosis or Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Systemic Lupus or Myasthenia Gravis? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
H. Chronic hepatitis or cirrhosis? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
I. Osteoporosis with fractures? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Do you have diabetes with complications including retinopathy, neuropathy, peripheral vascular disease, any related heart disorder (Including hypertension/high blood pressure) or kidney disease? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Do you have an implanted cardiac defibrillator? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
14. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Cardiomyopathy, Congestive Heart Failure, aortic or cardiac aneurysm, peripheral vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alcoholism or drug abuse? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Internal cancer, lymphoma or melanoma? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. A stroke or transient ischemic attack (TIA)? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?...	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
15. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
16. Have you been hospital confined three or more times in the past two years for a same or similar condition? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

T02-2014

# G. Medication Information



If you are applying **OUTSIDE** of an open enrollment or guaranteed issue period, please list all over-the-counter or prescription medications you have taken in the past 24 months in the table below.

## Applicant A

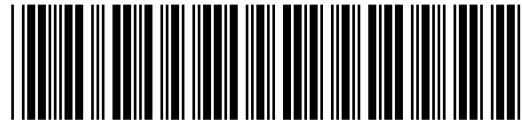
Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

## Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

T02-2014

# H. Agreement and Authorization



## IMPORTANT STATEMENTS

- You do not need more than one Medicare supplement certificate.
- If you purchase this certificate, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement certificate.
- If, after purchasing the certificate, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement certificate 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 certificate (or, if that is no longer available, a substantially equivalent certificate) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstated certificate 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 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 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 certificate under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement certificate (or, if that is no longer available, a substantially equivalent certificate) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstated certificate 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).

## AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO WOODMEN OF THE WORLD

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Woodmen of the World and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to Woodmen of the World. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, Woodmen of the World, P.O. Box 2397, Omaha, NE 68103-2397. I realize that my right to revoke this authorization is limited to the extent that Woodmen of the World has taken action in reliance on the authorization or the law allows Woodmen of the World to contest the issuance of the certificate or a claim under the certificate.
- "Personal Information" means all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate certificate and a completed and signed application will become part of each applicant's certificate.

I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. I understand that my certificate benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Woodmen of the World.

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** and an Outline of Coverage.

Dated at \_\_\_\_\_, on \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_, \_\_\_\_\_  
 City State Month Day Year Applicant A's Signature

Dated at \_\_\_\_\_, on \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_, \_\_\_\_\_  
 City State Month Day Year Applicant B's Signature (if applying)

T02-2014





# Part III. Account Information

**Complete the Following ONLY if Automated Bank Account Withdrawal is Chosen:**

This section is intended as authorization to debit your bank account.

Complete bank account information below **OR** attach a copy of a voided check (Do NOT use a deposit slip)

<b>Can attach voided check here</b>	<p><b>Applicant A</b></p> <p>Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings</p> <p>_____ Name of Financial Institution</p> <p>_____ Routing Number (9 digits on lower left side of check)</p> <p>_____ Account Number (Do NOT use Debit/Credit Card numbers)</p> <p>_____ Name as Shown on Account</p>	<p><b>Applicant B</b> <input type="checkbox"/> Same account as Applicant A</p> <p>Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings</p> <p>_____ Name of Financial Institution</p> <p>_____ Routing Number (9 digits on lower left side of check)</p> <p>_____ Account Number (Do NOT use Debit/Credit Card numbers)</p> <p>_____ Name as Shown on Account</p>
-------------------------------------	--	---

- Payments cannot be postponed until a later date.
- Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

**Example:**

The diagram shows a check with the following fields: Account Holder Name, Street Address, Town, City, ZIP Code, Date, Check #1234, Pay to, Financial Institution Name & Address, Signed By, Memo, and Dollars. Callouts point to the Routing/Transfer Number (9 digits on the left) and the Account Number (10 digits on the right).

**IMPORTANT: When choosing to pay initial premium by Automated Bank Account Withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY. The first withdrawal date may be different from the monthly date selected for renewal premiums.**

I authorize Woodmen of the World to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account to Woodmen of the World any preauthorized electronic fund transfers. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

<p> _____ Authorized Signature as Shown on Account</p> <p>_____ Date</p>	<p> _____ Authorized Signature as Shown on Account</p> <p>_____ Date</p>
--	--



T02\_637

**WOODMEN OF THE WORLD**

Administrative Office  
P.O. Box 2397  
Omaha, NE 68103-2397



**FAX Transmittal Cover For Application With Initial Payment  
By Automated Bank Account Withdrawal**

**If paying initial premiums by Automated Account Withdrawal, fax this cover and the following documents ONLY to 1-866-422-9139:**

- **Method of Payment Form (T02\_637)**
- **Application**
- **New Business Documents**

**NOTE: Applications faxed to the wrong fax number could cause processing delays. Do NOT send a signed check for the initial premium. Do NOT fax the forms multiple times. If you fax the forms, do NOT mail them.**

Producer Name  Dann Loewenthal	Producer Number or SSN  0 3 0 1 6 7 2
Phone Number  541.434.9613	Producer FAX Number  541.284.2994

Total number of pages being faxed (including cover sheet) \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**If you have questions with regard to this process, please contact Sales Support at 877-815-4776.**

This communication and any attachments transmitted with it are confidential and are solely for the use of the addressee. It may contain material that is legally privileged, proprietary or subject to copyright belonging to Woodmen of the World and its affiliates, and it may be subject to protection under federal or state law. If you are not the intended recipient, you are notified that any use of this material is strictly prohibited. If you received this transmission in error, please contact the sender immediately by telephone, collect calls accepted, at the number shown above. We will arrange for you to return the original material to us via the U.S. Postal Service, and if requested, we will reimburse you for such expense.



**OREGON - Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage**

**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 certificate to be issued by Woodmen of the World. Your new certificate will provide thirty (30) days within which you may decide without cost whether you desire to keep the certificate.

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 certificate.

**Statement to Applicant by Issuer, Insurance Producer, Broker or Other Representative:**

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement certificate 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 certificate is being purchased for the following reason(s) (check one):

**Applicant A**

- Additional benefits
- No change in benefits, but lower premiums
- Fewer benefits and lower premiums
- My plan has outpatient prescription drug coverage and I am enrolling in Part D
- Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment
- Other (please specify)

**Applicant B**

- Additional benefits
- No change in benefits, but lower premiums
- Fewer benefits and lower premiums
- My plan has outpatient prescription drug coverage and I am enrolling in Part D
- Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment
- Other (please specify)

If you still wish to terminate your present policy or certificate 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 certificate 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 or certificate until you have received your new certificate and are sure that you want to keep it.



**Signature of Insurance Producer, Broker or Other Representative**

\_\_\_\_\_ **Date**

WOODMEN OF THE WORLD, P.O. Box 2397, Omaha, Nebraska 68103-2397

**Applicant A**

**Applicant B**

Signature 	Signature 
Date	Date

T02\_24\_OR

## IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and client notifications on the following pages are to be given to the applicant(s) if applicable.

**Replacement Notice**

If replacing, both you and the applicant must sign the customer copy of the replacement notice.

**Premium Receipt / Notice of Information Practices**





**OREGON - Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage**

**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 certificate to be issued by Woodmen of the World. Your new certificate will provide thirty (30) days within which you may decide without cost whether you desire to keep the certificate.

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 certificate.

**Statement to Applicant by Issuer, Insurance Producer, Broker or Other Representative:**

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement certificate 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 certificate is being purchased for the following reason(s) (check one):

**Applicant A**

- Additional benefits
- No change in benefits, but lower premiums
- Fewer benefits and lower premiums
- My plan has outpatient prescription drug coverage and I am enrolling in Part D
- Disenrollment from a Medicare Advantage Plan  
Please explain reason for disenrollment
- Other (please specify)

**Applicant B**

- Additional benefits
- No change in benefits, but lower premiums
- Fewer benefits and lower premiums
- My plan has outpatient prescription drug coverage and I am enrolling in Part D
- Disenrollment from a Medicare Advantage Plan  
Please explain reason for disenrollment
- Other (please specify)

If you still wish to terminate your present policy or certificate 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 certificate 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 or certificate until you have received your new certificate and are sure that you want to keep it.



**Signature of Insurance Producer, Broker or Other Representative**

**Date**

WOODMEN OF THE WORLD, P.O. Box 2397, Omaha, Nebraska 68103-2397

**Applicant A**

**Applicant B**

Signature 	Signature 
Date	Date

T02\_24\_OR

# WOODMEN OF THE WORLD

A Fraternal Benefit Society

## Premium Receipt

---

All premiums must be made payable to Woodmen of the World.

**Do not make check payable to the agent or leave the payee blank.**

### Applicant A

Received from \_\_\_\_\_  
this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
an application for Form \_\_\_\_\_ Certificate  
and/or Riders \_\_\_\_\_ and  
Check for \_\_\_\_\_ Dollars.

### Applicant B

Received from \_\_\_\_\_  
this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
an application for Form \_\_\_\_\_ Certificate  
and/or Riders \_\_\_\_\_ and  
Check for \_\_\_\_\_ Dollars.

 Agent \_\_\_\_\_

 Agent \_\_\_\_\_

**No insurance of any kind shall take effect until a certificate is issued and delivered to the applicant, and the initial premium is paid, all during the life of the applicant. If no certificate is issued, Woodmen of the World shall have no liability except to refund the initial premium to the applicant. This is a receipt of your application and initial premium.**



## Notice of Information Practices

---

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

**THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: WOODMEN OF THE WORLD, DIRECTOR OF INDIVIDUAL UNDERWRITING, P.O. BOX 2397, OMAHA, NE 68103-2397.**

**Provide the completed premium receipt, if applicable, and notice to the applicant.**