2020 Enrollment Form

Humana Group Medicare

HMO (Health Maintenance Organization)
A Medicare Advantage Plan

Follow these easy steps to become a Humana Medicare Member

Have your Medicare card ready	**Each person applying must fill out a separate form.**
Contact us with questions	If you have questions, please contact a Licensed Humana Sales Agent at **1-800-824-8242** (TTY: **711**). We're available Monday - Friday, from 8 a.m. - 8 p.m. Eastern Time. However, please note that our automated phone system may answer your call during weekends and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day.
Sign and date the enrollment form	**If the enrollment form is not completed and returned within the allotted time period, the enrollment could be denied. Please don't send in the same enrollment form or apply to the same plan more than once.**

Humana®

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Additional Notes

Required Fields Are Indicated With An Asterisk*

Instructions

- Completely fill the ovals.
- Use black ink only.
- Print only one clear number or capital block letter in each box.
- If you make a mistake, fix it by crossing out the box with an X. Put in the correct letter or number above or below the box as shown.

Correct Numbers and Letters

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 identity, 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 the Office for Civil Rights Complaint Portal, available at **https://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, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

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.

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

Stamp Date

Required Fields Are Indicated With An Asterisk*

Humana Group Medicare HMO Enrollment Form

EMPLOYER OR UNION SPONSOR NAME* Please use the Employer/Union name listed with your mailing address on your materials.

Please fill in the information below exactly as it appears on your Medicare card.

MEDICARE HEALTH INSURANCE

LAST NAME*

FIRST NAME* **MI***

MEDICARE NUMBER*

IS ENTITLED TO	EFFECTIVE DATE*
HOSPITAL (PART A)	M M 0 1 Y Y Y Y
MEDICAL (PART B)	M M 0 1 Y Y Y Y

PROPOSED EFFECTIVE DATE*

M M – 0 1 – 2 0 Y Y

PLAN OPTION*

076 /

You can find the option number on the front page of your Summary of Benefits in the bottom right hand corner.

CATEGORY OF ENROLLEE*

- Medicare Eligible Retiree
- Medicare Eligible Spouse
- Medicare Eligible Dependent

DATE OF BIRTH* M M D D Y Y Y Y **SEX*** M F

RESIDENTIAL ADDRESS* P.O. Box not allowed. Physical address is required.

APT OR STE

CITY* **ST*** **ZIP***

COUNTY*

MAILING ADDRESS Your residential address is required above to confirm your service area. Place your mailing address/ P.O. Box here, if applicable. If your mailing address is the same as your residential address, please fill this oval.

APT OR STE

CITY **ST** **ZIP**

FPO Barcode

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE NUMBER*

It is important that we are able to reach you with the information you need to stay informed and take care of your health. Please provide your telephone number and email address.

TELEPHONE

( ) -

There may be times when Humana will use an automated system to call or text you. When that happens we will be sure to use the telephone number you provided.

EMAIL

By providing your email address, you authorize Humana to send you health information to this address.

PRIMARY CARE PHYSICIAN (PCP)*

PCP ID NUMBER*

Are you already a patient of the physician you chose? ◯ **Yes** ◯ **No**

You can obtain the PCP ID number on our website at http://www.humana-medicare.com or by using the provider directory.

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE NUMBER* ☐☐☐☐☐☐☐☐☐☐☐☐☐

1. **Once enrolled, will you have other medical health coverage where you are the Subscriber or are covered as a Spouse/Dependent?** ◯ Yes ◯ No

   If yes, complete the following:

ID NUMBER FOR THIS COVERAGE

TELEPHONE ( ) -

CARRIER NAME

POLICY NUMBER

CARRIER ADDRESS

CITY

ST

ZIP

Does your other coverage include prescription drug coverage? ◯ Yes ◯ No

2. **Once enrolled, will you or your spouse work?** ◯ Yes ◯ No

Some people may have other drug coverage, including private insurance, Workers' Compensation, TRICARE, federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

3. **Will you have other prescription drug coverage in addition to this plan for which you are applying?*** ◯ Yes ◯ No

   If yes, complete the following:

NAME OF OTHER COVERAGE

ID NUMBER FOR THIS COVERAGE

GROUP NUMBER FOR THIS COVERAGE

Rx BIN

Rx PCN

TELEPHONE

( ) -

4. **If you have end-stage renal disease (ESRD), please fill this oval.*** ◯ **I have ESRD**

   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis. If you don't attach this information, we may need to request it later, and if not received, your enrollment form could be denied.

PLEASE READ THIS IMPORTANT INFORMATION

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Humana, he/she may be paid based on my enrollment in Humana.

By completing this enrollment form, I agree to the following:
The Humana Group Medicare HMO Plan is a Medicare Advantage health plan that has a contract with the Federal government and I will need to keep my Medicare Parts A and B, and must continue to pay my Medicare Part B premium. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform Humana of any prescription drug coverage that I have or may get in the future. **I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.** I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. Once I've enrolled in this Humana plan, I can change or cancel my Humana coverage at any time and return to Medicare Parts A and B or another Medicare Advantage plan using a special election. However, I may not be eligible to return to the group plan or change plans outside of the group's open enrollment period. I can receive details of my options by calling my plan administrator or customer service.

This Humana plan serves a specific service area. If I move out of the service area that Humana serves, I need to notify Humana so I can disenroll and find a new plan in my area. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Humana when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan.

I understand that on the date Humana coverage begins, I must get all of my health care from Humana, except for emergency or urgently needed services or out-of-area dialysis. Services authorized by Humana and other services contained in my Humana Evidence of Coverage will be covered. Without authorization, **NEITHER MEDICARE NOR HUMANA WILL PAY FOR THE SERVICES.**

I understand that I am enrolling into a Humana Medicare Advantage Plan or a Humana Medicare Prescription Drug Plan and not a Medicare Supplement, Medigap, Medicare Select, or Medicaid plan.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Release of Information:
By joining this Medicare health plan, I acknowledge that Humana will release my information to Medicare and other plans as necessary for treatment, payment and health care operations. I also acknowledge that Humana will release my information (including my prescription drug event data) to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board (RRB). DO NOT pay Humana the Part D-IRMAA.

FPO
Barcode

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE NUMBER* ☐☐☐☐☐☐☐☐☐☐☐

I have read and understand the important information on the preceding pages. I have reviewed and received a copy of the Summary of Benefits.

SIGNATURE OF APPLICANT* or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.)

SIGNATURE DATE*

M M D D 2 0 Y Y

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this enrollment form means that I have read and understand the contents of this enrollment form. If signed by an authorized individual (as described above), the 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 from Medicare.

If you are the authorized legal representative, you **must** sign above and provide the following information:*

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

STREET ADDRESS

CITY **ST** **ZIP**

TELEPHONE **RELATIONSHIP TO APPLICANT**

(☐☐☐) ☐☐☐ – ☐☐☐☐

Language preference for Customer Service

◯ **English** ◯ **Spanish** ◯ **Chinese** ◯ **Other** _____

If an accessible format is needed, please select one option

◯ **Audio** ◯ **Large Print** ◯ **Accessible Screen Reader PDF**

◯ **Oral Over the Phone** ◯ **Braille**

Please contact a Licensed Humana Sales Agent at 1-800-824-8242 (TTY: 711) if you need information in another format or language.

INTERNAL MARKETPOINT AGENTS ONLY

WRITING AGENT NAME*

NUMBER (SAN)* **DATE***

M M D D 2 0 Y Y

REFERRING AGENT NAME

NUMBER (SAN) **DATE**

M M D D 2 0 Y Y

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Humana.com

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