

## 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 Supplemental Information



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

UTAH

- 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. Additional amounts must be purchased in \$25,000 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. Additional amounts must be purchased in \$25,000 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	Country or State of birth
Type of business or industry		Occupation	
Policyholder name if different than Primary Applicant (applicable for child-only application)			

## Existing Coverage

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**IMPORTANT: DO NOT** cancel any existing coverage until you receive written notification from Humana of your acceptance for 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 #
<hr/>		

#### 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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1.  No  Yes Is anyone applying for coverage a citizen of a country other than the United States?  
• **If YES:** Name(s): 

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2.  No  Yes Experienced weight gain or loss of more than 20 pounds in the past 12 months?
3.  No  Yes Has anyone applying for coverage participated in any dangerous or extreme sport activity in the past 24 months or plan to participate in the future?
4.  No  Yes Within the past 5 years, has anyone applying for coverage been denied for health or life insurance or had their health coverage ridered, rated or rescinded?



**Medical and Life products insured by Humana Insurance Company  
Dental products insured by HumanaDental Insurance Company  
1100 Employers Boulevard • De Pere, WI 54115**



# UTAH INDIVIDUAL HEALTH INSURANCE APPLICATION

## A. APPLICANT INFORMATION

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Marital Status  Legally Married  Single  Divorced  Widowed  Domestic Partner

Mailing Address \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Street Address \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home (or other) Phone (\_\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_\_) \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Does any listed proposed insured live, reside, work or attend school outside the state of Utah at any time during the year?  Yes  No If yes, % of time \_\_\_\_\_

Please check one of the following boxes:  New Application  Dependent Addition  Re-apply

## B. APPLICANT AND DEPENDENT INFORMATION (attach separate sheet if necessary)

In the section below, list yourself and all eligible family members to be included under the policy.

	Social Security # (for internal use only)	Name (Last, First, MI)	Date of Birth	Age	M/F	Weight	Height
Self						lbs.	
Spouse						lbs.	
Dependent						lbs.	
Dependent						lbs.	
Dependent						lbs.	
Dependent						lbs.	

Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. To be eligible for coverage, children must be under the age of 26, unmarried, and dependent upon you for 50 percent of their financial support. Financial dependency is not required for court-ordered child coverage. Any dependent not listed will not be considered for coverage.

## C. CURRENT/PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health care coverage, including Medicare or Medicaid, in effect within 24 months prior to the proposed effective date of this policy. Each person applying for coverage must be listed below. If no health care coverage was in effect within the past 24 months, please indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care coverage so that the insurer can determine whose coverage is primary.

Enrolling Individual's Name (Non-Medicare)	Insurer (Including policyholder name, insurer name and phone number)	Date of Coverage Month/Day/Year		Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage (Check all that apply) <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
		From	To		
Self				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical

If you were previously insured on a group plan, have you exhausted your COBRA rights?  Yes  No  NA If "Yes" Date Started \_\_\_\_\_ Date Ended \_\_\_\_\_

If COBRA was not an option for you, have you exhausted your Utah mini-COBRA rights?  Yes  No  NA If "Yes" Date Started \_\_\_\_\_ Date Ended \_\_\_\_\_

Have you ever been or are you currently insured through HIPUtah?  Yes  No If "Yes" Date Started \_\_\_\_\_ Date Ended \_\_\_\_\_

**Note:** If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous insurer. Submission of prior coverage information does not automatically waive any PEC limitation. However, you will be subject to an automatic PEC Waiting Period of up to 12 months until we receive evidence of prior coverage.

## D. EMPLOYMENT INFORMATION

Employer \_\_\_\_\_ Group Insurer \_\_\_\_\_ Job Title \_\_\_\_\_ Hrs/Week \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse's Group Insurer \_\_\_\_\_ Spouse's Job Title \_\_\_\_\_ Hrs/Week \_\_\_\_\_

1. Is any employer reimbursing or paying for any portion of this policy?  Yes  No

2. Are you self-employed?  Yes  No If self employed, do you have any full or part-time employees?  Yes  No

**E. HEALTH STATEMENT**

**IF ANY OF THE BELOW CONDITIONS OR QUESTIONS ARE CHECKED "YES" PROVIDE DETAILS IN SECTIONS G. & H. ON THE FOLLOWING PAGE.**

The federal Genetic Information Nondiscrimination Act prohibits health insurers from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. "Genetic information" includes your genetic tests, the genetic tests of your family members, and the manifestation of a disease or disorder in family members not covered by the policy. Genetic information can also include requests for, or receipt of, genetic services, or participation in clinical research which includes genetic services. Do not report genetic information on this form. However, information about manifested diseases or conditions of anyone applying for coverage is not considered genetic information and is to be reported on this form, even if the disease or condition is caused by or associated with genetics.

<b>EACH QUESTION MUST BE CHECKED "YES" OR "NO." This health statement must be complete or the application will be returned. Inaccurate health information may result in the policy being cancelled retroactively. It is your responsibility to notify the insurer of any change in health status while application is pending.</b>							
<b>Respond to the following questions:</b>		<b>YES</b>	<b>NO</b>	<b>Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following (cont.):</b>		<b>YES</b>	<b>NO</b>
1	<b>Pregnancy/Adoption:</b> Are you, your spouse, or any dependent family member pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months?			21	<b>Female Reproductive Conditions/Disorders:</b> Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, pelvic inflammatory disease, or any other disorder of the reproductive system?		
2	<b>Pregnancy/Fertility Related Treatment:</b> Are you, your spouse, or any dependent family member being treated for infertility, fertility evaluation or treatment (including medication), or miscarriage, complications related to pregnancy (including premature births)?			22	<b>Digestive Conditions/Disorders:</b> Ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, GERD, any other gallbladder or digestive disorder, hemorrhoids, polyps, or any other rectal disorder?		
3	<b>Last Menstrual Period:</b> Have you, your spouse or any dependent (whether or not proposed for insurance) missed her last menstrual period? If yes, provide date of last menstrual cycle on the following page.			23	<b>Nervous, Mental and Behavioral:</b> Mental health counseling, psychotherapy, depression, stress, anxiety, attention deficit hyperactivity disorder (ADHD), mental health disorder, or chemical imbalance that required consultation or medication?		
<b>Within the past 12 MONTHS has any applicant:</b>		<b>YES</b>	<b>NO</b>	<b>Within the past 10 YEARS has any applicant been diagnosed with or treated for any of the following:</b>		<b>YES</b>	<b>NO</b>
4	<b>Prescriptions/Medications/Immunizations:</b> Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?			24	<b>Gout, arthritis, Rheumatoid arthritis, fibromyalgia, or scleroderma?</b>		
5	<b>Conditions Requiring Follow Up Medical Consult/Treatment:</b> Do you, your spouse or any dependent family member have a condition for which hospitalization, tests, consultation, evaluation, surgery, or medication have been advised, but not completed?			25	<b>Musculoskeletal Conditions/Disorders:</b> Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, spondylolysis, or other musculoskeletal disorder?		
6	<b>Medical Consult/Treatment:</b> Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine & wellness care?			26	<b>Digestive Conditions/Disorders:</b> Crohn's disease. Colitis, colostomy, ileostomy, or other digestive disorder?		
7	<b>Conditions Requiring Initial Medical Consult/Treatment:</b> Had a health condition, problem, disorder, or any other medical or mental health conditions not listed for which medical or mental health advice or treatment has not been sought?			27	<b>Alcohol or Drug Use/Abuse:</b> been advised to reduce/limit alcohol use, or attended Alcoholics Anonymous (or similar program) for his/her own alcohol consumption, drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens?		
<b>Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:</b>		<b>YES</b>	<b>NO</b>	28	<b>Eating Disorders/Obesity Treatment:</b> including bulimia, anorexia, or obesity and any surgical services for obesity.		
8	<b>Urinary, bladder, incontinence, kidney or liver conditions or disorders:</b> Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?			29	<b>Respiratory Conditions/Disorders:</b> RSV, reactive airway disease, tuberculosis, asthma, sleep apnea, pleurisy, COPD, sarcoidosis, or emphysema?		
9	<b>Neurological Disorders:</b> Recurring headaches, migraines, head injury, epilepsy, seizures, convulsions, or other neurological disorder?			30	<b>Tobacco use (chewing or smoking)?</b> Quit Date: _____		
10	<b>Metabolic and Endocrine Conditions/Disorders:</b> Lupus, thyroid disorder, goiter, or any other lymph system disorder?			<b>Has any applicant EVER been diagnosed with or treated for any of the following:</b>		<b>YES</b>	<b>NO</b>
11	<b>Eyes, ears, nose, sinus, or throat conditions/disorders</b> or any other respiratory system disorder, including allergies or hay fever?			31	<b>Birth Defects/Congenital Abnormalities:</b> premature birth, development or learning disability, mental impairment, Down syndrome, or autism spectrum disorder?		
12	<b>Skin Conditions/Disorders:</b> Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?			32	<b>Nervous, Mental and Behavioral:</b> Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, or psychotic disorder?		
13	<b>Breast Conditions/Disorders:</b> Breast lumps, breast augmentation, or breast reduction?			33	<b>Transplant or Implanted Device:</b> Any organ or tissue transplant, pacemaker, or other implanted device?		
14	<b>Heart Conditions/Disorders:</b> Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition?			34	<b>Heart and Circulatory Conditions/Disorders:</b> Heart murmur, heart attack, bypass surgery, angioplasty/stent, blood clot, stroke, heart surgery, coronary artery disease, or congestive heart failure?		
15	<b>Back, neck, bone, joint or spinal disorder:</b> bone or joint disorders (including foot, knee, jaw, fracture, dislocation, or joint replacement)?			35	<b>Brain/Nervous System Conditions/Disorders:</b> Multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia?		
16	<b>Blood Conditions/Disorders:</b> Hemophilia, anemia, blood, or bleeding disorder?			36	<b>Diabetes (type I or II), insulin resistance?</b>		
17	<b>Male Reproductive Conditions/Disorders:</b> Impotence, prostate or testicular disorder, abnormal PSA, or other reproductive disorder?			37	<b>Immune System Conditions/Disorders:</b> Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?		
18	<b>Circulatory System Conditions/Disorders:</b> Varicose veins, or any other circulatory disorder?			38	<b>Cancer/Tumors:</b> (including skin cancer or melanoma) or tumors?		
19	<b>Hospitalization/Surgery:</b> Have you, your spouse, or any dependent family member been hospitalized or had surgery?			39	<b>Urinary/Liver Conditions/Disorders:</b> Cirrhosis, hepatitis, or renal failure?		
20	<b>Sexually transmitted diseases?</b>			<b>OTHER MEDICAL INFORMATION</b>		<b>YES</b>	<b>NO</b>
				40	Any medical condition or treatment that you are unsure of where it fits in above?		



## I. ACKNOWLEDGMENT & SIGNATURE

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I hereby apply to be enrolled with my listed dependents, if applicable, for coverage. When incorporated with the policy, this application will become part of the policy. Once fully signed and executed, insurer and I agree to terms set forth in the policy. In connection with both this application and any coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. I agree to act on behalf of myself and my dependents. I understand that coverage is dependent upon my satisfaction of applicable underwriting criteria. I also understand that no coverage will be in force until each person listed above is approved; that no benefits will be provided for any services which begin before the policy is effective; and that except as expressly provided in the policy, benefits will not extend beyond the termination of either my coverage or the policy.

**CONSENT AT ENROLLMENT.** I understand that no producer or insurer representative is allowed to permit me to answer any question inaccurately, untruthfully, or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to the insurer changes in the eligibility of any applicants who become enrolled.

I understand that the data obtained by the use of this authorization will only be used to determine eligibility for coverage and for future benefit administration. I understand that my choice of health care providers whose services will be covered may be restricted by the policy, and I agree that coverage for any services that are obtained without or contrary to required preauthorization/precertification requirements in the policy may be denied. I understand the policy for which I am applying may limit or exclude certain conditions, regardless of whether or not they are pre-existing. I also understand that the policy may limit or exclude conditions for which a family member or I have received, or have been recommended to receive, any medical advice, diagnosis, care, or treatment during the six months immediately preceding the date I apply for coverage, according to the pre-existing conditions limitation provisions of the policy.

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE.** According to information furnished, you may intend to lapse or otherwise terminate existing accident and health insurance and replace it with a new policy. For your own information and protection, you should be aware of and seriously consider certain factors that 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 plan. This could result in a denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present coverage.
2. You may wish to secure the advice of your present insurer or its producer 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 the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present coverage and replace it with a new policy, be certain to truthfully and completely answer all questions on the application concerning your medical/health history.
4. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though the policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

I hereby declare that to the best of my knowledge and belief, the information given on this application, including the health information on pages two and three of this application, is correctly recorded, true, and complete. I understand that material omissions or intentional misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or could void any coverage issued. **If I subsequently become aware of information different from that provided in this application, I agree to provide that additional information promptly to the insurer. A change of information prior to the effective date of the policy may void an offer to provide coverage.**

I understand there may not be participating providers in all specialty fields.

I understand that credit for prior coverage will be based upon the information contained in this application and/or proof of prior coverage, such as a Certificate of Creditable Coverage that I have obtained from my prior health care insurer(s) and provided to the insurer.

If any information provided is false or incomplete, the insurer may without advance notice pursue any remedies available under state or federal law, including but not limited to: declaring the policy null and void and canceling the policy retroactive to its original effective date; or imposing the pre-existing condition waiting period and denying claims that are pre-existing, subject to credit for prior coverage.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. THE INSURER SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I further certify that all information completed on this form is true, correct and complete and acknowledge the policy is subject to cancellation or other action permissible at law, if any completed information is found to be false or incorrect.

I attest that all information on this form is accurate. I have read the Acknowledgment of this document and agree to its terms. I have also completed an authorization to disclose protected health information, if such form accompanies this application.

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

(A faxed signature shall be valid as an original signature.)

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

(Required if applying for coverage. A faxed signature shall be valid as an original signature.)

Requested Effective Date \_\_\_\_\_ (Coverage is not in force until the insurer approves your application and determines the effective date.)

**J. PRODUCER AGREEMENT AND COMPENSATION DISCLOSURE (If applicable)**

I understand and agree that in acting as the producer for this applicant:

1. The application was completed by the applicant.
2. I am in possession of a valid license issued by the State of Utah that authorizes me to sell and service health insurance;
3. I have no authority to: a) make, alter, interpret, or discharge an application or policy in the name of a insurer; or b) waive any of the terms or conditions of the policy.
4. I have no authority to assign effective dates or to effect member changes.

Producer Name \_\_\_\_\_ License # \_\_\_\_\_ Agency \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Producer Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

(A faxed signature shall be valid as an original signature.)

**Producer Compensation Disclosure:**

(Compensation includes commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration.)

I have received written disclosure that the producer will receive compensation from the insurer or a third party administrator for the placement of insurance, including the amount or type of compensation.

Applicant 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

**Humana Insurance Company • N19 W24133 Riverwood Drive • Waukesha, WI 53188  
HumanaDental Insurance Company • 1100 Employers Boulevard • Green Bay, WI 54344**

# HumanaOne Dental & Vision Application



Requested Effective Date: \_\_\_/\_\_\_/\_\_\_

This form is for:  New Business (First time applicant)  Reinstatement (Reapplication)  Change/Modification to Existing Policy or Plan

UTAH

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

Dental and vision products offered do not have pre-existing waiting periods.

## 1. Coverage Options Please complete this section when selecting a dental or vision product.

<input type="checkbox"/> <b>Dental Coverage</b>	<input type="checkbox"/> <b>Vision Coverage</b>
Product Name _____	Product Name _____

## 2. Primary Applicant Information

First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / / _____
Home address (not P.O. Box) _____		City _____	State _____	ZIP code _____
E-mail _____	Home phone # ( ) _____		Daytime phone # ( ) _____	
Social Security # _____				

## 3. 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 _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / / _____
Social Security # _____		E-mail _____		
<b>Dependent</b> First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / / _____
Social Security # _____		E-mail _____		
<b>Dependent</b> First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / / _____
Social Security # _____		E-mail _____		

## 4. Replacement Questions Please answer the following.

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

## 5. Agent / Producer Information This section to be completed by Agent or Producer.

<b>1. Agent / Agency of Record: (for commissions and correspondence)</b>	<b>2. Writing Agent / Producer:</b>
Name (print) _____	Name (print) _____
Humana Agent # _____	Humana Agent # _____

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

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

## 6. 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 any agent or producer 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 product applied for is not an employer-sponsored group insurance policy 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 insurance policy 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. I agree to automatic withdrawal from my specified bank account or credit card for premium payment and administrative fees if selected on the HumanaOne Payment & Billing Authorization form. 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. 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 insurance information from my dependent in order to fully and truthfully complete this application. The policy provides dental and vision benefits only. Review your policy carefully. This document, together with any supplements, will form part of and be the basis for any policy issued. **A person that knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.**

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

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

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

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

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

**Dental products insured by HumanaDental Insurance Company**  
**Vision products insured or administered by Humana Insurance Company**  
**1100 Employers Boulevard • De Pere, WI 54155**



## 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



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

**Save a copy of this notice – it may be important to you in the future!**

According to the information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Humana Insurance Company. For your own 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 interest to make sure you understand all the 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 to truthfully and completely answer all questions on the application concerning your medical/health history.
4. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

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

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

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
*Primary Applicant or Legal Representative*



Insured by Humana Insurance Company



**UTAH NOTICE AND CONSENT FOR BLOOD  
TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV)  
ANTIBODY/ANTIGEN TESTING**

Examiner Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the insurer, the insurer may disclose test results to others involved in the underwriting and claims review process. If the HIV test is positive the results will be reported to the local health department or the State Department of Health and if the insurer is a member of the Medical Information Bureau (MIB, Inc.), the insurer may report the results in a generic code which signifies only non-specific blood test abnormalities. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer or your designated physician will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal medical authorities have concluded that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.



Insured by Humana Insurance Company



**UTAH NOTICE AND CONSENT FOR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

I have read and I understand this Notice of Consent for Blood Testing which may include AIDS virus (HIV) Antibody/Antigen testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the disclosure of the test results as described above.

In the event of a positive HIV test result, I authorize the insurer named above to send the test results to the following health care professional for post-test counseling and for Health Department reporting purposes:

Name: \_\_\_\_\_, M.D.  
Address:  
STREET: \_\_\_\_\_  
CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured (first and last name) \_\_\_\_\_ Birth Date \_\_\_\_\_

Signature of Proposed Insured or Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
State of Residence



Insured by Humana Insurance Company



## **NOTICE OF PARAMEDICAL EXAMINATION**

Please sign and date the enclosed **HIV** testing consent form and return it to HumanaOne, along with any other document(s) you have been asked to send back to us.

A representative from ExamOne will be contacting you to schedule an appointment for your paramed exam. Eating or drinking 12 hours prior to your scheduled appointment may alter the results of your test.

If you have not been contacted within three business days from the date of the enclosed letter, please call us at 1-800-825-7858. On completion of your testing, ExamOne will forward the results to our underwriting department. We will then review the report and contact you to inform you of our decision regarding your application for insurance.

Individual Underwriting Department  
HumanaOne



Insured by Humana Insurance Company, Humana Health Insurance Company of Florida, Inc.,  
Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc.

For AZ residents: Insured by Humana Insurance Company



## **UTAH NOTICE REGARDING REPLACEMENT**

### **REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?**

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed policy or contract's benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy or contract to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.



Insured by Humana Insurance Company



**UTAH 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.

\_\_\_\_\_  
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.)



Insured by Humana Insurance Company



## **UTAH 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?



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## NOTICE OF PRE-EXISTING CONDITION LIMITATION

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### What is a Pre-Existing Condition?

A pre-existing condition is any condition that was present before the effective date of coverage under the policy, whether or not any medical advice, diagnosis, care, or treatment was recommended or received.

### Pre-Existing Condition Limit

We will not pay benefits for services rendered for pre-existing conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the effective date of the policy, unless those conditions were fully disclosed on the application for this policy and benefits relating to those conditions are not specifically excluded. This limitation will not exceed 12 months from the effective date of coverage under the policy.

The pre-existing condition limitation will not apply if:

- A dependent is added to coverage within 31 days of the birth, placement, or adoption; or
- The covered person had creditable coverage under a prior health insurance policy. The 12 month limitation will be reduced by the number of days of coverage under a prior policy if such coverage was continuous to a date no more than 62 days prior to the effective date of the policy, exclusive of any applicable waiting period.

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Please contact us for additional information on pre-existing conditions or for assistance obtaining a certificate of creditable coverage from your prior insurance carrier. A helpful customer service representative can be reached at 1-800-825-7858, Monday through Friday, 7:00 a.m. to 7:00 p.m. Central time. If you would prefer, you may write to us at the following address:

HumanaOne  
Customer Service  
P O Box 1633  
Waukesha, WI 53187-1633



Insured by Humana Insurance Company



## UTAH NOTICE TO UNINSURABLE APPLICANTS FOR HEALTH INSURANCE

You have been denied health insurance coverage due to a health condition which is uninsurable. The Utah Comprehensive Health Insurance Pool (HIPUtah) was created to provide health insurance to residents of Utah who are denied health insurance and who are considered uninsurable. If you have lived in the State of Utah for 12 consecutive months prior to applying for insurance with this company you may be eligible for health insurance coverage with HIPUtah.

However, if you have not lived in the state of Utah for 12 consecutive months, but you are a Utah resident and you are coming from another State's high risk pool or have had 18 months of continuous coverage with the most recent coverage being through a group health plan, you may still be eligible for health insurance coverage with the Utah Comprehensive Insurance Pool.

Part or all of the preexisting waiting period will be waived if you are an eligible individual according to the Health Insurance Portability and Accountability Act (HIPAA) or your previous coverage was involuntarily terminated for reasons other than for nonpayment of premium or fraud, and application for HIPUtah is made within 63 days of that termination. The amount of credit given will depend on the length of time an applicant was previously covered under that health insurance.

If application for coverage with HIPUtah is made within 30 days of this denial letter and you are declined coverage with the pool, HIPUtah will issue a certificate of insurability and you may reapply for coverage with this company within 30 days of the certificate date.

To find out whether you qualify for pool coverage or to make application for pool coverage, call 1-800-705-9173, toll free. The HIPUtah's mailing address is P.O. Box 30192, Salt Lake City, Utah 84130-0192.



Insured by Humana Insurance Company

## UTAH PRESCRIPTION DRUG DISCLOSURE

THIS IS A SUMMARY OF INFORMATION REGARDING PRESCRIPTION DRUG COVERAGE PLEASE  
SEE THE POLICY FOR COMPLETE INFORMATION

### BENEFIT SUMMARY

Benefits for prescription drugs are payable for FDA approved drugs or devices, including insulin, diabetic supplies, hypodermic needles or syringes, self-administered injectable drugs (with our prior approval), medical formulas for PKU or other inherited diseases and spacers and/or peak flow meters required for asthma. For the High Deductible Health Plan, prescription drug expenses are subject to the medical calendar year deductible and are exempt from a copayment.

Drugs are grouped into 4 levels as follows:

- Level 1: lowest cost generic and brand-name drugs
- Level 2: higher cost generic and brand-name drugs
- Level 3: higher cost, mostly brand-named alternatives to drugs in Levels 1 and 2
- Level 4: self-administered injectable medications and high-technology drugs

Prescription drug products, or classes of certain prescription drug products, are generally reviewed on an ongoing basis for safety, clinical effectiveness and cost-effectiveness prior to assignment or a change in assignment to one of the levels. Coverage of a prescription drug or placement of the drug within a level is subject to change throughout the year. Visit [www.humana.com](http://www.humana.com) to obtain information on participating pharmacies and to view the most up-to-date drug list, or you may call (800) 825-7858 to speak to a Customer Service representative.

Plan Type	Plan Pays for services at Participating Pharmacy	Plan Pays for services at Non-Participating Pharmacy
<b>Individual Health Plan Retail 30 day supply<sup>1</sup></b>	100% after \$500 deductible and: Level 1 Drugs: \$15 per prescription Level 2 Drugs: \$35 per prescription Level 3 Drugs: \$55 per prescription Level 4 Drugs: 25% per prescription up to a \$2,5000 maximum out-of-pocket per calendar year	75% after \$500 deductible and: Level 1 Drugs: \$15 per prescription Level 2 Drugs: \$35 per prescription Level 3 Drugs: \$55 per prescription Level 4 Drugs: 25% per prescription up to a \$2,5000 maximum out-of-pocket per calendar year
<b>Mail Order 90 day supply</b>	100% after 3 times the retail copayment	75% after 3 times the retail copayment
<b>High Deductible Health Plan</b>	100% after deductible	75% after deductible
<b>Utah Basic Plan</b>	70% after deductible and 30% coinsurance per prescription	50% after deductible and 50% coinsurance per prescription

<sup>1</sup> If the ID card is not presented to a participating pharmacy at the time of purchase or drugs are obtained from a non-participating pharmacy, the covered person will be responsible for payment of 30% of the actual drug charge made by the dispensing pharmacy in addition to the copayment.

**PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS: Individual and High Deductible Health Plans**

- Drugs received before the effective date or after the termination date.
- Contraceptives (other than oral), implant systems and devices.
- Medication, drugs or hormones to stimulate growth unless a confirmed diagnosis of growth hormone deficiency.
- Herbs, minerals, vitamins, nutritional supplements, dietary products, fluoride except for pediatric multi-vitamins with fluoride or any non-prescription supplement. This exclusion does not apply to dietary products for treatment of inborn errors of amino acid or urea cycle metabolism.
- Drugs taken or administered in a hospital, rest home, sanitarium, skilled nursing facility, convalescent hospital, hospice facility or any other facility where drugs are provided on an inpatient basis. Such drugs are considered under Facility/Hospital Services.
- Legend drugs not recommended or deemed necessary by a health care practitioner; drugs prescribed for a non-covered sickness or bodily injury.
- Drugs prescribed for intended use other than for indications approved by the FDA or recognized off-label indications through peer-reviewed medical literature; experimental or investigational use drugs.
- Allergen extracts; anabolic steroids; anorectic or drugs used for weight control; drugs used to induce abortions: administration of medication; infertility services including medication; drugs used for cosmetic purposes; progesterone crystals or powder; drugs prescribed for impotence and/or sexual dysfunction; drug delivery implants, injectable drugs; orphan drugs.
- Therapeutic devices or appliances.
- Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription.
- Compound drugs except when prescribed for pediatric use for children up to 19 years of age.
- Drugs consumed or injected at the place where the prescription is given or drugs dispensed by a health care practitioner.
- Drugs used in treatment of nail fungus.
- Prescription refills exceeding the number specified by the health care practitioner or dispensed more than one year from the date of the original order.
- Any portion of a prescription order or refill that exceeds our drug specific dispensing limits; is dispensed to a covered person whose age exceeds our drug specific age limits or which exceeds the duration specific dispensing limit.
- Drugs that are lost, stolen, spilled, spoiled or damaged or for which a charge is customarily not made.
- Costs related to the mailing, sending or delivery of a drug.
- Drugs purchased for consumption by other than a covered person or any intentional misuse of the prescription drug benefit.
- Any service, supply or therapy to eliminate or reduce a dependency on or addiction to tobacco and tobacco products, including but not limited to nicotine withdrawal therapies, programs, services or medications.
- More than one prescription for the same drug or therapeutic equivalent medication prescribed by one or more health care practitioners and dispensed by one or more pharmacies until at least 75% of the previous prescription has been used or should have been used unless the drug or therapeutic equivalent medication is maintenance medication purchased through a mail order pharmacy in which case 66% of the previous prescription must have been used or should have been used based on the dosage schedule prescribed by the health care practitioner.
- Coverage may be declined for any drugs, medicine or medications until the conclusion of a review period not to exceed 6 months following FDA approval for the use and release of the drug, medicine or medication.

**PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS: Utah Basic Plan**

- Drugs received before the effective date or after the termination date.
- Drugs and medicines which do not bear the legend "Caution – federal law prohibits dispensing without a prescription" and/or which are not dispensed by a licensed pharmacist.
- Implantable contraceptives (hormonal or other).
- Infertility services including medication.
- Vitamins, special formulas, special diets, and food supplements except as provided by a hospital or skilled nursing facility during a confinement for which benefits are available, except as outlined in 31A-22-623.
- Costs related to the mailing, sending, or delivery of a drug.

# 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

# 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.