Humana.

Member ID:

DECLARATION OF PRIOR PRESCRIPTION DRUG COVERAGE

Date:_____

Enrollee First Name: _____ Enrollee Last Name: _____

Address: _____

Phone: _____

Name of Medicare Prescription Drug Plan: _____

**Check all boxes that apply to you. Include coverage date(s). Add another page if necessary. Remember to sign at the bottom of the form.**

| | | |
|---|---|---|
| ☐ | I had creditable* prescription drug coverage from an Employer/Union, including the Federal Employees Health Benefits Program (FEHBP). | From: M M Y Y Y Y<br>To: M M Y Y Y Y |
| ☐ | I had creditable* prescription drug coverage from Medicaid, State Pharmaceutical Assistance Program (SPAP), or another plan sponsored by my state. | From: M M Y Y Y Y<br>To: M M Y Y Y Y |
| ☐ | I had prescription drug coverage through my VA benefits (veterans, survivor, or dependent benefits). | From: M M Y Y Y Y<br>To: M M Y Y Y Y |
| ☐ | I had prescription drug coverage through my TRICARE or other military coverage. | From: M M Y Y Y Y<br>To: M M Y Y Y Y |

Member ID:

| | | |
|---|---|---|
| ☐ | I had a Medigap (Medicare Supplemental) policy with creditable* prescription drug coverage. | From: MM/YY<br>To: MM/YY |
| ☐ | I had prescription drug coverage through the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian organization (I/T/U). | From: MM/YY<br>To: MM/YY |
| ☐ | I had prescription drug coverage through PACE (Program of All-Inclusive Care for the Elderly). | From: MM/YY<br>To: MM/YY |
| ☐ | I had creditable* prescription drug coverage from a different source not listed above.<br><br>Name of other source: _____ | From: MM/YY<br>To: MM/YY |
| ☐ | I had Humana coverage. | From: MM/YY<br>To: MM/YY |
| ☐ | I have/had extra help from Medicare to pay for my prescription drug coverage. | From: MM/YY<br>To: MM/YY |
| ☐ | I lived in an area affected by Hurricane Katrina in August 2005 and joined a Medicare prescription drug plan before Dec. 31, 2006. | From: MM/YY<br>To: MM/YY |
| ☐ | I had prescription drug coverage through Puerto Rico Reforma. | From: MM/YY<br>To: MM/YY |
| ☐ | I never had creditable* drug coverage. | |

Member ID:

***"Creditable" means that the coverage you had before joining Humana met Medicare's minimum standards.**

**Please complete this section**
To the best of my knowledge, the information on this form is true and correct. I understand that if I didn't have creditable coverage and/or don't give proof of creditable prescription drug coverage if asked, my premium may be higher.

I understand that my signature - or the signature of the person authorized to act on my behalf under the laws of the state where the individual resides – on this document means I've read and understand the contents of this declaration. If signed by an authorized individual, as described above, this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by Humana by Medicare.

Signature: _____ Date: ⌊M⌋⌊M⌋⌊D⌋⌊D⌋⌊Y⌋⌊Y⌋⌊Y⌋⌊Y⌋

**If you're the authorized representative, you must provide the following information:**

First Name: _____ Last Name: _____

Address: _____ Apt or Ste:_____

City: _____ State: ⌊⌋⌊⌋ Zip Code: ⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋

Phone: (⌊⌋⌊⌋⌊⌋) ⌊⌋⌊⌋⌊⌋ - ⌊⌋⌊⌋⌊⌋⌊⌋ Relationship to enrollee:_____

**Contact Information**
If you have questions, please call our Customer Care team at **1-800-457-4708** . If you use a TTY, call **711**. You can call Monday through Friday, from 8 a.m. to 9 p.m.

You can call us anytime. Our live representatives are available from 8 a.m. to 9 p.m. (EST), Monday through Friday. Our automated phone system is available 24 hours a day, 7 days a week.

For 24 hour service you can visit us at www.humana.com. Please be sure to keep a copy of this letter for your records.

Humana is a Medicare Advantage HMO, PPO and PFFS organization and a stand-alone prescription drug plan with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.

# Important!

## At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **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 their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,** or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

## Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

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.

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## Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。

**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .

**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.

**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

**日本語 (Japanese):** 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

**فارسی (Farsi)**

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

**Diné Bizaad (Navajo):** Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.

**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

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