

Enrollment Application



Follow these easy steps to apply for a Humana Medicare Supplement insurance policy.

1 Have Your Medicare Card Ready

Please print legibly and complete the entire form. You will need to fill in the information exactly as it appears on your Medicare card. Each person must complete a separate application.

2 Read and Complete Other Coverage Information

Be sure you read and understand the information before completing this section. If you intend to replace your current Medicare Supplement policy or Medicare Advantage plan with this policy, be sure to complete the enclosed form titled Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage.

Please note: If you are under the age of 65 and have been diagnosed with End Stage Renal Disease (ESRD) you are not eligible to apply for coverage.

3 Complete Guaranteed Issue

Please fill out this section if you are eligible for guaranteed issue. If you are submitting a Notice of Replacement, please provide the criteria qualifying you for guaranteed acceptance on the form. For example, if you qualify for guaranteed acceptance due to a Medicare Advantage plan exit, please check “Disenrollment from a Medicare Advantage plan” and indicate that your plan is exiting the market and no longer available.

4 Read and Complete Medical Questions

5 Determine Your Premium

6 Be Sure to Include Your Initial Premium Payment

Your first month’s premium payment must be included. This is necessary even if you choose our Automatic Bank Withdrawal or Auto Credit Card Charge options for future premium payments.

7 Sign and Date the Enrollment Application

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Marking Instructions

- Please print clearly and press hard.
- Use blue or black ink only.
- Completely fill the ovals.

Correct Mark



Incorrect Marks



- Print legible numbers and capital block letters in the boxes.

Correct Numbers and Letters

1 2 3 A B C

- Print only one character per box.
- If you make a mistake, correct it by crossing out the box and writing the letter/number above or below the box as shown. Be sure to initial any and all corrections made.

T
S M I X H

- When filling out dates, such as effective dates or birth dates, be sure dates appear in the MMDDYYYY format. No dashes or spaces are necessary.

0 3 2 4 2 0 1 0

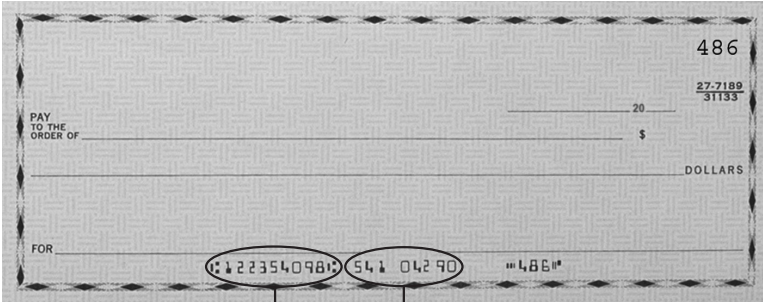
**Required Fields
Must Be Completed**



**Optional
Fields**



Sample Check
(If you are choosing the auto bank withdrawal.)



Routing Number Account Number

1

LAST NAME

[Grid of 15 boxes for last name]

FIRST NAME

[Grid of 15 boxes for first name]

MI

[Box for middle initial]

ADDRESS

[Grid of 25 boxes for address]

APT OR STE#

[Grid of 5 boxes for apartment or street number]

ADDRESS (continued)

[Grid of 15 boxes for continued address]

COUNTY

[Grid of 15 boxes for county]

CITY

[Grid of 20 boxes for city]

STATE

[Grid of 2 boxes for state]

ZIP CODE

[Grid of 5 boxes for zip code]

TELEPHONE

[Grid of 10 boxes for telephone number]

DATE OF BIRTH

[Grid of 8 boxes for date of birth: MM/DD/YYYY]

GENDER M F

MAILING ADDRESS (only if different from above street ADDRESS)

[Grid of 25 boxes for mailing address]

APT OR STE#

[Grid of 5 boxes for mailing apartment or street number]

CITY

[Grid of 20 boxes for mailing city]

STATE

[Grid of 2 boxes for mailing state]

ZIP CODE

[Grid of 5 boxes for mailing zip code]

E-MAIL ADDRESS (optional)

[Grid of 30 boxes for email address]

(E-mail address, if available, will be used as a means to communicate only coverage information.)

Select the policy you are applying for:

- Plan A
- Plan B
- Plan C
- Plan F
- High Deductible Plan F
- Plan K
- Plan L
- Plan N

PROPOSED EFFECTIVE DATE

[Grid of 8 boxes for proposed effective date: MM/01/20YY]

Please complete the information below as it appears on your Medicare card.

MEDICARE NUMBER

[Grid of 10 boxes for Medicare number]

IS ENTITLED TO

HOSPITAL INSURANCE (PART A)

EFFECTIVE DATE

[Grid of 8 boxes for effective date: MM/DD/YYYY]

MEDICAL INSURANCE (PART B)

[Grid of 8 boxes for effective date: MM/DD/YYYY]

PERSON TO NOTIFY IN AN EMERGENCY (optional):

LAST NAME

[Grid of 15 boxes for emergency last name]

FIRST NAME

[Grid of 15 boxes for emergency first name]

MI

[Box for emergency middle initial]

RELATIONSHIP TO APPLICANT

[Grid of 20 boxes for relationship to applicant]

TELEPHONE

[Grid of 10 boxes for emergency telephone number]

AGENT NUMBER (SAN)

[Grid of 6 boxes for agent number]

8. Do you currently have, or in the past 3 years have you had, been diagnosed with, or had a physician or medical professional advise you to have treatment for any of the following?

- Adrenal Gland Disorder Yes No Not Sure
- Alcohol or drug abuse Yes No Not Sure
- Alzheimer’s or Dementia Yes No Not Sure
- Amputation..... Yes No Not Sure
- Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig’s Disease) Yes No Not Sure
- Aneurysm Yes No Not Sure
- Artificial openings for feeding or elimination Yes No Not Sure
- Atrial fibrillation (A-fib) or heart arrhythmias..... Yes No Not Sure
- Bed sore (Decubitus Ulcer) Yes No Not Sure
- Blood clots..... Yes No Not Sure
- Brain tumor..... Yes No Not Sure
- Carotid Artery Disease..... Yes No Not Sure
- Cerebral hemorrhage Yes No Not Sure
- Cerebral Palsy (CP) Yes No Not Sure
- Chest pain (Angina Pectoris) or heart attack..... Yes No Not Sure
- Chronic Obstructive Pulmonary Disease (COPD) (Chronic Bronchitis or Emphysema) Yes No Not Sure
- Chronic Kidney Disease (CKD)..... Yes No Not Sure
- Cirrhosis of the liver..... Yes No Not Sure
- Coma, brain compression/anoxic damage or severe head injury Yes No Not Sure
- Crohn’s Disease..... Yes No Not Sure
- Cystic Fibrosis (CF)..... Yes No Not Sure
- Depression or Bipolar Disorders Yes No Not Sure
- Diabetes with acute complications..... Yes No Not Sure
- Diabetes with neurologic or peripheral circulatory manifestation..... Yes No Not Sure
- Diabetes with ophthalmologic manifestation..... Yes No Not Sure
- Diabetes with renal manifestation..... Yes No Not Sure
- Enlarged heart (Cardiomyopathy)..... Yes No Not Sure
- Epilepsy (seizure disorder or convulsions)..... Yes No Not Sure
- Extensive third degree burns Yes No Not Sure
- Hardening of the heart arteries (Coronary Artery Disease) (CAD or CHD)..... Yes No Not Sure
- Heart failure (Congestive Heart Failure) (CHF)..... Yes No Not Sure
- Hemophilia Yes No Not Sure
- Hepatitis B or C Yes No Not Sure
- Hip fracture or dislocation Yes No Not Sure
- Huntington’s Disease..... Yes No Not Sure
- Internal cancer..... Yes No Not Sure
- Intestinal obstruction/perforation Yes No Not Sure
- Kidney failure (renal failure) or End Stage Renal Disease (ESRD) Yes No Not Sure
- Leukemia Yes No Not Sure
- Lupus (Systemic Lupus Erythematosis) Yes No Not Sure
- Malnutrition..... Yes No Not Sure

12 empty boxes for Medicare number

- Marfan Syndrome
Multiple Sclerosis (MS)
Muscular Dystrophy
Myasthenia Gravis (MG)
Organ transplant
Paget's Disease
Pancreatitis
Paralysis
Parkinson's Disease
Peripheral Vascular Disease (PVD)
Pneumonia
Polymyositis
Respirator dependence
Rheumatoid Arthritis
Schizophrenia
Sickle Cell Anemia
Slipped disc (Degenerative Disc Disease)
Spinal cord disorders or injuries
Spinal Stenosis
Stroke (Cerebral Vascular Accident) (CVA)
Suicide attempt
Tuberculosis
Ulcerative Colitis
Uncontrolled high blood pressure (Hypertension)
Uncontrolled high cholesterol

9. Please list any prescription drugs (full medication name) you are currently taking or have taken within the past 12 months:

Three horizontal lines for listing prescription drugs

5 Premium Determination

Responses to these questions are not required if applying during your Medicare Supplement Open Enrollment Period or if you qualify for Guaranteed Issue as indicated in Section 3. All other applicants must answer these questions.

- 1. Did you have Medicare coverage prior to age 65?
2. Have you used tobacco products within the last 12 months?

If your application is accepted, and you answered No to both questions, you qualify for the Preferred rates. To determine your premium, refer to your Outline of Coverage.

Insured by Humana Insurance Company

Humana[®]

Discrimination is against the law

Humana Inc. and its subsidiaries (“Humana”) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Humana does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Humana provides:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call **1-800-866-0581 (TTY: 711)** or send an email to **Accessibility@humana.com**.

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

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call **1-800-866-0581 (TTY: 711)**.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019. If you use a TTY, call **1-800-537-7697**.

Complaint Forms are available at www.hhs.gov/ocr/office/file/index.html.

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Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-866-0581 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-866-0581 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-866-0581 (TTY: 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-866-0581 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-866-0581 (TTY: 711)번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-866-0581 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-866-0581 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-866-0581 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-866-0581 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-866-0581 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-866-0581 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-866-0581 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-866-0581 (TTY: 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-866-0581 (رقم هاتف الصم والبكم: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-866-0581 (TTY: 711) まで、お電話にてご連絡ください。

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-866-0581 (TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hólq, kojí' hódíłnih 1-800-866-0581 (TTY: 711).

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

Humana Insurance Company • P.O. Box 14309, Lexington, KY 40512-4309

Save this notice! It may be important to you in the future.

If you intend to cancel or terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with coverage issued by Humana Insurance Company, please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare Supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free number, 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

Statement to the Applicant by Issuer, Agent (Broker or other Representative)

I have reviewed your current health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

The replacement policy/certificate is being purchased for the following reason (check one):

- | | |
|---|--|
| <input type="checkbox"/> additional benefits | <input type="checkbox"/> no change in benefits, but lower premiums |
| <input type="checkbox"/> fewer benefits and lower premiums | <input type="checkbox"/> other (please specify) |
| <input type="checkbox"/> my plan has outpatient prescription drug coverage and I am enrolling in Part D | _____ |
| <input type="checkbox"/> disenrollment from a Medicare Advantage plan (please explain reason for disenrollment) | _____ |

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. Note: If the issuer of the Medicare supplement policy being applied for does not impose, or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 3 below.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy/certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy/certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy/certificate until you have received your new policy/certificate and are sure that you want to keep it.

Applicant's signature	Signature of agent/broker/representative	
Print name	Print name and address of agent or broker below	
Social Security number		Date

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Medical Records Release Authorization

Purpose of the Authorization

By signing this form, you will authorize the disclosure and use of the protected health information described below for pre-enrollment underwriting or to determine your eligibility for enrollment or benefits under an insurance plan. This authorization will not be used to determine eligibility for any person entitled to open enrollment or guaranteed issue. It will only be used for claims purposes after a policy has been issued to such persons.

Information we will use and/or disclose

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, employer or the Consumer Reporting Agency having information regarding myself 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, and non-public personal health information to share any and all such information with Humana Insurance Company, its reinsurer or its legal representatives.

- The information obtained by use of this authorization may be used by Humana Insurance Company to determine eligibility for coverage.
- Any information obtained will not be released by Humana Insurance Company to any person or organization except to reinsuring companies, 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. If a Consumer Reporting Agency is used, I may request to be interviewed in connection with the preparation of the report and I may request a copy of the report.
- Once personal and health (including medical 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.
- I understand that information regarding HIV, AIDS or ARC shall not be redisclosed without my written authorization.

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 2 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 (Humana Privacy Office, P.O. Box 1438 Louisville, KY 40202).
- The revocation will not apply to information that has already been released in response to this authorization.
- The revocation may impair our ability to evaluate or process an application or claim and may be a basis for denying an application or claims for benefits.
- The revocation will become effective after it is received by Humana's Privacy Office.

If you were required to answer medical questions on your Medicare Supplement Enrollment Application, you must complete this authorization to be eligible for enrollment.

LAST NAME

FIRST NAME

MI

MEDICARE NUMBER

SOCIAL SECURITY NUMBER

DATE

Applicant Signature _____ Date _____

Insured by Humana Insurance Company

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