

## Pre-Notice

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Information regarding your insurability will be treated as confidential. Humana or its reinsurers, may, however make a brief report thereon to Medical Information Bureau (MIB), 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 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 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Humana, or its reinsurers, may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

# HumanaOne Individual Insurance Application



Please print clearly in ink. Complete all questions. Fill in all fields or indicate "not applicable."

If you have not had continuous health coverage within the past 63 days, you must choose an effective date that is 30-45 days past the date of the application.

**ALABAMA**

Date of application: \_\_\_/\_\_\_/\_\_\_ Requested Effective Date: \_\_\_/\_\_\_/\_\_\_

- This application is for:
- New Business (First time applicant)
  - Reinstatement (Reapplication)
  - Change/modification to existing policy

Reason for change \_\_\_\_\_

Change/Modification to Existing Policy # \_\_\_\_\_

## Health & Dental Coverage Options

### Health Coverage

Please complete this section when selecting a health plan.

Plan name \_\_\_\_\_

Deductible \$ \_\_\_\_\_

### Dental Coverage

- Dental

**Please note:** You may purchase dental coverage if health coverage is chosen. If dental is selected, it will be approved if the health coverage is approved. If you are changing or modifying an existing/approved policy, dental is only available at your anniversary.

### Optional Benefits

Please select an optional benefit if available with chosen health plan.

- Office visit copay
- Prescription drug deductible:  \$0  \$500
- Lifetime Maximum Buy-Up
- Supplemental Accident Benefit:  \$500  \$1000

## Life Coverage Options

Please complete this section if choosing the term life rider or the term life plan for primary applicant and/or spouse.

Please include an additional page if you need to list multiple beneficiaries. Each additional page must be signed and dated.

### Primary Applicant:

- \$20,000 Term Life Rider** (can only be purchased with a health plan)

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

- Term Life Plan** (Minimum selection is \$25,000 and \$1,000 increments)

Term life insurance amount: \$ \_\_\_\_\_

Term length:  10 years  15 years  20 years

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

### Spouse:

- \$20,000 Term Life Rider** (can only be purchased with a health plan)

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

- Term Life Plan** (Minimum selection is \$25,000 and \$1,000 increments)

Term life insurance amount: \$ \_\_\_\_\_

Term length:  10 years  15 years  20 years

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

## Primary Applicant/Insured Information

If child-only coverage is requested, the youngest child is the Primary Applicant/Insured. Questions must be filled out by custodial parent or legal guardian.

First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Home address (not P.O. Box)			City		State	ZIP code
Social Security #		Country or State of birth		Email		
Type of business or industry	Occupation		Home phone # ( )		Daytime phone # ( )	
Mailing address (if different from home address)			City		State	ZIP code
Policyholder name if different than Primary Applicant (applicable for child-only application)						

## Parent or Guardian Information

Please complete this section if Primary Applicant/Insured is under 18 years of age.

First name	MI	Last name	Email		
Home address (not P.O. Box)		City	State	ZIP code	
Home phone # ( )	Daytime phone # ( )		Relationship to child(ren)		

## Family Information

Please complete only if your spouse and/or dependent children are applying for coverage. Attach an additional family information sheet if necessary. Each additional page must be signed and dated.

<b>Spouse</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Country or State of birth	Spouse's type of business or industry		Spouse's occupation			
Social Security #			Email			

<b>Dependent 1</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

<b>Dependent 2</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

<b>Dependent 3</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

<b>Dependent 4</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

## Existing Coverage

**IMPORTANT: DO NOT** cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

### • Existing Health Coverage

If you are applying for health coverage, please provide the status of current coverage, including Humana, for each applicant. If additional space is needed, please attach additional pages. Each additional page must be signed and dated.

No  Yes Do you or anyone applying for coverage have any health insurance coverage currently in force?

- **If yes, please supply the following for all applicants on the policy:**

Name(s) of covered persons \_\_\_\_\_

Insurance Carrier Name \_\_\_\_\_

Effective Date \_\_\_/\_\_\_/\_\_\_\_\_

### • Existing Dental Coverage

1.  No  Yes Does anyone applying for coverage currently have or had any group or individual dental coverage within the last 18 months?

- **If yes, please supply the following for all applicants on the policy:**

Name(s) \_\_\_\_\_

Effective Date \_\_\_/\_\_\_/\_\_\_\_\_

Insurance Carrier Name \_\_\_\_\_

Termination Date \_\_\_/\_\_\_/\_\_\_\_\_

Name(s) \_\_\_\_\_

Effective Date \_\_\_/\_\_\_/\_\_\_\_\_

Insurance Carrier Name \_\_\_\_\_

Termination Date \_\_\_/\_\_\_/\_\_\_\_\_

2.  No  Yes Will the insurance coverage applied for be used to replace existing dental coverage?

• Existing Life Coverage

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**Primary Applicant:**

1.  No  Yes Do you have any life insurance and/or annuity coverage currently in force?  
2.  No  Yes Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage?

• **If yes, please supply the following information:**

Company name	Amount \$	Policy #
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**Spouse:**

1.  No  Yes Do you have any life insurance and/or annuity coverage currently in force?  
2.  No  Yes Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage?

• **If yes, please supply the following information:**

Company name	Amount \$	Policy #
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**Eligibility & Health Status**

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Please answer for all individuals applying for coverage.

**For this insurance to be issued, the following eligibility and health questions must be answered fully and truthfully. All requested health information including routine physical exams and information related to spouse and dependents applying for coverage must be provided. If any of the answers are "yes", please provide complete details. Failure to disclose any health information may result in your policy being modified or terminated, back to your original effective date.**

1.  No  Yes Is anyone applying for coverage a citizen of a country other than the United States?

• **If yes:** Name(s): \_\_\_\_\_

**Has anyone applying for coverage:**

2.  No  Yes Experienced weight gain or loss of more than 20 pounds in the past 12 months?  
3. Within the past 12 months, has the primary applicant or spouse applying for coverage used any tobacco product?  
**Primary applicant:**  No  Yes **If yes:**  One time or less per week  More than once per week  
**Spouse:**  No  Yes **If yes:**  One time or less per week  More than once per week  
4.  No  Yes Does anyone applying for coverage plan to participate in any dangerous or extreme sport activities?  
5.  No  Yes Is the applicant, spouse or any of their dependents pregnant or an expectant mother or father?

**Within the past 5 years, has anyone applying for coverage:**

6.  No  Yes Been denied for health or life insurance or had their health coverage ridered, rated or rescinded?  
7.  No  Yes Been diagnosed with or received treatment for AIDS, or tested positive for AIDS or HIV?  
8.  No  Yes Had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any alcohol abuse, dependency or problem, or had any alcohol related arrests?  
9.  No  Yes Used any illegal or taken prescription drugs not prescribed by their health care provider or had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any drug abuse, dependency or problem; or had any drug related arrests?  
10.  No  Yes Had any testing or procedure performed that has been abnormal or the results of which are pending or unknown?  
11.  No  Yes Had or been advised to have inpatient or outpatient surgery, that is complete or has not been completed?  
12.  No  Yes Consulted, been advised or recommended to have follow-up testing or treatment by a health care provider or specialist that has not been completed?

## Eligibility & Health Status continued

13. **Within the past 5 years**, has anyone applying for coverage had signs of, been prescribed medication or received injections for, or been diagnosed with or treated for:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Chest pain or Heart Attack	M. <input type="checkbox"/> No <input type="checkbox"/> Yes Behavioral, Emotional, Mental or Nervous Disorder
B. <input type="checkbox"/> No <input type="checkbox"/> Yes High Blood Pressure or Hypertension	N. <input type="checkbox"/> No <input type="checkbox"/> Yes Eating Disorder
C. <input type="checkbox"/> No <input type="checkbox"/> Yes High Cholesterol or Triglycerides	O. <input type="checkbox"/> No <input type="checkbox"/> Yes Developmental Disorder or Delay
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Cancer or Tumor of any kind	P. <input type="checkbox"/> No <input type="checkbox"/> Yes Human Papilloma Virus or Sexually Transmitted Disease
E. <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes or High Blood Sugar	Q. <input type="checkbox"/> No <input type="checkbox"/> Yes Infertility
F. <input type="checkbox"/> No <input type="checkbox"/> Yes Stroke	R. <input type="checkbox"/> No <input type="checkbox"/> Yes Cyst, Growth, Lump or Polyp
G. <input type="checkbox"/> No <input type="checkbox"/> Yes Paralysis	S. <input type="checkbox"/> No <input type="checkbox"/> Yes Hernia
H. <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy or Seizure	T. <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis
I. <input type="checkbox"/> No <input type="checkbox"/> Yes Migraines or frequent or severe headaches	U. <input type="checkbox"/> No <input type="checkbox"/> Yes Implants, Pins, Plates, Rods Screws or Prosthesis
J. <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis	V. <input type="checkbox"/> No <input type="checkbox"/> Yes Connective Tissue or Autoimmune Disorder
K. <input type="checkbox"/> No <input type="checkbox"/> Yes Sleep Apnea	W. <input type="checkbox"/> No <input type="checkbox"/> Yes Birth Defect
L. <input type="checkbox"/> No <input type="checkbox"/> Yes Anxiety or Depression	

14. **Within the past 5 years**, has anyone applying for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Gallbladder, Liver or Pancreas	G. <input type="checkbox"/> No <input type="checkbox"/> Yes Breasts
B. <input type="checkbox"/> No <input type="checkbox"/> Yes Colon, Esophagus or Stomach	H. <input type="checkbox"/> No <input type="checkbox"/> Yes Menstrual Cycle
C. <input type="checkbox"/> No <input type="checkbox"/> Yes Bladder or Kidneys	I. <input type="checkbox"/> No <input type="checkbox"/> Yes Cervix, Ovaries, Uterus or Vagina
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Back, Disc, Neck or Spine	J. <input type="checkbox"/> No <input type="checkbox"/> Yes Penis, Prostate or Testicles
E. <input type="checkbox"/> No <input type="checkbox"/> Yes Lungs	K. <input type="checkbox"/> No <input type="checkbox"/> Yes Skin
F. <input type="checkbox"/> No <input type="checkbox"/> Yes Eyes, Ears, Nose, Throat or Sinuses	

15. **Within the past 5 years**, has anyone applying for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood Vessels, Heart or Circulatory System	E. <input type="checkbox"/> No <input type="checkbox"/> Yes Urinary System
B. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood, Gland, Pituitary, Thyroid or Lymph System	F. <input type="checkbox"/> No <input type="checkbox"/> Yes Musculoskeletal System
C. <input type="checkbox"/> No <input type="checkbox"/> Yes Brain or Nervous System	G. <input type="checkbox"/> No <input type="checkbox"/> Yes Respiratory System
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Digestive System	H. <input type="checkbox"/> No <input type="checkbox"/> Yes Reproductive System

16.  No  Yes Has anyone applying for coverage seen a health care provider or specialist for any reason (including routine visits) or symptom not previously disclosed above?

17.  No  Yes Within the past 24 months, has anyone applying for coverage been advised to take or taken any prescription medications or injections?

## Additional Eligibility or Health Status Question Information

To be completed if anyone applying for coverage answered "Yes" to any question(s) in the Eligibility & Health Status section. Please provide details such as; specific condition, dates of treatment, results or advice given, medication (dosage and frequency), treatment plan, recovery date, physician name and address. Attach an additional health information sheet if necessary. Additional information sheets must be signed and dated by the primary applicant or legal representative and/or spouse (if applying).

Question #	Letter	Person treated	Condition
Details:			
Question #	Letter	Person treated	Condition
Details:			
Question #	Letter	Person treated	Condition
Details:			

## Agreement and Signature

### True and Complete Acknowledgment:

I understand, agree and represent: I have read this document or it has been read to me. The answers are true and complete. I have received and reviewed any state or federal required disclosures. Neither I nor my company representative has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements. This policy applied for is not an employer-sponsored group health plan and it does not comply with state or federal small employer laws. I certify that I do not qualify for or have willingly waived a group health plan or receive favorable tax treatment under federal or state law that will be used to pay insurance premiums. If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the policy. Acceptance of premium and fees does not guarantee coverage. Any misrepresentation on this application may be used by Humana during the first two policy years to void the contract or modify the terms of coverage. This may result in loss of coverage, modification of coverage and/or claim denial. By signing below, I agree to terminate existing coverage if approved. As a parent or legal guardian of a dependent 18 years or older applying for coverage, I attest by my signature below, that I have gathered the necessary health information from my dependent in order to fully and truthfully complete this application.

*This document, together with any supplements, will form part of and be the basis for any policy issued.*

**Any person who submits an application containing a false, incomplete or deceptive statement may be guilty of insurance fraud.**

**If you decide not to sign this agreement, we will decline to enroll you in a medical plan or to give you medical benefits.**

Primary Applicant or Legal Guardian Signature \_\_\_\_\_ Date \_\_/\_\_/\_\_\_\_

Relationship of Legal Guardian \_\_\_\_\_

Spouse Signature \_\_\_\_\_ Date \_\_/\_\_/\_\_\_\_  
(if covered dependent)

### Agent / Producer Information

This section to be completed by Agent or Producer.

1. Agent/Agency of Record:	2. Writing Agent / Producer:
Name (print)	Name (print)
Humana Agent #	Humana Agent #

### Agent replacement question:

**Will this policy replace or change any existing life insurance policy(s) and/or annuity(s)?**  No  Yes

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the applicant in the benefit summary document or other plan literature.

Writing agent's signature \_\_\_\_\_ Date \_\_/\_\_/\_\_\_\_

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana."

**Medical and Life products insured by Humana Insurance Company**  
**Dental products insured by HumanaDental Insurance Company**

**HUMANA**  
*Guidance* when you need it most

## Pre-Notice

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Humana, or its reinsurers, may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

# HumanaOne PPO Annual Max Plan Enrollment Form



Please print clearly in ink. Complete all questions. Fill in all fields or indicate "not applicable."  
If you have not had continuous health coverage within the past 63 days, you must choose an effective date that is 30-45 days past the date of the enrollment form.

Date of form: \_\_\_/\_\_\_/\_\_\_ Requested Effective Date: \_\_\_/\_\_\_/\_\_\_

**ALABAMA**

- This form is for:
- New Business (First time enrollee)
  - Reinstatement (Reenrollment)
  - Change/modification to Existing Policy or Plan

Reason for change \_\_\_\_\_  
Change/Modification to Existing Policy or Plan # \_\_\_\_\_

## Health & Dental Coverage Options

### Health Coverage

Please complete this section when selecting a health plan.

Deductible Amount:  \$1,000  \$2,000  \$3,000

#### PPO Plan 50/30

(Please select each of the following for the PPO Plan 50/30)

**Please Note:** Some options may not be available with all deductibles, or annual maximums.

**1. Calendar Year Annual Maximum:**

- \$100,000  \$250,000

**2. Calendar Year Annual Outpatient Maximum:**

- \$5,000  
 \$10,000 (Available only with \$250,000 annual maximum)

**3. Supplemental Accident Benefit:**

- \$500  \$1,000

#### PPO Plan 75/55

(Please select each of the following for the PPO Plan 75/55)

**Please Note:** Some options may not be available with all deductibles, or annual maximums.

**1. Calendar Year Annual Maximum:**

- \$100,000  \$250,000

**2. Calendar Year Annual Outpatient Maximum:**

- \$5,000  
 \$10,000 (Available only with \$250,000 annual maximum)

**3. Supplemental Accident Benefit:**

- \$500  \$1,000

#### Dental Coverage

**Please note:** You may purchase dental coverage if health coverage is chosen. If dental is selected, it will be approved if the health coverage is approved. If you are changing or modifying an existing/approved policy or plan, dental is only available at your anniversary.

#### Important information about the Health Insurance Plan you are about to apply for

I have reviewed the plan information and understand the HumanaOne PPO Annual Max plan has calendar year policy limits for all covered services, for outpatient services, and for pharmacy services (where applicable). Expenses enrolled to the outpatient and pharmacy calendar year limits will also be enrolled to the all covered services calendar year limit. I understand any costs incurred for services above the calendar year limits are entirely my responsibility. I understand Humana has other plans available that do not have calendar year limits.

## Life Coverage Options

Please complete this section if choosing the term life rider or the term life plan for insured and/or spouse.

Please include an additional page if you need to list multiple beneficiaries. Each additional page must be signed and dated.

#### Primary Insured:

- \$20,000 Term Life Rider** (can only be purchased with a health plan)

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

- Term Life Plan** (Minimum selection is \$25,000 and \$1,000 increments)

Term life insurance amount: \$ \_\_\_\_\_

Term length:  10 years  15 years  20 years

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

#### Spouse:

- \$20,000 Term Life Rider** (can only be purchased with a health plan)

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

- Term Life Plan** (Minimum selection is \$25,000 and \$1,000 increments)

Term life insurance amount: \$ \_\_\_\_\_

Term length:  10 years  15 years  20 years

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

## Primary Insured Information

If child-only coverage is requested, the youngest child is the Primary Insured. Questions must be filled out by custodial parent or legal guardian.

First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Home address (not P.O. Box)			City	State	ZIP code	
Social Security #		Country or State of birth	Email			
Type of business or industry	Occupation		Home phone # ( )	Daytime phone # ( )		
Mailing address (if different from home address)			City	State	ZIP code	
Certificateholder name if different than Primary Insured (applicable for child-only enrollment form)						

## Parent or Guardian Information

Please complete this section if Primary Insured is under 18 years of age.

First name	MI	Last name	Email			
Home address (not P.O. Box)			City	State	ZIP code	
Home phone # ( )	Daytime phone # ( )		Relationship to child(ren)			

## Family Information

Please complete only if your spouse and/or dependent children are enrolling for coverage. Attach an additional family information sheet if necessary. Each additional page must be signed and dated.

<b>Spouse</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Country or State of birth	Spouse's type of business or industry			Spouse's occupation		
Social Security #			Email			

<b>Dependent 1</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

<b>Dependent 2</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

<b>Dependent 3</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

<b>Dependent 4</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

## Existing Coverage

**IMPORTANT: DO NOT** cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

### • Existing Health Coverage

If you are enrolling for health coverage, please provide the status of current coverage, including Humana, for each person enrolling.

If additional space is needed, please attach additional pages. Each additional page must be signed and dated.

No  Yes Do you or anyone enrolling for coverage have any health insurance coverage currently in force?

- If yes, please supply the following for all persons enrolling on the plan:

Name(s) of covered persons

Insurance Carrier Name

Effective Date \_\_\_/\_\_\_/\_\_\_\_\_

• Existing Dental Coverage

1.  No  Yes Does anyone enrolling for coverage currently have or had any dental coverage within the last 18 months?

• If yes, please supply the following for all persons enrolling for coverage on the plan:

Name(s) \_\_\_\_\_ Effective Date \_\_\_/\_\_\_/\_\_\_\_\_

Insurance Carrier Name \_\_\_\_\_ Termination Date \_\_\_/\_\_\_/\_\_\_\_\_

Name(s) \_\_\_\_\_ Effective Date \_\_\_/\_\_\_/\_\_\_\_\_

Insurance Carrier Name \_\_\_\_\_ Termination Date \_\_\_/\_\_\_/\_\_\_\_\_

2.  No  Yes Will the insurance coverage enrolled for be used to replace existing dental coverage?

• Existing Life Coverage

Primary Insured:

1.  No  Yes Do you have any life insurance and/or annuity coverage currently in force?

2.  No  Yes Will the insurance coverage enrolled for be used to replace any existing life and/or annuity coverage?

• If yes, please supply the following information:

Company name \_\_\_\_\_ Amount \$ \_\_\_\_\_ Plan # \_\_\_\_\_

Spouse:

1.  No  Yes Do you have any life insurance and/or annuity coverage currently in force?

2.  No  Yes Will the insurance coverage enrolled for be used to replace any existing life and/or annuity coverage?

• If yes, please supply the following information:

Company name \_\_\_\_\_ Amount \$ \_\_\_\_\_ Plan # \_\_\_\_\_

Eligibility & Health Status

Please answer for all individuals enrolling for coverage.

For this insurance to be issued, the following eligibility and health questions must be answered fully and truthfully. All requested health information including routine physical exams and information related to spouse and dependents enrolling for coverage must be provided. If any of the answers are "yes", please provide complete details. Failure to disclose any eligibility or health information may result in your plan being modified or terminated, back to your original effective date.

1.  No  Yes Is anyone enrolling for coverage a citizen of a country other than the United States?

• If yes: Name(s): \_\_\_\_\_

Has anyone enrolling for coverage:

2.  No  Yes Experienced weight gain or loss of more than 20 pounds in the past 12 months?

3. Within the past 12 months, has the primary insured or spouse enrolling for coverage used any tobacco product?

Primary Insured:  No  Yes

Spouse:  No  Yes

4.  No  Yes Does anyone enrolling for coverage plan to participate in any dangerous or extreme sport activities?

5.  No  Yes Is the primary insured, spouse or any of their dependents pregnant or an expectant mother or father?

Within the past 5 years, has anyone enrolling for coverage:

6.  No  Yes Been denied for health or life insurance or had their health coverage ridered, rated or rescinded?

7.  No  Yes Been diagnosed with or received treatment for AIDS, or tested positive for AIDS or HIV?

8.  No  Yes Had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any alcohol abuse, dependency or problem, or had any alcohol related arrests?

9.  No  Yes Used any illegal or taken prescription drugs not prescribed by their health care provider or had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any drug abuse, dependency or problem; or had any drug related arrests?

10.  No  Yes Had any testing or procedure performed that has been abnormal or the results of which are pending or unknown?

11.  No  Yes Had or been advised to have inpatient or outpatient surgery, that is complete or has not been completed?

12.  No  Yes Consulted, been advised or recommended to have follow-up testing or treatment by a health care provider or specialist that has not been completed?

## Eligibility & Health Status continued

13. **Within the past 5 years**, has anyone enrolling for coverage had signs of, been prescribed medication or received injections for, or been diagnosed with or treated for:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Chest pain or Heart Attack	M. <input type="checkbox"/> No <input type="checkbox"/> Yes Behavioral, Emotional, Mental or Nervous Disorder
B. <input type="checkbox"/> No <input type="checkbox"/> Yes High Blood Pressure or Hypertension	N. <input type="checkbox"/> No <input type="checkbox"/> Yes Eating Disorder
C. <input type="checkbox"/> No <input type="checkbox"/> Yes High Cholesterol or Triglycerides	O. <input type="checkbox"/> No <input type="checkbox"/> Yes Developmental Disorder or Delay
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Cancer or Tumor of any kind	P. <input type="checkbox"/> No <input type="checkbox"/> Yes Human Papilloma Virus or Sexually Transmitted Disease
E. <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes or High Blood Sugar	Q. <input type="checkbox"/> No <input type="checkbox"/> Yes Infertility
F. <input type="checkbox"/> No <input type="checkbox"/> Yes Stroke	R. <input type="checkbox"/> No <input type="checkbox"/> Yes Cyst, Growth, Lump or Polyp
G. <input type="checkbox"/> No <input type="checkbox"/> Yes Paralysis	S. <input type="checkbox"/> No <input type="checkbox"/> Yes Hernia
H. <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy or Seizure	T. <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis
I. <input type="checkbox"/> No <input type="checkbox"/> Yes Migraines or frequent or severe headaches	U. <input type="checkbox"/> No <input type="checkbox"/> Yes Implants, Pins, Plates, Rods Screws or Prosthesis
J. <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis	V. <input type="checkbox"/> No <input type="checkbox"/> Yes Connective Tissue or Autoimmune Disorder
K. <input type="checkbox"/> No <input type="checkbox"/> Yes Sleep Apnea	W. <input type="checkbox"/> No <input type="checkbox"/> Yes Birth Defect
L. <input type="checkbox"/> No <input type="checkbox"/> Yes Anxiety or Depression	

14. **Within the past 5 years**, has anyone enrolling for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Gallbladder, Liver or Pancreas	G. <input type="checkbox"/> No <input type="checkbox"/> Yes Breasts
B. <input type="checkbox"/> No <input type="checkbox"/> Yes Colon, Esophagus or Stomach	H. <input type="checkbox"/> No <input type="checkbox"/> Yes Menstrual Cycle
C. <input type="checkbox"/> No <input type="checkbox"/> Yes Bladder or Kidneys	I. <input type="checkbox"/> No <input type="checkbox"/> Yes Cervix, Ovaries, Uterus or Vagina
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Back, Disc, Neck or Spine	J. <input type="checkbox"/> No <input type="checkbox"/> Yes Penis, Prostate or Testicles
E. <input type="checkbox"/> No <input type="checkbox"/> Yes Lungs	K. <input type="checkbox"/> No <input type="checkbox"/> Yes Skin
F. <input type="checkbox"/> No <input type="checkbox"/> Yes Eyes, Ears, Nose, Throat or Sinuses	

15. **Within the past 5 years**, has anyone enrolling for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood Vessels, Heart or Circulatory System	E. <input type="checkbox"/> No <input type="checkbox"/> Yes Urinary System
B. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood, Gland, Pituitary, Thyroid or Lymph System	F. <input type="checkbox"/> No <input type="checkbox"/> Yes Musculoskeletal System
C. <input type="checkbox"/> No <input type="checkbox"/> Yes Brain or Nervous System	G. <input type="checkbox"/> No <input type="checkbox"/> Yes Respiratory System
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Digestive System	H. <input type="checkbox"/> No <input type="checkbox"/> Yes Reproductive System

16.  No  Yes Has anyone enrolling for coverage seen a health care provider or specialist for any reason (including routine visits) or symptom not previously disclosed above?

17.  No  Yes Within the past 24 months, has anyone enrolling for coverage been advised to take or taken any prescription medications or injections?

## Additional Eligibility or Health Status Question Information

To be completed if anyone enrolling for coverage answered "Yes" to any question(s) in the Eligibility & Health Status section. Please provide details such as; specific condition, dates of treatment, results or advice given, medication (dosage and frequency), treatment plan, recovery date, physician name and address. Attach an additional health information sheet if necessary. Additional information sheets must be signed and dated by the primary insured or legal representative and/or spouse (if enrolling).

Question #	Letter	Person treated	Condition
Details:			
Question #	Letter	Person treated	Condition
Details:			
Question #	Letter	Person treated	Condition
Details:			

## Agreement and Signature

### True and Complete Acknowledgment:

I understand, agree and represent: I have read this document or it has been read to me. The answers are true and complete. I have received and reviewed any state or federal required disclosures. Neither I nor my company representative has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements. This plan enrolled for is not an employer-sponsored group health plan and it does not comply with state or federal small employer laws. I certify that I do not qualify for or have willingly waived a group health plan or receive favorable tax treatment under federal or state law that will be used to pay insurance premiums. If this enrollment form for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate. Acceptance of premium and fees does not guarantee coverage. Any misrepresentation on this enrollment form may be used by Humana during the first two plan years to void the contract or modify the terms of coverage. This may result in loss of coverage, modification of coverage and/or claim denial. By signing below, I agree to terminate existing coverage if approved. As a parent or legal guardian of a dependent 18 years or older enrolling for coverage, I attest by my signature below, that I have gathered the necessary health information from my dependent in order to fully and truthfully complete this enrollment form.

*This document, together with any supplements, will form part of and be the basis for any certificate issued.*

**Any person who submits an enrollment form containing a false, incomplete or deceptive statement may be guilty of insurance fraud.**

**If you decide not to sign this agreement, we will decline to enroll you in a medical plan or to give you medical benefits.**

Primary Insured or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship of Legal Guardian \_\_\_\_\_

Spouse Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(if covered dependent)

### Agent / Producer Information

This section to be completed by Agent or Producer.

1. Agent/Agency of Record:	2. Writing Agent / Producer:
Name (print)	Name (print)
Humana Agent #	Humana Agent #

### Agent replacement question:

**Will this policy replace or change any existing life insurance policy(s) and/or annuity(s)?**  No  Yes

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary insured submitting this enrollment form in order to fully and accurately represent the terms and conditions of the plans and services of the insuring entity, or one of its subsidiaries. These provisions are available to me and the primary insured in the benefit summary document or other plan literature.

Writing Agent's Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this enrollment form as "Humana."

**Medical and Life products insured by Humana Insurance Company  
Dental products insured by HumanaDental Insurance Company**

**HUMANA**  
*Guidance* when you need it most

# HumanaOne Association Enrollment Form



## **Association Enrollment**

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The Association, Peoples' Benefit Alliance, is a membership organization that provides educational information and discounts on goods and services to its members. Membership in the Association is required, at additional cost, in order to be eligible for insurance coverage. The Association benefits information will be sent under separate cover. By signing below, you are requesting enrollment in the Association.

Primary Association Member or Legal Guardian Signature

\_\_\_\_\_ Date \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

# HumanaOne Individual Insurance Payment Authorization & Billing Form



## Quoted Monthly Payment Amount:

\$ \_\_\_\_\_ (total payment for all products selected; not including administrative or enrollment fees)

- PPO Annual Max Plan Association Dues: \$3.95 Monthly (non-refundable)
- Dental Preventive Plus Association Dues: 75¢ Monthly (non-refundable) (no dues apply if enrolled in PPO Annual Max Plan Association)
- Administration Fee (DHMO, Dental Preventive Plus & Vision Direct): \$1 Fee applies to each payment
- Enrollment Fee (Vision Direct & Dental Preventive Plus): \$35 One-Time Fee per plan (non-refundable)
- Dental DHMO Enrollment Fee: \$19 One-Time Fee (non-refundable)

## Payor Information

If you are paying for the plan(s), please provide the following information. Then tell us how you would like to pay for the plan(s) by completing 1 and 2 below. If you will be paying for someone else's plan(s), please also complete the Alternate Payor section below.

First name	MI	Last name	Home phone # ( )	Daytime phone # ( )
Home address (not P.O. Box)		City	State	ZIP code

**Alternate Payor:** If you are paying for an insurance plan(s) for someone else, please provide the following information about the primary applicant whose plan(s) you will be paying for. Please note, if you are paying for someone else's plan(s), you will be responsible for signing this authorization to withdraw funds from your selected accounts; not the primary applicant.

<b>Primary Applicant</b> First name	MI	Last name
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## 1. Initial Payment Options

Please choose either credit card or one-time bank withdrawal payment of the first month's payment. Initial payment for each product applied for will be drafted separately against your account.

### A. Credit Card Payment

- Visa       Mastercard

Card # \_\_\_\_\_

Expiration date      /

Cardholder's name \_\_\_\_\_

- I authorize Humana to draw initial payment of \$ \_\_\_\_\_ and fees from my Visa / Mastercard account.

### B. One-time Automatic Bank Withdrawal

Account holder's name \_\_\_\_\_

Bank name \_\_\_\_\_

Routing # \_\_\_\_\_

Account # \_\_\_\_\_

- I authorize Humana to draw initial payment of \$ \_\_\_\_\_ and fees from my designated checking account.

## 2. Subsequent Payment Options

Please indicate billing preference. If choosing automatic bank withdrawal, please complete the section to the right.

### A. Credit Card Payment (monthly billing)

If selected a fee of \$ \_\_\_\_\_ will apply.

- Mastercard

Card # \_\_\_\_\_

Expiration date      /

Cardholder's name \_\_\_\_\_

- I authorize Humana to draw subsequent payment of \$ \_\_\_\_\_ and fees from my Mastercard account until this authorization is revoked by me.

### B. Automatic Bank Withdrawal (monthly billing)

Account holder's name \_\_\_\_\_

Bank name \_\_\_\_\_

Routing # \_\_\_\_\_

Account # \_\_\_\_\_

- I authorize Humana to draw subsequent payment of \$ \_\_\_\_\_ and fees from my designated checking account until this authorization is revoked by me.

### C. Direct Bill

If selected a fee of \$ \_\_\_\_\_ will apply.

- Monthly billing \_\_\_\_\_

- Quarterly billing \_\_\_\_\_

- Semi-Annual billing \_\_\_\_\_

Payor Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# Medical Records Release Authorization

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## Purpose of the Authorization

By signing the form, you will authorize the disclosure and use of the protected health information described below for pre-enrollment underwriting or risk-rating of health insurance coverage for you, or to determine your eligibility for enrollment or benefits under a health plan.

## Information we will use and/or disclose

My dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., employer or the Consumer Reporting Agency having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness and copies of all hospital or medical records, non-public personal health information, and any other non-medical information to share any and all such information with the Company, its reinsurer or its legal representatives, and its affiliates.

- The information obtained by use of this authorization may be used by the Company to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
- Any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing health care operations or business or legal services in connection with any application, claim or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report and I (we) may request a copy of the report.
- Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.

## Expiration and revocation

- A copy of this authorization is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below. I have the right to revoke this authorization at any time.  
To revoke this authorization:
  - I must do so in writing and send my written revocation to Humana's Privacy Office.
  - The revocation will not apply to information that has already been released in response to this authorization.
  - The revocation may adversely affect my application, a claim or a pending insurance action.
  - The revocation will become effective after it is received by Humana's Privacy Office.

**If you decide not to sign this authorization, we will decline to enroll you in a medical plan or to give you medical benefits.**

Primary Applicant or Legal Guardian Signature \_\_\_\_\_ Date \_\_/\_\_/\_\_\_\_

Relationship of Legal Guardian \_\_\_\_\_

Spouse Signature \_\_\_\_\_ Date \_\_/\_\_/\_\_\_\_  
(if covered dependent)

Child Signature \_\_\_\_\_ Date \_\_/\_\_/\_\_\_\_  
(if covered dependent over the legal age)

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana".

**Medical and Life products insured by Humana Insurance Company  
Dental products insured by HumanaDental Insurance Company**

**HUMANA**<sup>®</sup>  
*Guidance* when you need it most

# Notice of Privacy Practices

for your **personal** health and financial information

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.**

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. We at Humana value our relationship with you, and we take your personal privacy seriously.

This notice explains Humana's privacy practices, our legal responsibilities, and your rights concerning your personal and health information. We follow the privacy practices described in this notice and will notify you of any changes.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

## What is personal and health information?

Personal and health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information created or received by a healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

## How does Humana protect my information?

In keeping with federal and state laws and our own policy, Humana has a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy policies and procedures

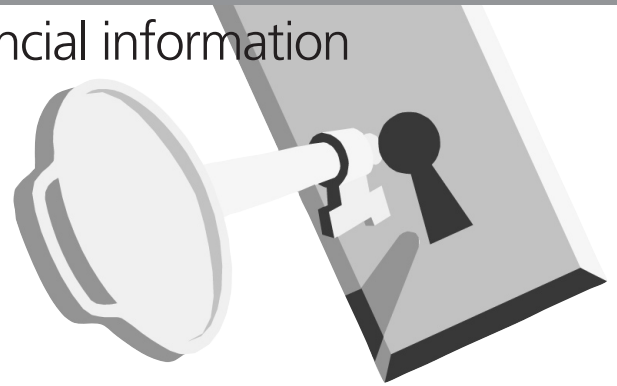
## How does Humana use and disclose my information?

We must use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law.

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments
- For healthcare operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, and determining premiums
- For performing underwriting activities
- To your plan sponsor to permit them to perform plan administration functions
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you
- To your family and friends if you are unavailable to communicate, such as in an emergency



# Notice of Privacy Practices *(continued)*

- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law
- To assist in disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill Humana's obligations under any workers' compensation law or contract
- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director.

## **Will Humana use my information for purposes not described in this notice?**

In all situations other than described in this notice, Humana will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission.

## **What does Humana do with my information when I am no longer a Humana member or I do not obtain coverage through Humana?**

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through Humana. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

## **What are my rights concerning my information?**

The following are your rights with respect to your information:

- **Access** – You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- **Alternate Communications** – You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life-threatening situation. We will accommodate your request if it is reasonable.
- **Amendment** – You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- **Disclosure** – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. Effective April 1, 2003 or whenever you became a Humana member, Humana began maintaining these types of disclosures and will maintain this information for a period of six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- **Notice** – You have the right to receive a written copy of this notice any time you request.
- **Restriction** – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

# Notice of Privacy Practices *(continued)*

## **How do I exercise my rights or obtain a copy of this notice?**

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- E-mailing us at [privacyoffice@humana.com](mailto:privacyoffice@humana.com)

Send completed request form to:  
Humana Privacy Office  
P.O. Box 1438  
Louisville, KY 40202

## **What should I do if I believe my privacy has been violated?**

If you believe your privacy has been violated in any way, you may file a complaint with Human by calling us at: 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov). We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

## **PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION**

Humana and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

## **How does Humana collect information about me?**

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive

information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

## **What information does Humana receive about me?**

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our Website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

## **Where will Humana disclose my information?**

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

## **What can I prevent with an opt-out disclosure?**

You can prevent the disclosures to non-affiliated third parties that provide products and services not offered by Humana or where the non-affiliated company provides services related to your plan by requesting to opt-out of such disclosures. Your opt-out request will apply to all members or individuals covered under your Humana identification number or member account.

Your opt-out request will continue to apply until you revoke your request or terminate your membership.

## **How do I request an opt-out?**

At any time you can tell Humana not to share any of your personal information with affiliated companies that provide offers of non-Humana products or services. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth, and your Humana member identification number. You can use any of the methods below to request or revoke your opt-out:

- Call us at 1-866-861-2762
- E-mail us at [privacyoffice@humana.com](mailto:privacyoffice@humana.com).

# Notice of Privacy Practices *(continued)*

- Send your opt-out request to us in writing:  
Humana Privacy Office  
P. O. Box 1438  
Louisville, KY 40202

Humana follows all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, Humana follows the law, rule, or regulation which provides greater protection.

The following affiliates and subsidiaries also adhere to Humana's privacy policies and procedures:

American Dental Providers of Arkansas, Inc.  
American Dental Plan of North Carolina, Inc.  
Cariten Insurance Company  
Cariten Health Plan  
CarePlus Health Plans, Inc.  
CompBenefits Company  
CompBenefits Dental, Inc.  
CompBenefits Insurance Company  
CompBenefits of Alabama, Inc.  
CompBenefits of Georgia, Inc.  
CorpHealth, Inc.  
CorpHealth Provider Link, Inc.  
DentiCare, Inc.  
EmpheSys, Inc.  
EmpheSys Insurance Company  
HumanaDental Insurance Company

Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.  
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.  
Humana Health Benefit Plan of Louisiana, Inc.  
Humana Employers Health Plan of Georgia, Inc.  
Humana Health Insurance Company of Florida, Inc.  
Humana Health Plan of Ohio, Inc.  
Humana Health Plan of Texas, Inc.  
Humana Health Plan, Inc.  
Humana Health Plans of Puerto Rico, Inc.  
Humana Insurance Company  
Humana Insurance Company of Kentucky  
Humana Insurance Company of New York  
Humana Insurance of Puerto Rico, Inc.  
Humana Medical Plan, Inc.  
Humana MarketPOINT, Inc.\*  
Humana MarketPOINT of Puerto Rico, Inc.\*  
Humana Medical Plan of Utah, Inc.  
Humana Wisconsin Health Organization Insurance Corporation  
Kanawha Insurance Company\*  
Managed Care Indemnity, Inc.  
Preferred Health Partnership, Inc.\*  
Preferred Health Partnership of Tennessee, Inc.  
The Dental Concern, Inc.  
The Dental Concern, Ltd.

\* These affiliates and subsidiaries are only covered by the Privacy Notice Concerning Financial Information section.

**HUMANA**<sup>®</sup>  
*Guidance* when you need it most

## HEALTH INSURANCE DISCLOSURES

### **FAIR CREDIT REPORTING ACT AND PRIVACY ACT PRE-NOTIFICATION:**

Public Law 91-508 and state privacy acts require that Humana Insurance Company advise person(s) applying for coverage that an investigative report may be made in connection with this application which will provide applicable information concerning character and general reputation. I (we) understand that this information may be obtained through a phone interview or personal interview with the person (s) applying for coverage or other third parties. I (we) may request to be interviewed in connection with the preparation of the report and I (we) may request a copy of the report.

### **NOTICE OF INFORMATION PRACTICES:**

I (we) understand that in order to properly underwrite insurance coverage, Humana Insurance Company must collect personal information concerning the insurability of person(s) applying for coverage. Humana Insurance Company may also contact other sources, including medical professionals and institutions, employer, and other insurance companies. I (we) understand that I (we) have the right to be told about, and to see (and receive a copy of) items of personal information about me (us) which may appear in my (our) files. I (we) understand that I (we) have the right to seek correction, amendment, or deletion of information I (we) believe to be inaccurate. If I (we) have questions or desire additional information about the items disclosed above, I (we) understand that I (we) may write to:

Humana Insurance Company  
P. O. Box 1633  
Waukesha, WI 53187-1633



Insured by Humana Insurance Company

Dental Insurance provided by HumanaDental Insurance Company

**ALABAMA IMPORTANT NOTICE:  
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? \_\_\_\_\_ YES \_\_\_\_\_ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? \_\_\_\_\_ YES \_\_\_\_\_ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) FINANCING (F)
1 _____			
2 _____			
3 _____			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because \_\_\_\_\_.

I certify that the responses herein are, to the best of my knowledge, accurate:

\_\_\_\_\_  
Applicant's Name and Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent's Name and Signature

\_\_\_\_\_  
Date

I do not want this notice read aloud to me. \_\_\_\_\_ (Applicants must initial only if they do not want the notice read aloud.)



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## **ALABAMA IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

**PREMIUMS:** Are they affordable?  
Could they change?  
You're older-are premiums higher for the proposed new policy?  
How long will you have to pay premiums on the new policy? On the old policy?

**POLICY VALUES:** New policies usually take longer to build cash values and to pay dividends.  
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.  
What surrender charges do the policies have?  
What expense and sales charges will you pay on the new policy?  
Does the new policy provide more insurance coverage?

**INSURABILITY:** If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.  
You may need a medical exam for a new policy.  
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.  
Suicide limitations may begin anew on the new coverage.

**IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:**  
How are premiums for both policies being paid?  
How will the premiums on your existing policy be affected?  
Will a loan be deducted from death benefits?  
What values from the old policy are being used to pay premiums?

**IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:**  
Will you pay surrender charges on your old contract?  
What are the interest rate guarantees for the new contract?  
Have you compared the contract charges or other policy expenses?

**OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**  
What are the tax consequences of buying the new policy?  
Is this a tax free exchange? (See your tax advisor.)  
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?  
Will the existing insurer be willing to modify the old policy?  
How does the quality and financial stability of the new company compare with your existing company?



Insured by Humana Insurance Company

# Consent for Electronic Delivery

Thank you for choosing HumanaOne. If you'd like to view, print, and save your policy and other documents online, please complete this form and return it to your agent. You must have Adobe® Acrobat Reader™ to open and save your documents. **Note: To opt for this service, you must include your signature and e-mail address.**

## › Agreement with Humana

This agreement is between you and Humana Inc., on behalf of its affiliates.

## › Consent to Electronic Transactions

I, the User, and Humana acknowledge and agree to the following provisions:

1. To conduct this enrollment and any changes made to this enrollment information through the use of an electronic transaction which will be verified by the use of an electronic signature.
2. This consent to conduct electronic transactions only applies to enrollment services and policy and/or certificate delivery and changes.
3. That I may request that this Agreement be terminated. If terminated, paper access to enrollment services and forms will be distributed at no cost to me if an address, phone number and a contact name are provided to a Humana representative.
4. That I may request a paper copy of this recorded transaction.
5. To be bound by this agreement as stated by law throughout the term of this Agreement.
6. This Agreement may be modified at any time if Humana provides notice.

E-mail address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



Insured by Humana Insurance Company, Humana Health Plan, Inc., Humana Health Insurance Company of Florida, Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Benefit Plan of Louisiana, Inc., HumanaDental Insurance Company or The Dental Concern, Inc.  
For residents of Arizona and Texas: Insured by Humana Insurance Company.

The HumanaOne brand of individual products are insured by subsidiaries of Humana, Inc.