HUMANA®

Certification of Medical Coverage

YOU MUST COMPLETE AND RETURN THIS FORM

Primary Insured: _____
Last name First name MI

Critical Illness Certificate Number:_____Certificate Effective Date_____/_____/_____

This form is being sent to you in accordance with New York regulation 11 NYCRR 52.15(b)(14). This form must be completed for every person covered under the Critical Illness Certificate. Once completed and signed, fax, e-mail or mail this form to Humana at the address provided below within 30 days of receipt. **Failure to return this form completed and signed within the specified time period will result in the Critical Illness Certificate being voided from its beginning with a full premium refund.**

In order to be covered under a Critical Illness Certificate, New York law requires that every person covered by the Critical Illness Certificate must have coverage in force under at least major medical insurance, or at least basic hospital and basic medical insurance as of the effective date of the Critical Illness Certificate.

If you, the Primary Insured, are not covered by a major medical insurance, or at least basic hospital and basic medical insurance, on the Effective Date of the Critical Illness, the Certificate will be voided from its beginning with a full premium refund. If you, the Primary Insured, have underlying coverage in force, but one or more dependents do not, the coverage for the dependents without underlying coverage in force on the effective date of the Critical Illness, the Certificate will be voided with a commensurate premium refund.

Does every person enrolling for coverage in this Enrollment form for Critical Illness Insurance currently have at least major medical insurance or at least basic hospital insurance and basic medical insurance in force on the date of this Enrollment form? ❍ No ❍ Yes;
If NO, please list the name(s) of the person(s)_____

True and complete acknowledgement I understand, agree and represent: I have read this document or it has been read to me and answers provided are true and complete to the best of my knowledge and belief. Any misrepresentation contained herein relied on by Humana may be used to reduce or deny claims or void the contract within the contestable period. Any person who knowingly and with intent to defraud any insurance company or other person files an Enrollment form for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Primary Insured Signature_____Date _____/_____/_____

Mail completed and signed form to:

Humana Specialty Enrollment
PO Box 14330
Lexington, KY 40512
Or fax to:
1-866-584-9140

The offering Company listed below is referred to in this form as "Humana".

Insured or administered by Humana Insurance Company of New York, 125 Wolf Road, Suite 501, Albany, NY 12205-1253.
Telephone: (518)-435-0459.