Enrollment Application

Follow these easy steps to apply for a Humana Connect Medicare Supplement insurance policy.

1 Have Your Medicare Card Ready

Please print legibly and complete the entire form. You will need to fill in the information exactly as it appears on your Medicare card. Each person must complete a separate application.

2 Read and Complete Other Coverage Information

Be sure you read and understand the information before completing this section. If you intend to replace your current Medicare Supplement policy or Medicare Advantage plan with this policy, be sure to complete the enclosed form titled Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage.

3 Determine Your Discount

4 Be Sure to Include Your Initial Premium Payment

Your first month's premium payment must be included. This is necessary even if you choose our Automatic Bank Withdrawal or Auto Credit Card Charge options for future premium payments.

5 Sign and Date the Enrollment Application

Humana®

Marking Instructions

- Please print clearly and press hard.
- Use blue or black ink only.
- Completely fill the ovals.

Correct Mark

Incorrect Marks

- Print legible numbers and capital block letters in the boxes.

Correct Numbers and Letters

1 2 3 A B C

- Print only one character per box.
- If you make a mistake, correct it by crossing out the box and writing the letter/number above or below the box as shown. Be sure to initial any and all corrections made.

- When filling out dates, such as effective dates or birth dates, be sure dates appear in the MMDDYYYY format. No dashes or spaces are necessary.

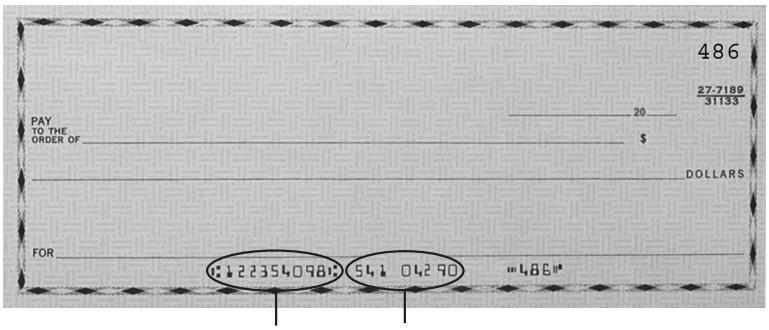
0 3 2 4 2 0 1 0

Required Fields Must Be Completed

Optional Fields

Sample Check

(If you are choosing the auto bank withdrawal.)



Routing Number **Account Number**

STAMP DATE MU001

Humana Insurance Company
2432 Fortune Drive, Lexington, KY 40509

1

LAST NAME FIRST NAME MI

ADDRESS APT OR STE#

ADDRESS (continued) COUNTY

CITY STATE ZIP CODE

TELEPHONE / – DATE OF BIRTH M M D D Y Y Y Y

GENDER ○ M ○ F

MAILING ADDRESS (only if different from above street ADDRESS) APT OR STE#

CITY STATE ZIP CODE

E-MAIL ADDRESS (optional)

(E-mail address, if available, will be used as a means to communicate only coverage information.)

Select the policy you are applying for:

- ○ Plan A
- ○ Plan C
- ○ Plan F
- ○ Plan G

PROPOSED EFFECTIVE DATE M M / 0 1 / 2 0 Y Y

Please complete the information below as it appears on your Medicare card.

MEDICARE NUMBER

IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL INSURANCE (PART A)	M M / D D / Y Y Y Y
MEDICAL INSURANCE (PART B)	M M / D D / Y Y Y Y

PERSON TO NOTIFY IN AN EMERGENCY (optional):

LAST NAME FIRST NAME MI

RELATIONSHIP TO APPLICANT TELEPHONE / –

AGENT NUMBER (SAN)

➤ **You Must Read and Sign**

APPLICANT MEDICARE NUMBER

2 Other Coverage Information

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB).

Yes or No answers are required to the following questions.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. a. Did you turn age 65 in the last six months? ◯ Yes ◯ No
   b. Did you enroll in Medicare Part B in the last six months? ◯ Yes ◯ No
   If yes, what is the effective date? M M / D D / Y Y Y Y
2. Are you covered for medical assistance through the State Medicaid program? ◯ Yes ◯ No
   (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)
   a. If yes, will Medicaid pay your premiums for this Medicare Supplement policy? ◯ Yes ◯ No
   b. Do you receive any benefits from Medicaid OTHER THAN payments toward Your Medicare Part B premium? ◯ Yes ◯ No
3. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
   START M M / D D / Y Y Y Y END M M / D D / Y Y Y Y
   a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ◯ Yes ◯ No
   b. Was this your first time in this type of Medicare plan? ◯ Yes ◯ No
   c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ◯ Yes ◯ No
4. Do you have another Medicare Supplement policy in force? ◯ Yes ◯ No
   a. If so, with what company?
   What plan do you have?
   b. If so, do you intend to replace your current Medicare Supplement policy with this policy? ◯ Yes ◯ No
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) ◯ Yes ◯ No
   a. If so, with what company?
   What policy do you have?
   b. What are your dates of coverage under this policy? (If you are still covered under this policy, leave "END" blank.)
   START M M / D D / Y Y Y Y END M M / D D / Y Y Y Y
   c. Do you intend to replace your current healthcare coverage with this Medicare Supplement policy? ◯ Yes ◯ No

➤ **You Must Read and Sign**

APPLICANT MEDICARE NUMBER

3 Discount Determination

If you qualify for the Household Discount disclosed in your Outline of Coverage, please provide the name and Medicare number of the individual living at your current address.

LAST NAME

FIRST NAME

MI

MEDICARE NUMBER

4 Payment Options

PREMIUM QUOTE

. **Premium quoted based on all applicable discounts.**

INITIAL PAYMENT

. **Amount you are submitting with your application. You must submit at least your first month's premium with all applicable discounts.**

CHECK NUMBER **Please indicate ACH in the Check Number fields if this is the preferred method for initial premium payment.**

MONEY ORDER

DEPOSITORY BANK NAME

ROUTING NUMBER

ACCOUNT NUMBER ◯ Checking ◯ Savings

CREDIT CARD NAME ◯ MasterCard ◯ Visa ◯ Discover

CREDIT CARD NUMBER

EXPIRATION DATE M M Y Y Y Y

Future Payment options: ◯ Same as above ◯ Automatic Withdrawal ◯ Coupon Book ◯ Auto Credit Card Charge

DEPOSITORY BANK NAME

ROUTING NUMBER

ACCOUNT NUMBER ◯ Checking ◯ Savings

If you choose the auto credit card charge option, complete the following: ◯ MasterCard ◯ Visa ◯ Discover

CREDIT CARD NUMBER

EXPIRATION DATE M M Y Y Y Y

I hereby authorize Humana to initiate debit/credit entries to my checking/savings account or my credit card account, as indicated above, in amounts appropriate to my coverage; and authorize the bank named above to debit/credit the same to such account. I authorize Humana to change the amount of the debit/credit, provided that I am given advance written notice. This authorization is to remain effective until I give Humana and the bank reasonable notice of termination.

APPLICANT MEDICARE NUMBER

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

The undersigned applicant certifies that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy. The applicant further acknowledges receipt of the currently available Outline of Coverage and the "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" publication.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.*

If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan.*

*If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5 Signature & Date

APPLICANT'S SIGNATURE:

SIGNATURE DATE: / /

AGENT'S SIGNATURE:

SIGNATURE DATE: / /

Sales Agent – Please list: All health insurance policies sold to the applicant which are still in force and all health insurance policies sold to the applicant within the past five years which are no longer in force (if none or not applicable, write NONE)

COMPANY

TYPE

COMPANY

TYPE

MU005

APPLICANT MEDICARE NUMBER

If you are the authorized legal representative, you **must** sign above on behalf of Applicant and provide the following information:

LAST NAME FIRST NAME MI

STREET ADDRESS

CITY ST ZIP

TELEPHONE / – RELATIONSHIP TO APPLICANT

OFFICE USE ONLY

WRITING AGENT

WRITING AGENT ID

COMMISSION LEVEL

MGA CODE

MKTS 5 4

AFFINITY CODE

AGENCY (optional)

AGENCY ID

Insured by Humana Insurance Company

Humana®

Discrimination is against the law

Humana Inc. and its subsidiaries ("Humana") comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Humana does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Humana provides:

• Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

• Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call **1-800-866-0581 (TTY: 711)**.

If you believe that Humana has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call **1-800-866-0581 (TTY: 711)**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800–368–1019. If you use a TTY, call **1-800-537-7697**.
Complaint Forms are available at www.hhs.gov/ocr/office/file/index.html.

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Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-866-0581 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-866-0581 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-866-0581 （TTY: 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-866-0581 (TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-800-866-0581 (TTY: 711)번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-866-0581 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-866-0581 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-866-0581 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-866-0581 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-866-0581 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-866-0581 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-866-0581 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-866-0581 (TTY: 711).

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-866-0581 (رقم هاتف الصم والبكم: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-866-0581 （TTY：711）まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-866-0581 (TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-866-0581 (TTY: 711).

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

Humana Insurance Company • P.O. Box 14309, Lexington, KY 40512-4309

Save this notice! It may be important to you in the future.

According to information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy/certificate to be issued by Humana Insurance Company. Your new policy/certificate will provide 30 days within which you may decide - without cost - whether you desire to keep the policy/certificate.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to the Applicant by Issuer, Agent (Broker or other Representative)

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan.

The replacement policy/certificate is being purchased for the following reason (check one):

- ☐ additional benefits
- ☐ fewer benefits and lower premiums
- ☐ my plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ disenrollment from a Medicare Advantage plan (please explain reason for disenrollment)
- ☐ no change in benefits, but lower premiums
- ☐ other (please specify)

_____

_____

Do not cancel your present policy/certificate until you have received your new policy/certificate and are sure that you want to keep it.

Applicant's signature	Signature of agent/broker/representative	
Print name	Print name and address of agent or broker below	
Social Security number		Date

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