Medicare Supplement Extra Services Opt-In

We consider it a privilege to provide your Medicare Supplement insurance coverage. As a Humana member you are eligible for a variety of extra services, products, and programs.

Some of these extra services, products, and programs are administered by third parties. In order to have access to them, we need your authorization to share your personal information, such as name and address, with the third parties.

If you'd like to know more, the next step is easy. Just provide the information below.

Thank you for your consideration.

YES, I'd like to receive information on the following health and wellness services:

Silver Sneakers® Fitness Program – Access to fitness programs at participating facilities.

I understand I don't have to sign this authorization and that Humana can't make determinations or decisions about my treatment, methods of payment, premium rates, enrollment, or benefits based on whether or not I sign this authorization. I understand that this authorization will allow Humana and its affiliates to use or disclose the protected health information described below.

Primary Applicant/Member Information

First name	MI	Last name		Date of birth	
Home address (not P.O. Box)			City	State	Zip code
Medicare ID Number			Home phone #	Daytime phone #	
Mailing address (if different from home address)			City	State	Zip Code

Humana®

PDN:_____
(FOR INTERNAL USE ONLY)

Consent:

In order to receive information and have access to Health and or wellness discounts, products, programs, services,etc., I authorize Humana to share my personal information with third-parties. Personal information can be my name, address, telephone number, email address, and date of birth. The third parties will use my information to confirm eligibility of and notify me of their products, services, and programs.

I understand it's Humana's policy not to disclose my personal information to third parties - except as permitted under the federal privacy laws. Humana is required to let me know that should my personal information be disclosed to third parties, the information can be redisclosed and may not be protected by privacy laws.

I understand this authorization will remain valid for no longer than 24 contiguous months after the date it is signed and that I may revoke this authorization at any time by sending my written revocation to Humana's Privacy Office P.O. Box 1438 Louisville, KY 40202. I understand that canceling my permission in writing won't apply to information already released.

⇨ Signature of applicant/member or legal representative _____ Date _____

⇨ If signed by legal representative, relationship to the applicant/member _____

Please note: Legal representatives must attach copies of authorization as required by law. Examples include healthcare power of attorney, healthcare surrogate, living will, or guardianship papers.

❑ **NO THANK YOU**

Insured by HumanaDental Insurance Company

Humana®

PDN:_____
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