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

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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.

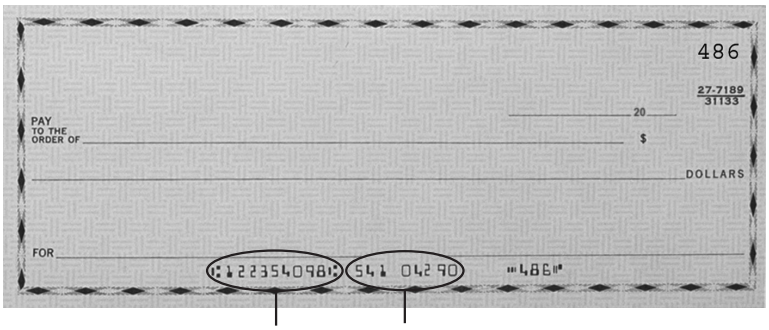
0 3 2 4 2 0 1 0

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 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

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.

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.

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,

APPLICANT MEDICARE NUMBER

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**

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**

APPLICANT MEDICARE NUMBER

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 Humana Insurance Company

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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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Illinois Medicare Supplement Policy Checklist

Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance _____/_____/_____

Which Humana Medicare Supplement Plan do you wish to enroll in?
☐ Plan A ☐ Plan F ☐ Plan G

☐ I am replacing my existing Medicare Supplement policy with a Humana Medicare Supplement policy and choosing the same plan (same level of coverage). If box is checked, you do not need to complete the rest of the form. Please sign and date the form at the bottom.

Service	Benefit	Medicare Pays*	Existing Coverage Pays	Supplement Pays*	You Pay*
Hospital Inpatient	First 60 days	All but $1,364 (Part A Deductible)		☐ Part A Deductible **or** ☐ $0	☐ $0 **or** ☐ Part A Deductible
	61st to 90th day	All but $341 a day		$341 a day	$0
	91st to 150th day (Lifetime Reserve)	All but $682 a day		$682 a day	$0
	Beyond 150 days	$0		All Medicare-approved amounts for an additional 365 days	$0
Skilled Nursing Home Care	First 20 days	All approved amounts		$0	$0
	Additional 80 days	All but $170.50 a day		☐ $170.50 a day **or** ☐ $0	☐ $0 **or** ☐ $170.50 a day
	Beyond 100 days	Nothing		$0	All costs

Service	Benefit	Medicare Pays*	Existing Coverage Pays	Supplement Pays*	You Pay*
Medical Expense	Physician's Services in hospital, office, or home; inpatient and outpatient medical services and supplies at a hospital; physical and speech therapy, and ambulance	Generally 80% of Medicare-approved amounts after $185 (Medicare Calendar Year deductible)		For charges covered under Part B Medicare: ☐ 20% **or** ☐ Part B Deductible ☐ 100% Part B Excess Charges	Charges not covered by Medicare and Policy
Prescription Drugs		Inpatient Prescription Drugs – 80% of allowable charges for immuno-suppressive drugs during the first year following a covered transplant		No benefit	All costs: outpatient drugs

* These figures are for 2019 and are subject to change each year. Refer to the Outline of Coverage to compare benefits and premiums among policies.

This policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

The undersigned applicant and agent have determined that the policy is appropriate and non-duplicative.

_____	_____	_____	_____
Signature of Applicant	Date	Signature of Agent	Date

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