

HumanaOne Individual Insurance Application



Please print clearly in ink and complete all questions and fill in all fields or indicate "not applicable."

Date of Application: _____ Requested effective date: _____

(If no continuous prior coverage, effective date may be later than requested.)

Is this application for: New Business (First time applicant) Reinstatement (reapplication)

Change/modification to existing policy

Current policy number _____

Reason for change _____

FLORIDA

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

Health Coverage Plans

Please choose one of the following health coverage plans.

Monogram Plan
\$ _____ deductible

Portrait Plan
\$ _____ deductible

\$0 prescription drug deductible
 No Yes

Autograph Plan Share 80
\$ _____ deductible

\$500 prescription drug deductible
 No Yes

Autograph Plan Share 70
\$ _____ deductible

Autograph Plan HSA-Eligible
\$ _____ deductible

Total
 Total Plus Rx
 Share 80

I understand by choosing the Balanced Benefit HSA-Eligible plan I have the option to request:

Health savings account application **-or-**
 Health savings account educational materials **-or-**
 Not interested at this time

Options Available with Health Coverage Plans

The following options are available with all health plans.

Lifetime Maximum Buy-Up
 Supplemental Accident Benefit :
 \$500 \$1000

Additional Coverage Options

You may purchase additional coverage if health coverage is chosen and approved.

Dental
 \$20,000 Term Life Rider
(applicant must be 18 or older to select this option)

Primary Applicant:

Primary beneficiary name _____
 Secondary beneficiary name _____

Spouse:

Primary beneficiary name _____
 Secondary beneficiary name _____

Term Life Plan for Primary Applicant

The amount of term life insurance I want is _____.
(Minimum selection is \$25,000 and \$1,000 increments)

Term length:
 10 years
 15 years
 20 years

Primary beneficiary name _____
Relationship _____ Benefit % _____
Secondary beneficiary name _____
Relationship _____ Benefit % _____

Term Life Plan for Spouse

The amount of term life insurance I want is _____.
(Minimum selection is \$25,000 and \$1,000 increments)

Term length:
 10 years
 15 years
 20 years

Primary beneficiary name _____
Relationship _____ Benefit % _____
Secondary beneficiary name _____
Relationship _____ Benefit % _____

Primary Applicant Information

If child-only coverage is requested, the youngest child is the Primary Applicant; questions must be filled out by custodial parent.

Last name	First name	Middle initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height	Weight
Home address (not P O Box)		City			
State	Zip code	Birth date	Country / State of birth		

continued

Primary Applicant Information (continued)

If child-only coverage is requested, the youngest child is the Primary Applicant; questions must be filled out by custodial parent.

Mailing address (If different from home address)			
City		State	Zip code
Home phone number ()	Daytime phone number ()	Social Security number - -	Driver's license number
Type of business or industry	Occupation	If translation service is needed, please indicate language preference:	
Email address (If you are 18 years of age or older)		Policy owner name if different than Primary Applicant	
Do you wish to designate another person (secondary addressee to receive copies of any premium lapse notices?) <input type="checkbox"/> No <input type="checkbox"/> Yes			
Name		Address	

Parent or Guardian Information

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

Parent or guardian full legal name		Parent or guardian's Social Security number	
Address			
Birth date	Relationship to child(ren)	Email address	

Family Information

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

Spouse name (include last name if different from Primary Applicant)			Middle initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Birth date	Social Security number	Country / State of birth	Height	Weight
Spouse's type of business or industry		Spouse's occupation	Full-time student <input type="checkbox"/> No <input type="checkbox"/> Yes	

Name (include last name if different from Primary Applicant)				Middle initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Social Security number	Birth date	Height	Weight	Full-time student <input type="checkbox"/> No <input type="checkbox"/> Yes	

Name (include last name if different from Primary Applicant)				Middle initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Social Security number	Birth date	Height	Weight	Full-time student <input type="checkbox"/> No <input type="checkbox"/> Yes	

Name (include last name if different from Primary Applicant)				Middle initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Social Security number	Birth date	Height	Weight	Full-time student <input type="checkbox"/> No <input type="checkbox"/> Yes	

Name (include last name if different from Primary Applicant)				Middle initial	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Social Security number	Birth date	Height	Weight	Full-time student <input type="checkbox"/> No <input type="checkbox"/> Yes	

continued

General Eligibility

Please answer for all individuals applying for coverage.

1. Has anyone applying for coverage used any type of tobacco product in the past 12 months? No Yes

If yes, check all that apply:

Primary Applicant - How frequently do you use tobacco?

More than once per week

One time or less per week

Spouse - How frequently do you use tobacco?

More than once per week

One time or less per week

2. Within the past 10 years has anyone applying for coverage been previously denied, rated or had health conditions excluded or ridered from life, disability, annuity or health insurance coverage? No Yes

If yes, please supply the following:

Name of person: _____

Denied Rated Ridered

Name of person: _____

Denied Rated Ridered

3. Are you or anyone applying for coverage a U.S. citizen(s) or are you permanent legal residents that have resided in the U.S. for the past 2 years? Yes No

If no, list names

Name(s): _____

Recreational Activity

During the next two years does anyone applying for coverage participate or plan to participate in any of the following activities: Bungee jumping, private aviation, motorized vehicle racing, rock climbing, rodeo events, scuba diving or sky diving? No Yes

If yes:

Name of person _____

What activities _____

When (month/year) _____

Lifestyle

Has anyone applying for coverage:

1. In the past 5 years been convicted for driving under the influence? No Yes

2. In the past 5 years used marijuana? No Yes

3. In the past 10 years used any other illegal, controlled drugs or substances or been diagnosed as alcohol or chemically dependent?

No Yes

If yes to any question listed above:

Question Number _____

Name of person _____

When (month/year) _____

Existing Coverage

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

IMPORTANT: It is important that you do not cancel any existing coverage until you receive notification from Humana of your acceptance for coverage.

Humana Coverage

1. Has anyone applying for coverage ever had Humana group or individual coverage? No Yes
- If yes, please supply the following for all applicants on the policy:

Name(s)	
Effective Date	Termination Date

Name(s)	
Effective Date	Termination Date

Fill out the following for each line of coverage which you have chosen.

Existing Health Coverage

1. Has anyone applying for coverage had any group or individual health plan coverage within the last 18 months? No Yes
- If yes, please supply the following information for each applicant for the last 18 months:

Name(s)	
Insurance carrier name	
Effective date	Termination date

Name(s)	
Insurance carrier name	
Effective date	Termination date

2. If anyone applying for coverage has any existing group or individual health plan coverage, do you agree to terminate this existing coverage if approved for the coverage being applied for? No Yes

Existing Dental Coverage

1. Does anyone applying for coverage currently have any group or individual dental coverage? No Yes
- If yes, please supply the following for all applicants on the policy:

Name(s)	
Insurance carrier name	
Effective date	Termination date

Name(s)	
Insurance carrier name	
Effective date	Termination date

2. Has anyone applying for coverage had this existing dental coverage within the last 18 months? No Yes
- If yes, will the insurance coverage applied for be used to replace existing dental coverage? No Yes

Existing Life Coverage

Primary Applicant:

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

Company name	
Amount	Policy number

Spouse:

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

Company name	
Amount	Policy number

Evidence of Health Status

For this insurance to be issued, the following health questions must be answered fully and truthfully. All of the health information, including routine physical exams, 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.

Please answer for all individuals applying for coverage.		
1.	Within the past 2 years been advised to have or have had a check-up (annual or otherwise), electrocardiogram, x-ray, lab tests, or other medical tests (such as: blood tests, urine analysis, MRI, CT scan, blood pressure check, etc)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2.	a. Within the past 2 years been treated in the ER, an Urgent Care Center, or been hospitalized? b. Within the past 2 years have you had, or been advised to have, any inpatient /outpatient surgery that is complete or yet to be completed?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes
3.	Within the past 10 years had cosmetic or reconstructive surgery, implant(s), internal fixation (i.e. pins, plates, rods, screws, etc.), prosthesis or prosthetic device, joint replacement, monitoring device, pacemaker, or valve replacement?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4.	Had a positive pregnancy test in the last 90 days, or are currently an expectant parent, male or female, regardless of whether or not the mother is listed on the application?	<input type="checkbox"/> No <input type="checkbox"/> Yes
5.	Within the past 10 years been diagnosed or treated by a medical professional for fatigue, fever, loss of appetite, oral thrush, recurrent infections or weight loss with no known cause?	<input type="checkbox"/> No <input type="checkbox"/> Yes
6.	Within the past 10 years 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes

In the past 10 years, has anyone applying for coverage been treated for, or been advised or counseled by a physician or other licensed health care professional that they have or may have had any of the following: (Check all conditions which apply)

7. Cardiovascular, Circulatory, or Heart Disorder	
<input type="checkbox"/> a. Angina, Chest Pain or Heart Attack <input type="checkbox"/> b. High Blood Pressure or Hypertension <input type="checkbox"/> c. Coronary Artery Disease <input type="checkbox"/> d. Heart Murmur, Mitral Valve Prolapse or Irregular Heartbeat <input type="checkbox"/> e. Edema, Phlebitis, Varicose Veins, Deep Vein Thrombosis, Blood Clot, or Aneurysm	<input type="checkbox"/> f. Congenital Heart Disorder (existing at or dating from birth) <input type="checkbox"/> g. Congestive Heart Failure <input type="checkbox"/> h. Valve Disorder <input type="checkbox"/> No to all Cardiovascular, Circulatory, or Heart Disorders
8. Blood, Gland, Endocrine, Pituitary or Lymph Node Disorder	
<input type="checkbox"/> a. Elevated Cholesterol or Triglycerides <input type="checkbox"/> b. Diabetes, High or Low Blood Sugar <input type="checkbox"/> c. Anemia <input type="checkbox"/> d. Obesity <input type="checkbox"/> e. Thyroid or Glandular Disorder	<input type="checkbox"/> f. Enlarged or Swollen Lymph Nodes <input type="checkbox"/> g. Blood, Endocrine, Pituitary or Lymph Node Disorder <input type="checkbox"/> No to all Blood, Gland, Endocrine, Pituitary or Lymph Node Disorders
9. Digestive Disorder	
<input type="checkbox"/> a. Gastroesophageal Reflux Disease (GERD) or Heartburn <input type="checkbox"/> b. Ulcer, Gastritis or Hernia <input type="checkbox"/> c. Irritable Bowel Syndrome (IBS), Colitis or Crohn's Disease <input type="checkbox"/> d. Diverticulitis, Diverticulosis, Hemorrhoids, or Colon Polyps	<input type="checkbox"/> e. Cirrhosis or Hepatitis <input type="checkbox"/> f. Stomach, Liver, Pancreas, Spleen, Colon or Gallbladder Disorder <input type="checkbox"/> No to all Digestive Disorders
10. Genitourinary Disorder	
<input type="checkbox"/> a. Bladder Infection, Cystitis or Bladder Disorder <input type="checkbox"/> b. Kidney Disorder, Kidney Stones or Kidney Infection	<input type="checkbox"/> No to all Genitourinary Disorders
11. Muscular Skeletal Disorder	
<input type="checkbox"/> a. Back or Spine Disorder, <input type="checkbox"/> b. Arthritis, Bursitis, Tendonitis or Gout <input type="checkbox"/> c. Fibromyalgia <input type="checkbox"/> d. Temporomandibular Joint Syndrome (TMJ) <input type="checkbox"/> e. Connective Tissue Disorder or Systemic Lupus	<input type="checkbox"/> f. Bone, Joint, Muscular, Neuromuscular Disorder or Injury <input type="checkbox"/> g. Muscular Dystrophy, Amyotrophic Lateral Sclerosis (ALS), or Polio <input type="checkbox"/> No to all Muscular Skeletal Disorders
12. Brain or Nerve System Disorder	
<input type="checkbox"/> a. Headaches-recurrent or severe <input type="checkbox"/> b. Epilepsy, Seizures, Tics or Tremors <input type="checkbox"/> c. Stroke or Transient Ischemic Attack (TIA) <input type="checkbox"/> d. Alzheimer's, Dementia or Memory Loss <input type="checkbox"/> e. Migraines, or Dizziness / Fainting	<input type="checkbox"/> f. Multiple Sclerosis or Paralysis <input type="checkbox"/> g. Cerebral Palsy or Parkinson's <input type="checkbox"/> h. Concussion, Brain Injury or Head Trauma <input type="checkbox"/> No to all Brain or Nervous Disorders
13. Congenital or Development Disorder	
<input type="checkbox"/> a. Cleft Palate or Cleft Lip <input type="checkbox"/> b. Club Foot / Feet <input type="checkbox"/> c. Autism, Down's Syndrome or Mental Retardation	<input type="checkbox"/> d. Huntington's Chorea <input type="checkbox"/> e. Developmental Disorder or Delay <input type="checkbox"/> No to all Congenital or Development Disorders

In the past 10 years, has anyone applying for coverage been treated for, or been advised or counseled by a physician or other licensed health care professional that they have or may have had any of the following: (Check all conditions which apply)

14. Respiratory Disorder	
<input type="checkbox"/> a. Allergies, Bronchitis or Asthma <input type="checkbox"/> b. Chronic Obstructive Pulmonary Disease (COPD) <input type="checkbox"/> c. Emphysema, Pneumonia or Shortness of Breath	<input type="checkbox"/> d. Tuberculosis or Cystic Fibrosis <input type="checkbox"/> e. Sleep Apnea <input type="checkbox"/> No to all Respiratory Disorders
15. Cyst or Tumor	
<input type="checkbox"/> a. Cancer, Carcinoma or Melanoma <input type="checkbox"/> b. Cyst, Growth, Lump, Mass or Tumor	<input type="checkbox"/> No to all Cyst or Tumors
16. Female Reproductive Disorder	
<input type="checkbox"/> a. Disorder of the Breast or Abnormal Mammogram <input type="checkbox"/> b. Abnormal Pap Smear <input type="checkbox"/> c. Endometriosis, Infertility, Uterine Fibroids or Pelvic Inflammatory Disease <input type="checkbox"/> d. Complication of Pregnancy / Cesarean Section	<input type="checkbox"/> e. Menopausal Disorder <input type="checkbox"/> f. Menstrual Disorder <input type="checkbox"/> g. Cervical, Ovarian, Uterine or Vaginal Disorder <input type="checkbox"/> Not Applicable or No to all Female Reproductive Disorders
17. Male Reproductive Disorder	
<input type="checkbox"/> a. Penile, Prostate or Testicular Disorder <input type="checkbox"/> b. Infertility or Sexual Dysfunction	<input type="checkbox"/> Not Applicable or No to all Male Reproductive Disorders
18. Sexually Transmitted Disease	
<input type="checkbox"/> a. Chancroid or Chlamydia <input type="checkbox"/> b. Genital Warts or Condyloma Acuminatum <input type="checkbox"/> c. Genital Herpes	<input type="checkbox"/> d. Human Papilloma Virus (HPV) <input type="checkbox"/> e. Gonorrhea or Syphilis <input type="checkbox"/> No to all Sexually Transmitted Diseases
19. Emotional or Mental Disorder	
<input type="checkbox"/> a. Anxiety, Depression or Panic Disorder <input type="checkbox"/> b. Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) <input type="checkbox"/> c. Eating Disorder	<input type="checkbox"/> d. Counseling-Psychiatric or Psychological <input type="checkbox"/> e. Bipolar Disorder, Obsessive Compulsive Disorder, Multiple Personality Disorder, or Schizophrenia <input type="checkbox"/> No to all Emotional or Mental Disorders
20. Skin Conditions	
<input type="checkbox"/> a. Acne or Rosacea <input type="checkbox"/> b. Eczema, Discoid Lupus or Psoriasis	<input type="checkbox"/> No to all Skin Conditions
21. Eyes, Ears, Nose or Throat Condition	
<input type="checkbox"/> a. Disorder of the Ear, Ear Infections or Tubes In Ears <input type="checkbox"/> b. Hearing Loss or Cochlear Implants <input type="checkbox"/> c. Disorder of the Nose, Deviated Septum or Sinus Infection <input type="checkbox"/> d. Meniere's, Labyrinthitis or Vertigo	<input type="checkbox"/> e. Disorder of the Throat, Tonsils or Adenoids <input type="checkbox"/> f. Disorder of the Eyes, Blindness, Cataracts or Glaucoma <input type="checkbox"/> g. Speech Impairment <input type="checkbox"/> No to all Eye, Ear, Nose, or Throat Conditions
22. In the past 10 years has anyone applying for coverage been seen by or consulted by a doctor, or any other person providing health care services for any other condition not listed on this application? <input type="checkbox"/> No <input type="checkbox"/> Yes	
23. Has anyone applying for coverage, within the past 2 years been prescribed or taken any prescription medications, other than for the common cold or flu? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please list all details and medications in Additional Health Question Information section below.</i>	

Additional Health Question Information

To be completed if anyone applying for coverage answered "Yes" to any question(s) or checked any above conditions in the Evidence of Health Status section. Attach an additional health information sheet if necessary.

Person treated	Question number
Condition	
Treatment dates (First diagnosed / treated, last seen by a physician, and planned future dates)	
Type of treatment	
Medications-prescribed or taken (include name of medication, dosage and frequency taken)	
Medication-First prescribed / taken (month/year)	
Medication-Last prescribed / taken or date discontinued (month/year)	
Recovery complete? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide date (month/year)	
Physician name	
Physician address and telephone	

Payment Authorization & Billing Information

If another person will be paying for coverage they must sign the agreement and signature page.

Who will be paying for this plan(s)? _____ Name Phone number (_____) _____

Address _____

Initial Payment Options

Initial payment must total one month's premium for each product selected. Agent / Producer payments are not accepted. Please choose your preference for payment of first month's premium. Please complete credit card or one time bank withdrawal below.

Credit card One time bank withdrawal

Credit Card Payment

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

Visa Mastercard

Card number _____

Expiration date (Month/Year) _____

Cardholder's name _____

I authorize Humana to bill my VISA / Mastercard account for the initial premium payment.

One Time Automatic Bank Withdrawal

(Please print)

Account holder's name _____

Phone number (_____) _____

Bank name _____

Address _____

Routing number _____

Account number _____

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

Subsequent Payment Options

Please indicate both billing preference and payment method. If direct bill is selected a fee may apply. If choosing automatic bank withdrawal, please complete section to the right.

<input type="checkbox"/> Monthly billing	<input type="checkbox"/> Automatic bank withdrawal
	<input type="checkbox"/> Direct bill
<input type="checkbox"/> Quarterly billing	Direct bill
<input type="checkbox"/> Semi-Annual billing	Direct bill

Subsequent Automatic Bank Withdrawal

(Please print)

Account holder's name _____

Phone number (_____) _____

Bank name _____

Address _____

Routing number _____

Account number _____

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

Agent / Broker / Producer Information

This section to be completed by Agent, Broker or Producer.

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

Name (print) _____

Tax ID -or- Social Security # -or- Humana ID _____

Commission split: No Yes

If yes, percentage _____ (Total should equal 100%)

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

Name (print) _____

Tax ID -or- Social Security # -or- Humana ID _____

Percentage of sales: No Yes

If yes, percentage _____ (Total should equal 100%)

1. Writing Agent / Broker / Producer:

Name (print) Joseph L LePage

Tax ID -or- Social Security # -or- Humana ID 1298794

Florida license number P143427

Signature _____

Commission split: No Yes

If yes, percentage _____ (Total should equal 100%)

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

Name (print) _____

Tax ID -or- Social Security # -or- Humana ID _____

Florida license number _____

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 / Broker / 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 _____

Thank you for choosing HumanaOne.

Agreement and Signature

True and Complete Acknowledgment:

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers are true and complete.
- I have received and reviewed any state or federal required disclosures.
- Neither I nor my company representative has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements.
- This policy applied for is not an employer-sponsored group health plan and it does not comply with state or federal small employer laws. I certify that I do not qualify for a group health plan or receive favorable tax treatment under federal or state law.
- 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 for premium payment and administrative fees if selected under the product section.
- If I have selected the Pre-employment or College Graduate Health Plans to terminate coverage at the end of the reduced premium period if I have obtained substantially similar health insurance coverage.
- Premiums already paid will be refunded to me if a policy is not issued.
- **Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk.**

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

Authorization

My spouse, 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 Humana, or its reinsurer or its legal representatives, and its affiliates.

My spouse, dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
- If you decide not to sign this authorization, we will decline to enroll you in a medical plan or to give you medical benefits.
- Any information obtained will not be released by Humana 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 I (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.
- 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.

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 Representative Signature _____ Date _____
(MM/DD/YYYY)

Name and Relationship of Legal Representative _____

Spouse Signature _____ Date _____
(if covered dependent) (MM/DD/YYYY)

Payor Signature _____ Date _____
(if other than insured) (MM/DD/YYYY)

Child Signature _____ Date _____
(if over legal age and applying for dependent coverage) (MM/DD/YYYY)

