

## Pre-Notice

---

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



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 Health Insurance Company of Florida, Inc.  
Dental products insured by HumanaDental Insurance Company**

**FLORIDA**

**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.**

**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	Birth date / /
Home address (not PO 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 PO 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.

<b>Spouse</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
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	Birth date / /
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	Birth date / /
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	Birth date / /
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	Birth date / /
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:** Replaced Policy Number \_\_\_\_\_  
 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:** Replaced Policy Number \_\_\_\_\_  
 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

---

**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 #
--------------	-----------	----------

---

**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 #
--------------	-----------	----------

---

**Eligibility & Health Status**

---

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): \_\_\_\_\_

**To the best of your knowledge and belief, 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 Has the applicant, spouse or any of their dependents been diagnosed as pregnant by a licensed member of the medical profession or an expectant mother or father?

**To the best of your knowledge and belief, 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 Has been tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Aids-Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?  
8.  No  Yes Had any signs or symptoms of, been diagnosed by a licensed member of the medical profession, 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 a licensed member of the medical profession or had any signs or symptoms of, been diagnosed by a licensed member of the medical profession, 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 by a licensed member of the medical profession that has been abnormal or the results of which are pending or unknown?  
11.  No  Yes Had or been advised by a licensed member of the medical profession 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 licensed member of the medical profession that has not been completed?

## Eligibility & Health Status continued

13. **Within the past 5 years**, to the best of your knowledge and belief, has anyone applying for coverage had signs of, been prescribed medication or received injections for, or been diagnosed with or treated by a licensed member of the medical profession 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 Diagnosis
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**, to the best of your knowledge and belief, has anyone applying for coverage been prescribed medication or received injections for or been diagnosed with any injury, condition or disease by a licensed member of the medical profession that affected one of the following:

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**, to the best of your knowledge and belief, has anyone applying for coverage been prescribed medication or received injections for or been diagnosed with any injury, condition or disease by a licensed member of the medical profession that affected one of the following:

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 Within the past 5 years, to the best of your knowledge and belief, has anyone applying for coverage seen a licensed member of the medical profession for any reason (including routine visits) or symptom not previously disclosed above?

17.  No  Yes Within the past 24 months, to the best of your knowledge and belief, 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:

## Payment Authorization & Billing Information

If an applicant is paying for the plan, they must complete 1 & 2 below. If someone other than an applicant will be paying for the plan, please fill out the separate alternate payor information page. Agent/Producer, Employer payments are not accepted.

Quoted Premium Payment Amount: \$ \_\_\_\_\_

### 1. Initial Premium Payment Options

Initial premium payment must total one month's premium for each product selected. Please choose your preference for payment of first month's premium. Please complete credit card or one-time bank withdrawal below.

#### Credit Card Payment

Initial payment for each product applied for will be drafted separately against your account.

Visa  Mastercard

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

Expiration date \_\_\_\_\_ / \_\_\_\_\_

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

I authorize Humana to draw initial premium payment from my VISA / Mastercard account.

#### One-time Automatic Bank Withdrawal

Please print.

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

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

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

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

I authorize Humana to draw initial premium payment from the account above.

### 2. Subsequent Premium Payment Options

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

**Direct Bill, if selected a fee of \$ \_\_\_\_\_ will apply.**

Monthly billing

Quarterly billing

Semi-Annual billing

**Automatic Bank Withdrawal (monthly billing)**

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

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

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

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

I authorize Humana to draw premium payment and fees from the account above until this authorization is revoked by me.

### Agent / Producer Information

This section to be completed by Agent or Producer.

#### 1. Agent/Agency of Record (for commissions and correspondence)

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Commission split:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### 1. Writing Agent / Producer:

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Florida License # \_\_\_\_\_

Signature \_\_\_\_\_

Commission split:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### 2. Agent/Agency of Record (for split-commissions)

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Percentage of sales:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### 2. Writing Agent / Producer (for split-commissions)

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Florida License # \_\_\_\_\_

Signature \_\_\_\_\_

Percentage of sales:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

## 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.
- To automatic withdrawal from my specified bank account or credit card for premium payment and administrative fees if selected under the product section.
- 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 knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.**

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

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

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

(if covered dependent)

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

## Alternate Payor Information

If someone other than an applicant will be paying for the plan, please complete the following information and 1 & 2 below.

### Who will be paying for this plan(s)?

First name	MI	Last name	Home phone # ( )	Daytime phone # ( )
Home address (not PO Box)		City	State	Zip code

Quoted Premium Payment Amount: \$

## 1. Initial Premium Payment Options

Initial premium payment must total one month's premium for each product selected. Please choose your preference for payment of first month's premium. Please complete credit card or one-time bank withdrawal below.

### Credit Card Payment

Initial payment for each product applied for will be drafted separately against your account.

Visa       Mastercard

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

Expiration date      / \_\_\_\_\_

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

I authorize Humana to draw initial premium payment from my VISA / Mastercard account.

### One-time Automatic Bank Withdrawal

Please print.

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

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

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

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

I authorize Humana to draw initial premium payment from the account above.

## 2. Subsequent Premium Payment Options

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

**Direct Bill, if selected a fee of \$      will apply.**

Monthly billing

Quarterly billing

Semi-Annual billing

**Automatic Bank Withdrawal (monthly billing)**

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

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

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

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

I authorize Humana to draw premium payment and fees from the account above until this authorization is revoked by me.

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

## Pre-Notice

---

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 PPO Annual Max Plan Enrollment Form



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 Health Insurance Company of Florida, Inc.  
Dental products insured by HumanaDental Insurance Company**

**FLORIDA**

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: \_\_\_/\_\_\_/\_\_\_

This form is for:  New Business (First time enrollee)  Reinstatement (Reapplication)  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:** 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 applied to the outpatient and pharmacy calendar year limits will also be applied 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.

<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:**

Replaced Plan Number \_\_\_\_\_

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:

Replaced Plan Number

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):

To the best of your knowledge and belief, 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 To the best of your knowledge and belief, within the next 2 years, does anyone enrolling for coverage plan to participate in: bungee jumping, hang gliding, martial arts, motorized vehicle racing, private aviation, aerial photography, crop dusting, rock climbing, rodeo, scuba diving, or sky diving?

5.  No  Yes Is the primary insured, spouse or any of their dependents been diagnosed as pregnant by a licensed member of the medical profession or an expectant mother or father?

To the best of your knowledge and belief, 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 Has been tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Aids-Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?

8.  No  Yes Had any signs or symptoms of, been diagnosed with by a licensed member of the medical profession, 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 by a licensed member of the medical profession or had any signs or symptoms of, been diagnosed with by a licensed member of the medical profession, 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 by a licensed member of the medical profession that has been abnormal or the results of which are pending or unknown?

11.  No  Yes Had or been advised by a licensed member of the medical profession 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 licensed member of the medical profession that has not been completed?

## Eligibility & Health Status continued

13. **Within the past 5 years**, to the best of your knowledge and belief, has anyone enrolling for coverage had signs of, been prescribed medication or received injections for, or been diagnosed with or treated by a licensed member of the medical profession 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**, to the best of your knowledge and belief, has anyone enrolling for coverage been prescribed medication or received injections for, or been diagnosed with any injury, condition or disease by a licensed member of the medical profession that affected one of the following:

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**, to the best of your knowledge and belief, has anyone enrolling for coverage been prescribed medication or received injections for, or been diagnosed with any injury, condition or disease by a licensed member of the medical profession that affected one of the following:

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 Within the past 5 years, to the best of your knowledge and belief, has anyone enrolling for coverage seen a licensed member of the medical profession for any reason (including routine visits) or symptom not previously disclosed above?

17.  No  Yes Within the past 24 months, to the best of your knowledge and belief, has anyone enrolling for coverage been advised to take or taken any prescription medications or injections by a licensed member of the medical profession?

## 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:

## Payment Authorization & Billing Information

If you are paying for the plan, you must complete 1 & 2 below. If someone other than yourself will be paying for the plan, please fill out the separate alternate payor information page. Agent/Producer, Employer payments are not accepted.

Quoted Premium Payment Amount: \$ \_\_\_\_\_

Association Dues: \$3.95 Monthly (non-refundable)

### 1. Initial Premium Payment Options

Initial premium payment must total one month's premium for each product selected. Please choose your preference for payment of first month's premium. Please complete credit card or one-time bank withdrawal below.

#### Credit Card Payment

Initial payment for each product enrolled for will be drafted separately against your account.

Visa  Mastercard

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

Expiration date \_\_\_\_\_ / \_\_\_\_\_

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

I authorize Humana to draw initial premium payment from my VISA / Mastercard account.

#### One-time Automatic Bank Withdrawal

Please print.

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

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

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

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

I authorize Humana to draw initial premium payment from the account above.

### 2. Subsequent Premium Payment Options

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

**Direct Bill, if selected a fee of \$ \_\_\_\_\_ will apply.**

Monthly billing

Quarterly billing

Semi-Annual billing

**Automatic Bank Withdrawal (monthly billing)**

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

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

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

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

I authorize Humana to draw premium payment and fees from the account above until this authorization is revoked by me.

### Agent / Producer Information

This section to be completed by Agent or Producer.

#### 1. Agent/Agency of Record (for commissions and correspondence)

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Commission split:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### 1. Writing Agent / Producer:

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

License # \_\_\_\_\_

Signature \_\_\_\_\_

Commission split:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### 2. Agent/Agency of Record (for split-commissions)

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Percentage of sales:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### 2. Writing Agent / Producer (for split-commissions)

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

License # \_\_\_\_\_

Signature \_\_\_\_\_

Percentage of sales:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### Agent replacement question:

Will this plan 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 application 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

## 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 sales 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.
- To automatic withdrawal from my specified bank account or credit card for premium payment and administrative fees if selected under the payment authorization and payment options section.
- 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 policy is primarily governed by the laws of the District of Columbia where the master policy is filed. As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under your approved policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under your approved policy, consult your agent or the Department of Financial Services.**

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

**Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.**

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

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

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

(if covered dependent)

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

## Alternate Payor Information

If someone other than the primary insured will be paying for the plan, please complete the following information and 1 & 2 below.

### Who will be paying for this plan(s)?

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

Quoted Premium Payment Amount: \$ \_\_\_\_\_

Association Dues: \$3.95 Monthly (non-refundable)

### 1. Initial Premium Payment Options

Initial premium payment must total one month's premium for each product selected. Please choose your preference for payment of first month's premium. Please complete credit card or one-time bank withdrawal below.

#### Credit Card Payment

Initial payment for each product enrolled for will be drafted separately against your account.

Visa                       Mastercard

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

Expiration date        /

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

I authorize Humana to draw initial premium payment from my VISA / Mastercard account.

#### One-time Automatic Bank Withdrawal

Please print.

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

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

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

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

I authorize Humana to draw initial premium payment from the account above.

### 2. Subsequent Premium Payment Options

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

**Direct Bill, if selected a fee of \$ \_\_\_\_\_ will apply.**

Monthly billing

Quarterly billing

Semi-Annual billing

**Automatic Bank Withdrawal (monthly billing)**

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

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

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

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

I authorize Humana to draw premium payment and fees from the account above until this authorization is revoked by me.

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

# HumanaOne Association Enrollment Form



## **Association Enrollment**

---

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
-------------------------------------	----	-----------

## 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

## 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 Health Insurance Company of Florida, Inc.  
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

# 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.

**FLORIDA NOTICE TO APPLICANT REGARDING REPLACEMENT  
OF ACCIDENT AND SICKNESS INSURANCE**

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance you have and replace it with a policy to be issued by Humana Health Insurance Company of Florida, Inc. For your information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy:

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain that all questions on the application concerning your medical/health history are truthfully and completely answered. 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 it should be carefully reviewed before being signed to be certain that all information has been properly recorded.

(4) New policies may be issued at an older age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.

(5) The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.

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

Applicant's Name \_\_\_\_\_

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_



Humana - Individual Product Segment  
Underwriting Department  
2 Riverwood Place  
N19 W24133 Riverwood Drive  
Suite #250  
Waukesha WI 53188

FLORIDA  
NOTICE OF AIDS VIRUS (HIV) ANTIBODY TESTING  
AND CONSENT FOR TESTING

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test results. A series of tests will be performed by certified laboratory through a medically accepted procedure.

PRE-TESTING CONSIDERATIONS:

Many public health organizations have recommended that before taking an AIDS-related blood test, a person should seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

MEANING OF POSITIVE TEST RESULT:

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance.

CONFIDENTIALITY OF TEST RESULTS:

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who need such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

HUMANA  
*one*

NOTIFICATION OF TEST RESULT:

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Florida Department of Health and Rehabilitation, Tallahassee, Florida 323990700. Because a trained person should deliver that information so that you can understand clearly what the test result means. Please list your provided physician so that the insurer can have him or her tell you the test result and explain its meaning.

CONSENT:

I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given written materials about AIDS. I voluntarily consent to the withdrawal of blood from me by needle, the testing of my blood for HIV antibodies, and the disclosure as described above.

I know that I may request to receive a copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for ninety (90) days from the date shown below.

\_\_\_\_\_  
Name of Proposed Insured

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

DISCLOSURE OF POSITIVE TEST RESULTS

-----  
Please send my positive test results to the following physician:

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I do not want you to send this information to my doctor. Instead, I want you to send this information to the Florida Department of Health and Rehabilitation.

Check Here (yes) \_\_\_\_\_

