

## Applying for a Humana Plan is Simple.

Just Follow 3 Easy Steps...

**Step 1** Print the application and complete in black ink.

**Step 2** Call or fax in to pre-screen your application.

**Step 3** Fax or mail the completed application to the number below

*To assist you with completing the application here is a checklist:*

\_\_\_ Plan Name:

Copy the plan name as written in your proposal along with the deductible amount.

\_\_\_ Eligibility & Health Status Section:

All medical questions must be answered.

Please provide thorough details to every “yes” answer.

You will most likely need to use a separate sheet of paper and attach it to the application.

Please sign and date any attachments.

\_\_\_ Choose Your Payment Method:

Fill out Page #18

1. First Payment Options: Credit Card or Bank Withdrawal

2. Subsequent Payment Options:

- Automatic Bank Withdrawal
- Monthly Credit Card Payments (Mastercard Only, a \$10 fee will be added)
- Direct Bill (a \$10 fee will be added to your premium for paper bills)

\_\_\_ Signatures

Be sure to sign both page #6 and page #17.

*Please call with any questions; our office hours are 9am – 9pm Monday thru Friday*

404 575-1960

800 910-1507

404 575-1967 fax

Once the application is complete, please call us or fax in, so that we may pre-screen it for detail and completeness before mailing it to us. After our review is complete, please fax or mail the application with chosen payment option to:

**HealthPlanStore**  
817 West Peachtree Street  
Suite 915  
Atlanta, GA 30308

## › HumanaOne Paper Application Checklist

### Contact information:

› Fax Applications to:  
1-866-217-2122

› For Agents  
Agent Service Center  
1-800-833-2572

› For Applicants  
Agency Application Team  
1-800-552-0758

### To ensure faster processing, please follow these tips when submitting a paper application.

- Ensure you are contracted with Humana, licensed in the state the applicant resides, and appointed with Humana at the time the application is sold.
- Keep the original application and submit a faxed copy to the HumanaOne Paper Application team at 1-866-217-2122.
- Your packet includes state-specific information which you are required to share with your client based on their insurance needs. Please be sure to carefully review these forms and provide them to your client before beginning their application. If you have any questions about how these forms are to be used, please contact the Agent Service Center at 1-800-833-2572.
- For applicants without current or prior coverage (within the last 63 days), effective dates may be no earlier than 30 days after the application is received by Humana.
- Submit all pages of the most current application and any additional state-specific documents.
- Complete and clearly print Agent/Broker/Producer information, including Agent listed, Agent name, Agent SAN, and Agent signature.
- The effective date should be “mm/dd/yyyy.” If you include “ASAP” or “immediate” we’ll call to ask for the requested effective date.
- Clearly write the name of the plan, including deductible, and all options checked “yes” or “no.”
- Provide all applicant/dependent information including names, dates of birth, heights, weights, and contact information.
- If an applicant answers “yes” to any health question, then the “Additional Information” section must be completed.
- If the applicant answers “yes” to questions 1 or 2, please also include the condition.
- An applicant’s signature and responses to health questions will not be accepted if crossed-out and/or correction fluid is used to change original information.
- Alternate payers and any applicant 18 years or older must sign and date before the application is submitted.
- Do not use agent payment information, or business payment information (except for sole proprietors). Please note that in Florida we cannot accept any business payments, whether or not the business is a sole proprietorship.

Please note: When a standard offer is made, the policy is auto-issued. Underwriting will not send additional documents.



## Pre-Notice

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Information regarding your insurability will be treated as confidential. Humana or its reinsurers, may, however make a brief report thereon to Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

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

# HumanaOne Individual Insurance Application



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

**Medical and Life products insured by Humana Health Insurance Company of Florida, Inc.**  
**Dental products insured by HumanaDental Insurance Company**

**FLORIDA**

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

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

This application is for:  New Business (First time applicant)  Reinstatement (Reapplication)  Change/modification to existing policy  
 Reason for change \_\_\_\_\_  
 Change/Modification to Existing Policy # \_\_\_\_\_

## Health & Dental Coverage Options

### Health Coverage

Please complete this section when selecting a health plan.

Plan name \_\_\_\_\_  
 Deductible \$ \_\_\_\_\_

### Dental Coverage

Dental

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

### Optional Benefits

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

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

## Life Coverage Options

Please complete this section if choosing the term life rider or the term life plan for primary applicant and/or spouse. Please include an additional page if you need to list multiple beneficiaries. Each additional page must be signed and dated.

### Primary Applicant:

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

Primary beneficiary name \_\_\_\_\_  
 Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_  
 Contingent beneficiary name \_\_\_\_\_  
 Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

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

Term life insurance amount: \$ \_\_\_\_\_  
 Term length:  10 years  15 years  20 years  
 Primary beneficiary name \_\_\_\_\_  
 Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_  
 Contingent beneficiary name \_\_\_\_\_  
 Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

### Spouse:

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

Primary beneficiary name \_\_\_\_\_  
 Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_  
 Contingent beneficiary name \_\_\_\_\_  
 Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

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

Term life insurance amount: \$ \_\_\_\_\_  
 Term length:  10 years  15 years  20 years  
 Primary beneficiary name \_\_\_\_\_  
 Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_  
 Contingent beneficiary name \_\_\_\_\_  
 Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

## Primary Applicant/Insured Information

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

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

## Parent or Guardian Information

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

First name	MI	Last name	Email		
Home address (not PO Box)		City	State	Zip code	
Home phone # ( )	Daytime phone # ( )		Relationship to child(ren)		

## Family Information

Please complete only if your spouse and/or dependent children are applying for coverage. Attach an additional family information sheet if necessary.

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

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

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

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

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

## Existing Coverage

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

### • Existing Health Coverage

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

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

- If yes, please supply the following for all applicants on the policy:** Replaced Policy Number \_\_\_\_\_  
 Name(s) of covered persons \_\_\_\_\_  
 Insurance Carrier Name \_\_\_\_\_ Effective Date \_\_\_/\_\_\_/\_\_\_\_\_

### • Existing Dental Coverage

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

- If yes, please supply the following for all applicants on the policy:** Replaced Policy Number \_\_\_\_\_  
 Name(s) \_\_\_\_\_ Effective Date \_\_\_/\_\_\_/\_\_\_\_\_  
 Insurance Carrier Name \_\_\_\_\_ Termination Date \_\_\_/\_\_\_/\_\_\_\_\_
- Name(s) \_\_\_\_\_ Effective Date \_\_\_/\_\_\_/\_\_\_\_\_
- Insurance Carrier Name \_\_\_\_\_ Termination Date \_\_\_/\_\_\_/\_\_\_\_\_

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

• Existing Life Coverage

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**Primary Applicant:**

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

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

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

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

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

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

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Please answer for all individuals applying for coverage.

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

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

• **If yes:** Name(s): \_\_\_\_\_

**To the best of your knowledge and belief, has anyone applying for coverage:**

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

**To the best of your knowledge and belief, within the past 5 years, has anyone applying for coverage:**

6.  No  Yes Been denied for health or life insurance or had their health coverage ridered, rated or rescinded?  
7.  No  Yes Has been tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Aids-Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?  
8.  No  Yes Had any signs or symptoms of, been diagnosed by a licensed member of the medical profession, sought counsel for or treated for any alcohol abuse, dependency or problem, or had any alcohol related arrests?  
9.  No  Yes Used any illegal or taken prescription drugs not prescribed by a licensed member of the medical profession or had any signs or symptoms of, been diagnosed by a licensed member of the medical profession, sought counsel for or treated for any drug abuse, dependency or problem; or had any drug related arrests?  
10.  No  Yes Had any testing or procedure performed by a licensed member of the medical profession that has been abnormal or the results of which are pending or unknown?  
11.  No  Yes Had or been advised by a licensed member of the medical profession to have inpatient or outpatient surgery, that is complete or has not been completed?  
12.  No  Yes Consulted, been advised or recommended to have follow-up testing or treatment by a licensed member of the medical profession that has not been completed?

## Eligibility & Health Status continued

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

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

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

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

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

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

16.  No  Yes Within the past 5 years, to the best of your knowledge and belief, has anyone applying for coverage seen a licensed member of the medical profession for any reason (including routine visits) or symptom not previously disclosed above?

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

## Additional Eligibility or Health Status Question Information

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

Question #	Letter	Person treated	Condition
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Details:

Question #	Letter	Person treated	Condition
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Details:

Question #	Letter	Person treated	Condition
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Details:

## Payment Authorization & Billing Information

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

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

### 1. Initial Premium Payment Options

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

#### Credit Card Payment

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

Visa  Mastercard

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

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

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

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

#### One-time Automatic Bank Withdrawal

Please print.

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

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

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

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

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

### 2. Subsequent Premium Payment Options

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

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

Monthly billing

Quarterly billing

Semi-Annual billing

**Automatic Bank Withdrawal (monthly billing)**

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

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

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

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

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

### Agent / Producer Information

This section to be completed by Agent or Producer.

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

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

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

Commission split:  No  Yes

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

#### 1. Writing Agent / Producer:

Name (print) **Joseph LePage**

Humana Agent # **1298794**

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

Signature \_\_\_\_\_

Commission split:  No  Yes

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

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

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

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

Percentage of sales:  No  Yes

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

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

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

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

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

Signature \_\_\_\_\_

Percentage of sales:  No  Yes

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

#### Agent replacement question:

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

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

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

## Agreement and Signature

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### True and Complete Acknowledgment:

I understand, agree and represent:

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

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

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

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

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

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

(if covered dependent)

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

## Alternate Payor Information

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

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

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

Quoted Premium Payment Amount: \$

## 1. Initial Premium Payment Options

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

### Credit Card Payment

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

Visa       Mastercard

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

Expiration date      / \_\_\_\_\_

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

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

### One-time Automatic Bank Withdrawal

Please print.

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

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

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

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

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

## 2. Subsequent Premium Payment Options

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

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

Monthly billing

Quarterly billing

Semi-Annual billing

**Automatic Bank Withdrawal (monthly billing)**

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

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

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

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

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

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

## Pre-Notice

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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 PPO Annual Max Plan Enrollment Form



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

**Medical and Life products insured by Humana Health Insurance Company of Florida, Inc.  
Dental products insured by HumanaDental Insurance Company**

**FLORIDA**

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

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

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

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

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

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

## Health & Dental Coverage Options

### Health Coverage

Please complete this section when selecting a health plan.

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

#### PPO Plan 50/30

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

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

**1. Calendar Year Annual Maximum:**

\$100,000  \$250,000

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

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

**3. Supplemental Accident Benefit:**

\$500  \$1,000

#### PPO Plan 75/55

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

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

**1. Calendar Year Annual Maximum:**

\$100,000  \$250,000

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

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

**3. Supplemental Accident Benefit:**

\$500  \$1,000

### Dental Coverage

**Please note:** If you are changing or modifying an existing/approved policy or plan, dental is only available at your anniversary.

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

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

## Life Coverage Options

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

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

#### Primary Insured:

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

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

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

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

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

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

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

Term length:  10 years  15 years  20 years

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

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

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

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

#### Spouse:

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

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

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

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

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

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

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

Term length:  10 years  15 years  20 years

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

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

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

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

## Primary Insured Information

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

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

## Parent or Guardian Information

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

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

## Family Information

Please complete only if your spouse and/or dependent children are enrolling for coverage. Attach an additional family information sheet if necessary.

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

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

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

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

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

## Existing Coverage

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

### • Existing Health Coverage

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

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

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

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

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

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

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

• Existing Dental Coverage

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

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

Replaced Plan Number

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

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

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

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

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

• Existing Life Coverage

Primary Insured:

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

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

• If yes, please supply the following information:

Company name Amount \$ Plan #

Spouse:

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

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

• If yes, please supply the following information:

Company name Amount \$ Plan #

Eligibility & Health Status

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

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

• If yes: Name(s):

To the best of your knowledge and belief, Has anyone enrolling for coverage:

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

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

Primary Insured:  No  Yes Spouse:  No  Yes

4.  No  Yes To the best of your knowledge and belief, within the next 2 years, does anyone enrolling for coverage plan to participate in: bungee jumping, hang gliding, martial arts, motorized vehicle racing, private aviation, aerial photography, crop dusting, rock climbing, rodeo, scuba diving, or sky diving?

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

To the best of your knowledge and belief, Within the past 5 years, has anyone enrolling for coverage:

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

7.  No  Yes Has been tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Aids-Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?

8.  No  Yes Had any signs or symptoms of, been diagnosed with by a licensed member of the medical profession, sought counsel for or treated for any alcohol abuse, dependency or problem, or had any alcohol related arrests?

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

10.  No  Yes Had any testing or procedure performed by a licensed member of the medical profession that has been abnormal or the results of which are pending or unknown?

11.  No  Yes Had or been advised by a licensed member of the medical profession to have inpatient or outpatient surgery, that is complete or has not been completed?

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

## Eligibility & Health Status continued

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

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

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

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

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

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

16.  No  Yes Within the past 5 years, to the best of your knowledge and belief, has anyone enrolling for coverage seen a licensed member of the medical profession for any reason (including routine visits) or symptom not previously disclosed above?

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

## Additional Eligibility or Health Status Question Information

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

Question #	Letter	Person treated	Condition
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Details:

Question #	Letter	Person treated	Condition
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Details:

Question #	Letter	Person treated	Condition
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Details:

## Payment Authorization & Billing Information

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

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

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

### 1. Initial Premium Payment Options

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

#### Credit Card Payment

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

Visa  Mastercard

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

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

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

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

#### One-time Automatic Bank Withdrawal

Please print.

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

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

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

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

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

### 2. Subsequent Premium Payment Options

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

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

Monthly billing

Quarterly billing

Semi-Annual billing

**Automatic Bank Withdrawal (monthly billing)**

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

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

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

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

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

### Agent / Producer Information

This section to be completed by Agent or Producer.

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

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

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

Commission split:  No  Yes

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

#### 1. Writing Agent / Producer:

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

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

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

Signature \_\_\_\_\_

Commission split:  No  Yes

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

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

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

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

Percentage of sales:  No  Yes

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

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

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

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

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

Signature \_\_\_\_\_

Percentage of sales:  No  Yes

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

#### Agent replacement question:

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

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

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

## Agreement and Signature

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### True and Complete Acknowledgment:

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers are true and complete.
- I have received and reviewed any state or federal required disclosures.
- Neither I nor my company sales representative has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements.
- This plan enrolled for is not an employer-sponsored group health plan and it does not comply with state or federal small employer laws. I certify that I do not qualify for or have willingly waived a group health plan or receive favorable tax treatment under federal or state law that will be used to pay insurance premiums.
- If this enrollment form for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate. Acceptance of premium and fees does not guarantee coverage.
- To automatic withdrawal from my specified bank account or credit card for premium payment and administrative fees if selected under the payment authorization and payment options section.
- Any misrepresentation on this enrollment form may be used by Humana during the first two plan years to void the contract or modify the terms of coverage. This may result in loss of coverage, modification of coverage and/or claim denial.
- By signing below, I agree to terminate existing coverage if approved.
- As a parent or legal guardian of a dependent 18 years or older enrolling for coverage, I attest by my signature below, that I have gathered the necessary health information from my dependent in order to fully and truthfully complete this enrollment form.
- **This policy is primarily governed by the laws of the District of Columbia where the master policy is filed. As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under your approved policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under your approved policy, consult your agent or the Department of Financial Services.**

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

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

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

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

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

(if covered dependent)

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## Alternate Payor Information

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

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

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

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

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

## 1. Initial Premium Payment Options

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

### Credit Card Payment

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

Visa       Mastercard

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

Expiration date      /

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

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

### One-time Automatic Bank Withdrawal

Please print.

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

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

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

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

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

## 2. Subsequent Premium Payment Options

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

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

Monthly billing

Quarterly billing

Semi-Annual billing

**Automatic Bank Withdrawal (monthly billing)**

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

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

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

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

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

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

# HumanaOne Association Enrollment Form



## **Association Enrollment**

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

Primary Association Member or Legal Guardian Signature

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

# Medical Records Release Authorization

## Purpose of the Authorization

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

## Information we will use and/or disclose

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

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

## Expiration and revocation

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

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

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

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

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

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

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

**Medical and Life products insured by Humana Health Insurance Company of Florida, Inc.  
Dental products insured by HumanaDental Insurance Company**

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

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