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-nevada.com

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 ("the Company")
P.O. Box 14535, Oklahoma City, OK 73113-8892
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

*Not available for newly eligible Medicare Beneficiaries.

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 both (1) age 65 or older and (2) enrolled in Medicare Part B. *If you are a qualified open enrollee, you may apply for and receive any Medicare Supplement Plan available from the Company; however, Plan F is only available if a Medicare Beneficiary before 1/1/2020.*

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)	Did you enroll in Medicare Part B in the last six months?
		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 six 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 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 supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual *(eligible for Plans A or G, or Plan F if a Medicare Beneficiary before 1/1/2020)*; 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 G, or Plan F if a Medicare Beneficiary before 1/1/2020*); 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 G, or Plan F if a Medicare Beneficiary before 1/1/2020*); or
- Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material misrepresentation (*eligible for Plans A or G, or Plan F if a Medicare Beneficiary before 1/1/2020*); 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 the Company, or, if that Plan is no longer available, Plans A or G, or Plan F if a Medicare Beneficiary before 1/1/2020*); or
- Upon first becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months (*eligible for all plans available from the Company; however, Plan F is only available if a Medicare Beneficiary before 1/1/2020*); 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 G, or Plan F if a Medicare Beneficiary before 1/1/2020*).

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 Initial Premium: (=) _____

Total Cash with Application: _____

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

_____/_____/_____ (mm/dd/yyyy)

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

☐ I authorize Bank Draft Payments

☐ Draft Initial Premium On (Date) _____/_____/_____ (mm/dd/yyyy)

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 the Company (unless specified otherwise). The Company will draft premiums due in the mode and from the account identified above for the life of the policy unless instructed in writing to do 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? Yes ☐ No ☐
2. Have you been diagnosed with emphysema, chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disorders? Yes ☐ No ☐
3. Have you been diagnosed with Parkinson's disease, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with fractures, cirrhosis or chronic hepatitis? Yes ☐ No ☐
4. Have you been diagnosed with Alzheimer's disease, senile dementia, or any other cognitive disorder? Yes ☐ No ☐
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)? Yes ☐ No ☐
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"**. Yes ☐ 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"**. Yes ☐ 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? Yes ☐ No ☐
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? Yes ☐ No ☐
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? Yes ☐ No ☐
11. Have you been advised by a physician that surgery may be required within 12 months for cataracts? Yes ☐ No ☐
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes ☐ No ☐
13. Have you been hospital confined three or more times in the last two years? Yes ☐ No ☐
14. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes ☐ No ☐
15. Have you been diagnosed with or treated for chronic kidney disease, kidney failure, or kidney disease requiring dialysis? Yes ☐ No ☐
16. Do you have an implanted cardiac defibrillator? Yes ☐ No ☐

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)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Medical Condition	

Medication Name (copy off pharmacy label)	
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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	

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 may have the right to deny benefits or rescind your coverage.

Signed at (City and State):_____ Date: _____/_____/_____

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

Producer's Signature_____ Producer Number: _____

Producer's Phone:_____

Part XI – Producer Supplement

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 I have (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 2100651 100%

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 14535, Oklahoma City, OK 73113, 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)

(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 14535, Oklahoma City, OK 73113

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 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 14535, Oklahoma City, OK 73113

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

Discrimination is Against the Law

Individual Assurance Company, Life, Health & Accident (IAC) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. IAC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

IAC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact IAC's Policy Owner Service Department at 888-524-3629.

If you believe that IAC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Compliance Department
Individual Assurance Company
P.O. Box 30685
Edmond, OK 73003
Phone: (405) 285-0838
Fax: (405) 285-0836
Email: compliance@iaclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, IAC's Compliance Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-524-3629.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-524-3629.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-524-3629.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-524-3629.

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa1-888-524-3629.

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.1-888-524-3629.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-524-3629.

العربيـــة (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-524-3629.

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-888-524-3629.

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-524-3629.

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. بمی باشد. با 1-888-524-3629 تماس بگیرید.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-524-3629 まで、お電話にてご連絡ください。

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-524-3629 पर कॉल करें।

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ1-888-524-3629.

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-524-3629.

اُردُو (Urdu)
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-888-524-3629.

http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

Receipt

Receipt

Please Note: All premium checks must be made payable to Individual Assurance Company, Life, Health & Accident. ***Do not make check payable to the insurance agent or leave the payee line blank.***

Received from _____ the sum

of $ _____ for _____ months premium, with this application.

If for any reason the application is not approved and the policy is not issued, this premium is to be refunded. No liability is created or assumed by the Company, except for refund of this premium, until the policy applied for has been issued.

Date Receipt and Outline of Coverage was prepared _____ , 20 _____

By _____
Agent's Signature

Individual Assurance Company, Life, Health & Accident, P.O. Box 14535, Oklahoma City, OK 73113

IAC APP RECEIPT(01/01/2019)