Enrollment Application

Follow these easy steps to apply for a Humana 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.

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.

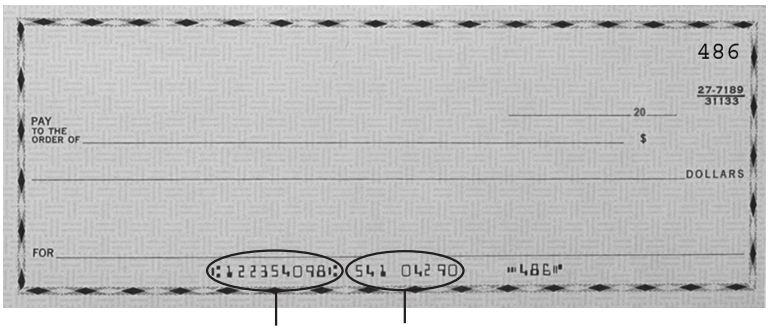
0 3 2 4 2 0 1 0

Required Fields Must Be Completed

Optional Fields

Sample Check

(If you are choosing the auto bank withdrawal.)



Routing Number **Account Number**

STAMP DATE MU001

Humana Health Plan, Inc.
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
- ○ High Deductible Plan F
- ○ Plan G
- ○ Plan N

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. If you have lost, or you are losing or replacing, other 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
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 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 6.
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 6.

If you answered yes to either question in this section you qualify for the Preferred rates.

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.

1. **HEIGHT** ☐ **FT** ☐☐ **IN** **WEIGHT** ☐☐☐ **LBS**
2. In the last year, have you been hospitalized, confined to a nursing facility; or are you bedridden or confined to a wheelchair? ◯ Yes ◯ No
3. In the past 90 days have you received Home Health care? ◯ Yes ◯ No
4. Have you tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection? ◯ Yes ◯ No
5. Do you now have or within the last two years have you had or been advised by a physician that you need treatment or surgery for:
   a. Heart, Coronary, or Carotid Artery Disease (not including high blood pressure), Peripheral Vascular Disease, Congestive Heart Failure or any other type of Heart Failure, Enlarged Heart, Stroke, Transient Ischemic Attacks (TIA), or Heart Rhythm disorders? ◯ Yes ◯ No
   b. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other Chronic Pulmonary disorders? Have you used supplementary oxygen in the last year? ◯ Yes ◯ No
   c. Parkinson's Disease, Multiple or Lateral Sclerosis, Huntington's Disease, Muscular Dystrophy, Lupus, Hepatitis, or Lou Gehrig's Disease? ◯ Yes ◯ No
   d. Alzheimer's Disease, senile dementia, organic brain disorders, senility disorder, schizophrenia, other major depressive disorders, mental or nervous disorders, cirrhosis, alcoholism or drug abuse? ◯ Yes ◯ No
   e. Kidney disease requiring dialysis or diabetes requiring more than 50 units of insulin daily? ◯ Yes ◯ No
   f. Internal cancer, leukemia or melanoma? ◯ Yes ◯ No
   g. 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
   h. Rheumatoid arthritis, Paget's Disease, degenerative bone disease, crippling arthritis, vertebral or hip fractures/dislocations, spinal cord disorders/injuries? ◯ Yes ◯ No
   i. Organ transplantation? ◯ Yes ◯ No
6. Please list any prescription drugs (full medication name) you are currently taking or have taken within the past 12 months:

_____

_____

_____

APPLICANT MEDICARE NUMBER

5 Premium Determination

All applicants must answer these questions, unless applying during a Medicare Supplement Open Enrollment Period or qualify for guaranteed acceptance as indicated in Section 3.

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. To determine your premium, refer to your Outline of Coverage.

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 **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: ◯ **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

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.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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 materially 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.

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**

➤ **You Must Read and Sign**

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

ATTACHMENTS

AM001 AM002 AM003 AM006 AM007 AM008 GR BN MAN

➤ **You Must Read and Sign**

Insured by Humana Health Plan, Inc.

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 Health Plan, Inc. • 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 Health Plan, Inc. 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

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KENTUCKY MEDICARE SUPPLEMENT COMPARISON STATEMENT

Current Insurance _____ Annual Premium _____
(Insurer Name)

Proposed Insurance _____ Annual Premium _____
(Insurer Name)

MEDICARE (PART A): HOSPITAL INSURANCE - COVERED SERVICES PER BENEFIT PERIOD (1)				PRIVATE INSURANCE CHECKLIST	
Services	Benefit	Medicare Pays*	You Pay*	Current Insurance Pays (Plan)**	Proposed Insurance Pays (Plan)**
HOSPITALIZATION Semi-private room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $	$		
	61st to 90th day	All but $ a day	$ a day		
	91st to 150th day***	All but $ a day	$ a day		
	Beyond 150 days	Nothing	All costs		
POST HOSPITAL SKILLED NURSING FACILITY CARE In a facility approved by Medicare. You must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge (2)	First 20 days	100% of approved amount	Nothing		
	Additional 80 days	All but $ a day	$ a day		
	Beyond 100 days	Nothing	All costs		
HOME HEALTH CARE	Visits limited to medically necessary skilled care.	Full cost of services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.		
HOSPICE CARE Available to terminally ill.	Up to _____ days if doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.		
BLOOD	Blood	All but first 3 pints	For first 3 pints****		
FOREIGN TRAVEL	Medically necessary emergency care in a foreign country.	Emergency hospital services in qualified Mexican or Canadian hospitals.*****	All costs not covered by Medicare.		

* These figures are for 20_____ and are subject to change each year.
** If the policy being replaced is not a standardized policy, insert "N/A" after "Plan" and complete this column.
*** 60 reserve days may be used only once; days used are not renewable.
**** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.
***** Please refer to your Medicare Handbook for more information.
(1) A benefit period begins on the first day you received service as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row.
(2) Medicare and private Medicare supplement insurance will not pay for most nursing home care. You pay for custodial care and most care in a nursing home.

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KENTUCKY MEDICARE SUPPLEMENT COMPARISON STATEMENT (Continued)

MEDICARE (PART B): MEDICAL INSURANCE - COVERED SERVICES PER CALENDAR PERIOD				PRIVATE INSURANCE CHECKLIST	
Services	Benefit	Medicare Pays*	You Pay*	Current Insurance Pays (Plan)**	Proposed Insurance Pays (Plan)**
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance etc.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $ ____ deductible).	$_____deductible** plus 20% of balance of approved amount (plus up to 15% above approved charge).***		
HOME HEALTH CARE	Visits limited to medically necessary skilled care.	Full cost of services; 80% of approved amount for durable medical equipment (after $ _____ deductible).	Nothing for services; 20% of approved amount for durable medical equipment (after $ _____ deductible).		
AT-HOME RECOVERY BENEFIT	Short-term athome assistance with activities of daily living.****	Nothing	All costs		
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary.	80% of approved amount (after $____ deductible)	Subject to deductible plus 20% of approved amount		
BLOOD	Blood	80% of approved amount (after $____ deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount after $____ deductible)*****		
PREVENTIVE CARE - PATIENT EDUCATION	Annual physical exam, preventive testing, influenza vaccines	Screening pap smears once every 24 months; screening mammograms once every 12 months.	All costs not covered by Medicare.		
OUTPATIENT PRESCRIPTION DRUGS	Outpatient prescription drugs	Nothing	All costs		
FOREIGN TRAVEL	Medically necessary emergency care in a foreign country	Doctor and ambulance service in Canada and Mexico if in connection with covered inpatient.	All costs not covered by Medicare.		
OTHER******					

* If the policy being replaced is not a standardized policy, insert "N/A".

** Once you have had $_____ of expense for covered services in 20 _____, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

*** YOU PAY FOR charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered.

**** At home recovery benefits must be received in conjunction with Medicare approved home health care benefits.

***** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

****** Use this area to compare pre-standardization and/or innovative benefits.

NOTICE TO APPLICANT: Do not sign this form unless it has been explained to you.

_____ _____ _____ _____

Applicant Date Agent Date

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. If you are applying during open enrollment or a guaranteed issue period, you are not required to complete this form.

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, drug, substance or alcohol abuse, 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 Humana Health Plan, Inc., its reinsurer or its legal representatives, and its affiliates.

- The information obtained by use of this authorization may be used by Humana Health Plan, Inc. to determine eligibility for coverage.
- Any information obtained will not be released by Humana Health Plan, Inc. 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 Humana Health Plan, Inc.
2432 Fortune Drive, Lexington, KY 40509