Enrollment Application



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

- 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.
- 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.
- Determine Your Discount
- 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.
- Sign and Date the Enrollment Application



Marking Instructions

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

Correct Mark

Incorrect Marks





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

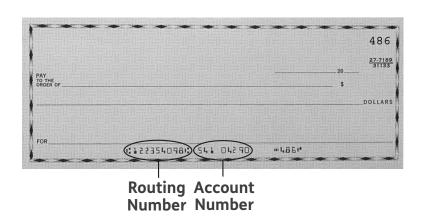
Correct Numbers and Letters 1 2 3 A B C

- 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.

Required Fields Must Be Completed Optional Fields





STAMP DATE	MUUUI	2432 Fortun			KY 4050 9)			
1 LAST NAME					CT NAME				MT
LAST NAME				FIF	RST NAME				MI
ADDRESS							APT (OR STE#	
ADDRESS (contin	d\			CO	UNTY				
ADDRESS (conti	ilueu)				ONTY				
CITY							STATE	ZIP CODI	E
TELEPHONE –			DATE OI	F BIRTH	YY	7			
GENDER OM	\bigcirc F								
MAILING ADDRE	ESS (only if o	different from	above stree	t ADDRES	S)		APT (OR STE#	
CITY							STATE	ZIP COD	E
E-MAIL ADDRESS (optional) (E-mail address, if available, will be used as a means to communicate only coverage information.)									
Please complete the information below as it appears on your									
Select the policy applying for:	y you are		Please con Medicare o	•	e informat	tion below	as it appe	ars on your	
O Plan A			MEDICARE	NUMBER					
O Plan F									
O Plan G			IS ENTITLE	ED TO		PROPOS	ED EFFECT	IVE DATE	
PROPOSED EFFE			HOSPITAL II		i i			YYY	Y
PERSON TO NOTIFY IN AN EMERGENCY (optional):									
LAST NAME				FIF	RST NAME				MI
RELATIONSHIP	TO APPLICA	NT			TE	ELEPHONE -	-		
ОН85026НС			➤ You Mus	st Read a		JMBER (SA	N)		

		MU002 AP	PLICANT ME	DICARE NUMI	3EK
_					
2	Ot	ther Coverage Information			
• '	You do	o not need more than one Medicare Supplement policy.			
1	multipl	purchase this policy, you may want to evaluate your existing health coverage.			
		hay be eligible for benefits under Medicaid and may not need a Medicare			ro
	Supple	eling services may be available in your state to provide advice concernin ement insurance and concerning medical assistance through the state N Jualified Medicare Beneficiary (QMB) and a Specified Low-income Medica	Medicaid prog	gram, including	
Ye	s or No	o answers are required to the following questions.			
PL	EASE /	ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.			
1.	a. D	Did you turn age 65 in the last six months? Yes No			
	b. D	oid you enroll in Medicare Part B in the last six months? OYes ON	lo		
	If	f yes, what is the effective date? MM DD MM MM			
2.	Are y	you covered for medical assistance through the State Medicaid program?	?	⊃ No	
		TE TO APPLICANT: If you are participating in a "Spend-Down Program" an se answer NO to this question.)	nd have not I	met your "Sha	re of Cost,"
	a. If	f yes, will Medicaid pay your premiums for this Medicare Supplement pol	licy? O Ye	s O No	
		Oo you receive any benefits from Medicaid OTHER THAN payments towar Yes No	d Your Medic	are Part B prer	nium?
3.	a Med cover STAR	f you are still covered under the Medicare plan, do you intend to replace	end dates be	elow. If you are	e still
		Medicare Supplement policy? Yes No			
		Was this your first time in this type of Medicare plan? Yes No		.	
		Did you drop a Medicare Supplement policy to enroll in the Medicare plan		○ No	
4.	Do yo	ou have another Medicare Supplement policy in force? Yes N	0		
	a. If	fso, with what company?			
	V	What plan do you have?			
	b. If	f so, do you intend to replace your current Medicare Supplement policy with this	s policy? 🔘	Yes No	
5.		e you had coverage under any other health insurance within the past 63 n, or individual plan.) Yes No	days? (For e	xample, an en	nployer,
	a. If	f so, with what company?			
	V	What policy do you have?			
		What are your dates of coverage under this policy? (If you are still covered	d under this p	oolicy, leave "E	ND" blank.)
		START MM DD MMM D	D Y	YYY	,
		Oo you intend to replace your current healthcare coverage with this Medical Yes No	are Suppleme	ent policy?	

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
EAST NAME FIRST NAME MI
MEDICARE NUMBER
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.
DEPOSITORY BANK NAME
ROUTING NUMBER ACCOUNT NUMBER Checking Savings
1; in the second of the second
CREDIT CARD NAME MasterCard Visa Discover
CREDIT CARD NUMBER EXPIRATION DATE
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
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.

APPLICANT MEDICARE NUMBER

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

MU003

Outline of Coverage and the "Choosing a Medigap Policy: A Guide to Health Inspublication.	surance for People with Medicare"		
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 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.			
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.			
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

TYPE

APPLICANT MEDICARE NUMBER

OH85026HC

applicable, write NONE)

COMPANY

COMPANY

MU004

MU005		AP	PLICAN	Γ MEDICARE I	NUMBER
If you are the authorized legal represe information:	ntative, you <u>must</u>	sign above on behalf o	f Applico	ant and provic	le the following
LAST NAME		FIRST NAME			MI
STREET ADDRESS					
CITY			ST	ZIP	
TELEPHONE /		RELATIONSHIP TO APPLICANT			
	OFFICE U	JSE ONLY			
WRITING ACENT					
WRITING AGENT					
WRITING AGENT ID	COMMISSION LEVEL	MGA CODE		MKTS	AFFINITY CODE
				7	
AGENCY (optional)				AGENCY ID	

Insured by Humana Insurance Company

Humana_®

OH85026HC 118

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.



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. Lique 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).

(Arabic): العربية

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 0581-866-800-1 (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。

:(Farsi) فارسى

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1800-866-2008-1 (TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hólǫ́, 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

S	save this notice	! It may be imp	ortant to you	in the future.
V ccord	ing to information	ou bava furnished v	intend to torn	inata aviatina Maa

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.

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

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 Issael, Age	erre (broker of other Representative)
I have reviewed your current medical or health insurance co Supplement policy will not duplicate your existing Medicare S because you intend to terminate your existing Medicare Sup	Supplement or, if applicable, Medicare Advantage coverage
The replacement policy/certificate is being purchased for the	e following reason (check one):
☐ additional benefits	☐ no change in benefits, but lower premiums
☐ fewer benefits and lower premiums	□ other (please specify)
☐ 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)	
Do not cancel your present policy/certificate until you have rewant to keep it.	eceived your new policy/certificate and are sure that you
Applicant's signature	Signature of agent/broker/representative
Print name	Print name and address of agent or broker below
Social Security number	Date

Humana.