

Applying for a Humana Plan is Simple.

Just Follow 3 Easy Steps...

Step 1 Print this application and complete in black or blue ink.

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

Step 3 Fax the application to us and we will submit it to Humana.

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

All applicant(s) must sign and date the application.

Leave the Coverage Options section blank, or call us for help completing it.

All medical questions must be answered; please provide thorough details to all yes answers; attach an additional sheet if necessary. Please call with any questions.

Life Coverage is only required if applying for term life

Billing options

a. Initial payment options:

i. Credit card

ii. Electronic Funds Transfer / Bank Draft

b. Subsequent payment options:

i. Paper Bill mailed to specified address (\$10 surcharge per month)

ii. Electronic Funds Transfer / Bank Draft

iii. Recurring Mastercard charge

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

404-575-1960

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 submitting it.

HealthPlanStore
817 West Peachtree St.
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

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



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

Date of application: ___/___/___ Requested Effective Date: ___/___/___

- This application is for:
- New Business (First time applicant)
 - Reinstatement (Reapplication)
 - Change/Modification to Existing Policy

GEORGIA

Reason for change _____

Change/Modification to Existing Policy # _____

Coverage Options

<p>Health Coverage Please complete this section when selecting a health plan.</p> <p>Plan name _____</p> <p>Deductible \$ _____</p> <p>Dental Coverage</p> <p><input type="checkbox"/> Dental Traditional Plus</p>	<p>Optional Benefits Please select an optional benefit if available with chosen health plan.</p> <p><input type="checkbox"/> Office visit copay</p> <p><input type="checkbox"/> Prescription drug deductible: <input type="checkbox"/> \$150 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500</p> <p><input type="checkbox"/> Supplemental Accident Benefit: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500</p> <p><input type="checkbox"/> Mental Disorder Benefit</p> <p><input type="checkbox"/> Carryover Deductible</p>
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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 or plan, dental is only available at your anniversary.

Life Coverage

Please complete this section if choosing 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.

<p>Primary Applicant:</p> <p><input type="checkbox"/> Term Life Plan (Minimum selection is \$25,000. Additional amounts must be purchased in \$25,000 increments.)</p> <p>Term life insurance amount: \$ _____</p> <p>Term length: <input type="checkbox"/> 10 years <input type="checkbox"/> 15 years <input type="checkbox"/> 20 years</p> <p>Primary beneficiary name _____</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Relationship _____</td> <td style="width: 30%;">Benefit % _____</td> </tr> <tr> <td colspan="2">Contingent beneficiary name _____</td> </tr> <tr> <td>Relationship _____</td> <td>Benefit % _____</td> </tr> </table>	Relationship _____	Benefit % _____	Contingent beneficiary name _____		Relationship _____	Benefit % _____	<p>Spouse:</p> <p><input type="checkbox"/> Term Life Plan (Minimum selection is \$25,000. Additional amounts must be purchased in \$25,000 increments.)</p> <p>Term life insurance amount: \$ _____</p> <p>Term length: <input type="checkbox"/> 10 years <input type="checkbox"/> 15 years <input type="checkbox"/> 20 years</p> <p>Primary beneficiary name _____</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Relationship _____</td> <td style="width: 30%;">Benefit % _____</td> </tr> <tr> <td colspan="2">Contingent beneficiary name _____</td> </tr> <tr> <td>Relationship _____</td> <td>Benefit % _____</td> </tr> </table>	Relationship _____	Benefit % _____	Contingent beneficiary name _____		Relationship _____	Benefit % _____
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Relationship _____	Benefit % _____												

Primary Applicant Information

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		E-mail		
Type of business or industry	Occupation		Home phone # ()		Daytime phone # ()	
Mailing address (if different from home address)			City		State	ZIP code

Family Information

Please complete only if your spouse and/or dependent children are applying for coverage. Attach an additional family information sheet if necessary. Each additional page must be signed and dated.

Spouse 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 #			E-mail			
Dependent 1 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						
Dependent 2 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						
Dependent 3 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						
Dependent 4 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/Prior Coverage

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

• Existing or Prior Health Coverage

If you are applying for health coverage, please provide the status of current coverage or coverage within the past 24 months, 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 major medical health insurance coverage currently in force?

• **If YES, please supply the following for all applicants applying for coverage on the policy:**

Name(s) of covered persons _____

Major Medical Insurance Carrier Name _____

Effective Date ___/___/_____

• **If NO, please answer the following question:**

No Yes Have you or anyone applying for coverage had major medical health insurance coverage within the past 24 months?

• **If YES, please supply the following for all applicants applying for coverage on the policy:**

Name(s) of covered persons _____

Major Medical Insurance Carrier Name _____

Effective Date ___/___/_____

Termination 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 applying for coverage on the policy:

Name(s) Effective Date ___/___/____
Insurance Carrier Name Termination Date ___/___/____
Name(s) Effective Date ___/___/____
Insurance Carrier Name Termination Date ___/___/____

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

• Existing Life Coverage

Primary Applicant:

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

• If YES, please supply the following information:

Company name Amount \$ Policy #

Spouse:

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

• If YES, please supply the following information:

Company name Amount \$ Policy #

Eligibility & Health Status

Please answer for all individuals applying for coverage.

For this insurance to be issued, the following eligibility and health questions must be answered fully and truthfully. All requested health information including routine physical exams and information related to spouse and dependents applying for coverage must be provided. If any of the answers are "yes", please provide complete details. Failure to fully disclose any eligibility or health information may cause your claim to be reduced or denied, including the applicability of a condition specific deductible; or may result in your policy being rescinded or modified 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):

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 or dependent applying for coverage used any tobacco product?

Primary Applicant: No Yes
Spouse: No Yes
Dependent: No Yes

4. No Yes Has anyone applying for coverage participated in any dangerous or extreme sport activity in the past 24 months or plan to participate in the next year?
5. No Yes Are you or is any immediate family member (whether applying for coverage or not) pregnant, an expectant parent, in the process of adopting a child, or undergoing infertility treatment?

Within the past 1-5 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 Been diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS), or tested positive for AIDS or Human Immunodeficiency Virus (HIV)?
8. No Yes Had any signs or symptoms of, been diagnosed with, 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 or had any signs or symptoms of, been diagnosed with, 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 that has been abnormal or the results of which are pending or unknown?
11. No Yes Had surgery or been advised to have surgery that has not been completed?
12. No Yes Consulted, advised or recommended to have follow-up testing or treatment by a health care provider or specialist that has not been completed?

Eligibility & Health Status continued

13. **Within the past 5 years**, has anyone applying for coverage had signs of, been prescribed medication or received injections for, or been diagnosed with or treated for:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Chest pain or Heart Attack	M. <input type="checkbox"/> No <input type="checkbox"/> Yes ADD/ADHD (Attention Deficit Disorder) or any other Behavioral, Emotional, Mental or Nervous Disorders
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 Uterine Fibroids
G. <input type="checkbox"/> No <input type="checkbox"/> Yes Paralysis	S. <input type="checkbox"/> No <input type="checkbox"/> Yes Cyst, Growth, Lump or Polyp
H. <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy or Seizure	T. <input type="checkbox"/> No <input type="checkbox"/> Yes Hernia
I. <input type="checkbox"/> No <input type="checkbox"/> Yes Migraines or frequent or severe headaches	U. <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis
J. <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis	V. <input type="checkbox"/> No <input type="checkbox"/> Yes Implants, Pins, Plates, Rods, Screws or Prosthesis
K. <input type="checkbox"/> No <input type="checkbox"/> Yes Sleep Apnea	W. <input type="checkbox"/> No <input type="checkbox"/> Yes Connective Tissue or Autoimmune Disorder
L. <input type="checkbox"/> No <input type="checkbox"/> Yes Anxiety or Depression	X. <input type="checkbox"/> No <input type="checkbox"/> Yes Birth Defect

14. **Within the past 5 years**, has anyone applying for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

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

15. **Within the past 5 years**, has anyone applying for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder (not previously disclosed) involving or affecting:

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, including Bone/Joint Disorders
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 24 months, has anyone applying for coverage seen a health care provider or specialist for a routine physical/wellness exam, or been seen for *any* reason not previously disclosed?

17. No Yes Within the past 24 months, has anyone applying for coverage been advised to take or taken any prescription medications or injections not previously disclosed?

Additional Eligibility or Health Status Question Information

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

Question #	Letter	Person treated	Condition
Details:			
Question #	Letter	Person treated	Condition
Details:			
Question #	Letter	Person treated	Condition
Details:			

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 agree to immediately notify Humana of any changes to the information contained in this form that occur prior to the policy effective date. I have received and reviewed any state or federal required disclosures. I acknowledge that neither I nor the agent have the right to waive or incompletely answer 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 will not use pre-tax income to pay premiums associated with this policy or otherwise 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. Unless Humana agrees to an earlier date, the effective date for sickness begins on the 15th day after the approved effective date of the policy. Acceptance of premium and fees does not guarantee coverage. 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. I agree to terminate any existing coverage if this application is approved and coverage accepted. 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 regarding 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 presents false information in an application for insurance or life settlement contract is guilty of a crime and, upon conviction, may be subject to fines or confinement in prison, or both.

If you decide not to sign this agreement, 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 (if covered dependent) _____ Date __/__/____

Agent / Producer Information

This section to be completed by Agent or Producer.

Agent / Agency of Record: (for commissions and correspondence)

Name (print) _____

Humana Agent # _____

Writing Agent / Producer:

Name (print) _____

Humana Agent # _____

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

Writing Agent's Signature _____ Date __/__/____

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

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

POS plans offered by Humana Employers Health Plan of Georgia, Inc. and insured by Humana Insurance Company

Life products insured by Humana Insurance Company

Dental products insured by HumanaDental Insurance Company

HUMANA
Guidance when you need it most

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 Insurance Company
POS plans offered by Humana Employers Health Plan of Georgia, Inc. , and/or insured by Humana Insurance Company
PPO plans insured by Humana Insurance Company
Dental products insured by HumanaDental Insurance Company

HUMANA[®]
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, association dues, administrative or enrollment fees)

Please note: Rates quoted are not guaranteed. The final rate will be based on underwriting completion and approval of the application or enrollment form.

- Medical Plan Association Dues: \$3.95 Monthly (non-refundable) (Dues apply to specific plans in: AL, AZ, FL, IL, MI, WI)
- Dental Preventive Plus Association Dues: 75¢ Monthly (non-refundable) (Dues apply in: AL, AR, AZ, FL, IL, IN, KS, KY, LA, MI, MO, MS, NC, NE, NM, NV, OH, OK, SC, TN, TX, VA, WI, unless enrolled in a Medical 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 # ()
Mailing address		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.

Primary Applicant 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 ____ / ____ / ____