Enrollment Application

Follow these easy steps to apply for a Humana Value 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 Complete Guaranteed Acceptance

Please fill out this section if you are eligible for guaranteed acceptance. If a Notice of Replacement Form is required to be submitted with your application, please provide the criteria qualifying you for guaranteed acceptance on the form. For example, if you qualify for guaranteed acceptance due to a Medicare Advantage plan exit, please check "Disenrollment from a Medicare Advantage plan" and indicate that your plan is exiting the market and no longer available.

4 Read and Complete Medical Questions

5 Determine Your Premium

6 Determine Your Discount

7 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.

8 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

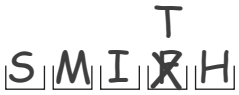
Incorrect Marks

- 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.

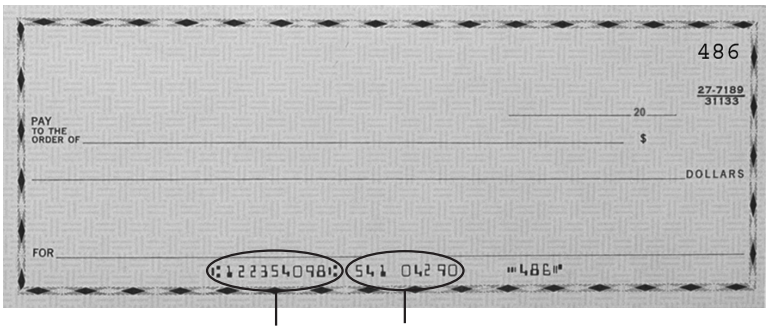
0 3 2 4 2 0 1 0

Required Fields Must Be Completed

Optional Fields

Sample Check

(If you are choosing the auto bank withdrawal.)



Routing Number **Account Number**

STAMP DATE MU001

HumanaDental 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 K

○ Plan F ○ Plan N

○ High Deductible 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 coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy must 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. Upon receipt of timely notice, the issuer must either return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility or provide coverage to the end of the term for which premiums were paid, at the option of the insured, subject to adjustment for paid claims. 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 reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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. If you have lost, or you are losing or replacing, health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application

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
   c. Did you enroll in Medicare Part C in the last six months? ◯ Yes ◯ No
      If yes, what is the effective date? M M / D D / Y Y Y Y
   d. Did you enroll in Medicare Part D 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

➤ **You Must Read and Sign**

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

3 Guaranteed Acceptance

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. Are you applying for coverage during your Medicare Supplement Open Enrollment Period? ◯ Yes ◯ No
   If yes, please go directly to Section 5.
2. Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed acceptance? ◯ Yes ◯ No If yes, please go directly to Section 5. Additionally, if you are submitting a Notice of Replacement, please provide the criteria qualifying you for guaranteed acceptance on the form. For example, if you qualify for guaranteed acceptance due to a Medicare Advantage plan exit, please check "Disenrollment from a Medicare Advantage plan" and indicate that your plan is exiting the market and no longer available.
3. Have you lost or are you losing Medicaid coverage which qualifies you for guaranteed acceptance? ◯ Yes ◯ No If yes, please go directly to Section 5.

4 Medical Questions

IF YOU ARE APPLYING FOR COVERAGE DURING YOUR MEDICARE SUPPLEMENT OPEN ENROLLMENT PERIOD OR QUALIFY FOR GUARANTEED ACCEPTANCE, YOU ARE NOT REQUIRED TO ANSWER THE FOLLOWING QUESTIONS.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

HEIGHT FT **IN** **WEIGHT** **LBS**

1. In the last year, have you been hospitalized, confined to a nursing facility, or are you bedridden or confined to a wheelchair? ◯ Yes ◯ No
2. In the past 90 days have you received Home Health care? ◯ Yes ◯ No
3. Have you used supplementary oxygen in the last year? ◯ Yes ◯ No

4. Do you now have or within the last two years have you taken medication or been advised to take medication for or received medical advice, treatment or been advised that you need treatment or surgery for:

   a. Heart, Coronary, or Carotid Artery Disease, high blood pressure (hypertension) or high cholesterol, Peripheral Vascular Disease, Congestive Heart Failure or any other type of Heart Failure, Stroke, Transient Ischemic Attacks (TIA), or Heart Rhythm disorders? ◯ Yes ◯ No

   b. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other Chronic Pulmonary disorders? ◯ Yes ◯ No

   c. Parkinson's Disease, Multiple or Lateral Sclerosis, Huntington's Disease, Muscular Dystrophy, Systemic Lupus, Hepatitis (excluding A or E), Lou Gehrig's Disease? ◯ Yes ◯ No

   d. Inflammatory Bowel Disease, Crohn's Disease, Ulcerative Colitis, or Barrett's Esophagus? ◯ Yes ◯ No

   e. Alzheimer's Disease, senile dementia, brain seizures, epilepsy, senility disorder, schizophrenia, major depressive disorders, other mental or nervous disorders, liver disease or disorder, cirrhosis, alcoholism or drug abuse? ◯ Yes ◯ No

   f. Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV) infection or blood disorder? ◯ Yes ◯ No

   g. Kidney disease requiring dialysis or Kidney failure? ◯ Yes ◯ No

   h. Diabetes? ◯ Yes ◯ No

   i. Internal cancer, leukemia or melanoma? ◯ Yes ◯ No

   j. Amputation caused by disease or trauma or neuralgic or poor circulation that has caused an ulcer on the skin? Do you have any paralytic conditions? ◯ Yes ◯ No

   k. Rheumatoid arthritis, Paget's Disease, Osteoporosis, degenerative bone or joint disorder, degenerative disk disease, crippling arthritis, vertebral or hip fractures/dislocations, spinal cord disorders/injuries, or chronic pain? ◯ Yes ◯ No

   l. Organ, bone marrow or stem cell transplant or awaiting transplant (excluding corneas)? ◯ Yes ◯ No

5. Please list any prescription drugs (full medication name) you are currently taking or have taken within the past 12 months:

_____

_____

_____

5 Premium Determination

If applying during your Medicare Supplement Open Enrollment Period or if you qualify for guaranteed acceptance, please skip the first question as it does not apply to your premium determination. If you did not answer "Yes" to either question in Section 3, please answer both questions. All applicants must answer the second question in this section.

1. Did you have Medicare coverage prior to age 65? ◯ Yes ◯ No

2. Have you used tobacco products within the last 12 months? ◯ Yes ◯ No

If your application is accepted, and you answered **No** to both questions, you qualify for the Preferred rates. You also qualify for the Preferred rates if you are a non-tobacco user applying during open enrollment or you qualify for guaranteed issue. To determine your premium, refer to your Outline of Coverage.

APPLICANT MEDICARE NUMBER

6 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

7 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.

I understand that if my application is not submitted during an open enrollment or guaranteed issue period, Humana has the right to reject my application and any premiums paid will be refunded. I also understand that the policy will not pay benefits for stays beginning or medical expenses incurred during the first three months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within six months prior to the insurance effective date. Coverage is not limited if you enroll during an open enrollment or guaranteed issue period or satisfy the creditable coverage requirements.

➤ **You Must Read and Sign**

APPLICANT MEDICARE NUMBER

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement may be subject to prosecution for fraud.

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.

8 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**

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**

➤ **You Must Read and Sign**

Insured by HumanaDental 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.

Humana®

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

HumanaDental 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 HumanaDental 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)

_____

_____

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy/certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy/certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

Humana®

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.

QuitNet® Comprehensive – Access to a tobacco cessation program.

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:_____
(FOR INTERNAL USE ONLY)

GNHH83YHH1V

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Medical Records Release Authorization

Purpose of the Authorization

By signing this form, you will authorize the disclosure and use of the protected health information described below for pre-enrollment underwriting or to determine your eligibility for enrollment or benefits under an insurance plan.

Information we will use and/or disclose

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, employer or the Consumer Reporting Agency having information regarding myself including information concerning advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, alcohol or Substance use disorder, 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 HumanaDental Insurance Company, its reinsurer or its legal representatives, and its affiliates.

- The information obtained by use of this authorization may be used by HumanaDental Insurance Company to determine eligibility for coverage.
- Any information obtained will not be released by HumanaDental Insurance Company to any person or organization except to reinsuring companies, 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 may request to be interviewed in connection with the preparation of the report and I may request a copy of the report.
- Once personal and health (including medical 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 2 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 (Humana Privacy Office, P.O. Box 1438 Louisville, KY 40202).
  - 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 were required to answer medical questions on your Medicare Supplement Enrollment Application, you must complete this authorization to be eligible for enrollment.

LAST NAME **FIRST NAME** **MI**

Medicare Number **SOCIAL SECURITY NUMBER** ___ – ___ – ____

DATE MM / DD / YYYY

Applicant Signature _____ Date _____
Insured by HumanaDental Insurance Company

Humana®