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.**

Please note: If you are under the age of 65 and have been diagnosed with End Stage Renal Disease (ESRD) you are not eligible to apply for coverage.

3 Complete Open Enrollment and Guaranteed Issue

Please fill out this section if you are eligible for open enrollment or guaranteed issue. If you are submitting a Notice of Replacement, please provide the criteria qualifying you for guaranteed acceptance on the form. For example, if you qualify for guaranteed acceptance due to a Medicare Advantage plan exit, please check "Disenrollment from a Medicare Advantage plan" and indicate that your plan is exiting the market and no longer available.

4 Read and Complete Medical Questions

If you are applying for coverage during your Medicare Supplement Open Enrollment Period or qualify for guaranteed issue, do not complete the medical questions. Refer to Section 8 for assistance in determining if you qualify for either open enrollment or guaranteed issue.

5 Determine Your Premium

Do not complete this section if you are applying for coverage during your Medicare Supplement Open Enrollment Period or qualify for guaranteed issue. Refer to Section 8 for assistance in determining if you qualify for either open enrollment or guaranteed issue.

6 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.

7 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.

S M I T H

- 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.

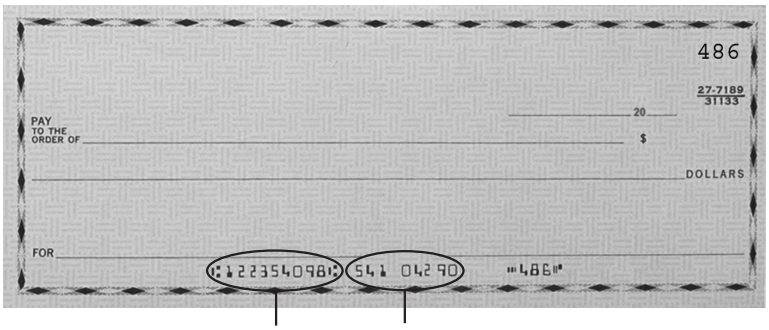
0 3 2 4 2 0 1 0

Required Fields Must Be Completed

Optional Fields

Sample Void 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

Form Number: CA85026M20-1

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 B
- ○ Plan C*
- ○ Plan F*
- ○ High Deductible Plan F*
- ○ Plan G
- ○ High Deductible Plan G
- ○ Plan K
- ○ Plan L
- ○ Plan N

*Only applicants eligible for Medicare prior to 1/1/2020 may purchase Plan C, Plan F and High Deductible Plan F.

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 coverages.
- You may be eligible for benefits under Medi-Cal or Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medi-Cal or Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or 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 Medi-Cal or 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.
- Counseling services are available in this state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, or access the department's Internet Web site, www.Insurance.ca.gov, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.
- A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet Web site (www.Insurance.ca.gov).

Yes or No answers are required to the following questions. If you have lost, or you are losing or replacing, 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 issue in one or more of our Medicare Supplement plans. A copy of the notice from your prior insurer may be requested.

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 under the age of 65 and eligible for Medicare due to End Stage Renal Disease (ESRD)? ◯ Yes ◯ No
3. Are you covered for medical assistance through California's Medi-Cal program? ◯ Yes ◯ No
   (NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.)
   a. If yes, will Medi-Cal pay your premiums for this Medicare Supplement policy? ◯ Yes ◯ No
   b. Do you receive any benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium? ◯ Yes ◯ No
4. If you had coverage from any Medicare plan other than 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

➤ **You Must Read and Sign**

APPLICANT MEDICARE NUMBER

a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? A Notice of Replacement Form is required to be completed. ◯ 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

5. 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? A Notice of Replacement Form is required to be completed. ◯ Yes ◯ No
6. 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

3 Open Enrollment and Guaranteed Issue

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. Refer to Section 8 for assistance in determining if you qualify for either open enrollment or guaranteed issue.

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 issue? ◯ Yes ◯ No
   If yes, please go directly to Section 6. Additionally, if you are submitting a Notice of Replacement, please provide the criteria qualifying you for guaranteed acceptance on the form. For example, if you qualify for guaranteed acceptance due to a Medicare Advantage plan exit, please check "Disenrollment from a Medicare Advantage plan" and indicate that your plan is exiting the market and no longer available.
3. Have you lost or are you losing Medi-Cal or Medicaid coverage which qualifies you for guaranteed acceptance? ◯ Yes ◯ No
   If yes, please go directly to Section 6.

If you answered yes to any question in this section, you qualify for the Preferred rates. Please refer to the Outline of Coverage for rates.

4 Medical Questions

IF YOU ARE APPLYING FOR COVERAGE DURING YOUR MEDICARE SUPPLEMENT OPEN ENROLLMENT PERIOD OR QUALIFY FOR GUARANTEED ISSUE, DO NOT COMPLETE THE FOLLOWING MEDICAL QUESTIONS.
A MEDICAL RECORDS RELEASE AUTHORIZATION FORM IS REQUIRED. Refer to Section 8 for assistance in determining if you qualify for either open enrollment or guaranteed issue.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

HEIGHT FT IN **WEIGHT** LBS

1. Have you been hospitalized within the last year? ..... ◯ Yes ◯ No ◯ Not Sure
2. Have you been confined to a nursing facility within the last year? ..... ◯ Yes ◯ No ◯ Not Sure
3. Are you bedridden? ..... ◯ Yes ◯ No ◯ Not Sure
4. Are you confined to a wheelchair? ..... ◯ Yes ◯ No ◯ Not Sure

➤ **You Must Read and Sign**

APPLICANT MEDICARE NUMBER

5. Have you used supplementary oxygen within the last year? ... Yes No Not Sure
6. Have you received Home Health care within the last 90 days? ... Yes No Not Sure
7. Have you ever been treated or diagnosed by a physician or medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? (NOTE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.) ... Yes No Not Sure
8. Do you currently have, or in the past 3 years have you had, been diagnosed with, or had a physician or medical professional advise you to have treatment for any of the following?

Adrenal Gland Disorder ... Yes No Not Sure
Alcohol or drug abuse ... Yes No Not Sure
Alzheimer's or Dementia ... Yes No Not Sure
Amputation ... Yes No Not Sure
Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease) ... Yes No Not Sure
Aneurysm ... Yes No Not Sure
Artificial openings for feeding or elimination ... Yes No Not Sure
Atrial fibrillation (A-fib) or heart arrhythmias ... Yes No Not Sure
Bed sore (Decubitus Ulcer) ... Yes No Not Sure
Blood clots ... Yes No Not Sure
Brain tumor ... Yes No Not Sure
Carotid Artery Disease ... Yes No Not Sure
Cerebral hemorrhage ... Yes No Not Sure
Cerebral Palsy (CP) ... Yes No Not Sure
Chest pain (Angina Pectoris) or heart attack ... Yes No Not Sure
Chronic Obstructive Pulmonary Disease (COPD) (Chronic Bronchitis or Emphysema) Yes No Not Sure
Chronic Kidney Disease (CKD) ... Yes No Not Sure
Cirrhosis of the liver ... Yes No Not Sure
Coma, brain compression/anoxic damage or severe head injury ... Yes No Not Sure
Crohn's Disease ... Yes No Not Sure
Cystic Fibrosis (CF) ... Yes No Not Sure
Depression or Bipolar Disorders ... Yes No Not Sure
Diabetes with acute complications ... Yes No Not Sure
Diabetes with neurologic or peripheral circulatory manifestation ... Yes No Not Sure
Diabetes with opthalmologic manifestation ... Yes No Not Sure
Diabetes with renal manifestation ... Yes No Not Sure
Enlarged heart (Cardiomyopathy) ... Yes No Not Sure
Epilepsy (seizure disorder or convulsions) ... Yes No Not Sure
Extensive third degree burns ... Yes No Not Sure
Hardening of the heart arteries (Coronary Artery Disease) (CAD or CHD) ... Yes No Not Sure
Heart failure (Congestive Heart Failure) (CHF) ... Yes No Not Sure
Hemophilia ... Yes No Not Sure
Hepatitis B or C ... Yes No Not Sure
Hip fracture or dislocation ... Yes No Not Sure
Huntington's Disease ... Yes No Not Sure
Internal cancer ... Yes No Not Sure
Intestinal obstruction/perforation ... Yes No Not Sure

➤ **You Must Read and Sign**

Kidney failure (renal failure) or End Stage Renal Disease (ESRD)	Yes	No	Not Sure
Leukemia	Yes	No	Not Sure
Lupus (Systemic Lupus Erythematosis)	Yes	No	Not Sure
Malnutrition	Yes	No	Not Sure
Marfan Syndrome	Yes	No	Not Sure
Multiple Sclerosis (MS)	Yes	No	Not Sure
Muscular Dystrophy	Yes	No	Not Sure
Myasthenia Gravis (MG)	Yes	No	Not Sure
Organ transplant	Yes	No	Not Sure
Paget's Disease	Yes	No	Not Sure
Pancreatitis	Yes	No	Not Sure
Paralysis	Yes	No	Not Sure
Parkinson's Disease	Yes	No	Not Sure
Peripheral Vascular Disease (PVD)	Yes	No	Not Sure
Pneumonia	Yes	No	Not Sure
Polymyositis	Yes	No	Not Sure
Respirator dependence	Yes	No	Not Sure
Rheumatoid Arthritis	Yes	No	Not Sure
Schizophrenia	Yes	No	Not Sure
Sickle Cell Anemia	Yes	No	Not Sure
Slipped disc (Degenerative Disc Disease)	Yes	No	Not Sure
Spinal cord disorders or injuries	Yes	No	Not Sure
Spinal Stenosis	Yes	No	Not Sure
Stroke (Cerebral Vascular Accident) (CVA)	Yes	No	Not Sure
Suicide attempt	Yes	No	Not Sure
Tuberculosis	Yes	No	Not Sure
Ulcerative Colitis	Yes	No	Not Sure
Uncontrolled high blood pressure (Hypertension)	Yes	No	Not Sure
Uncontrolled high cholesterol	Yes	No	Not Sure

9. Please list any prescription drugs (full medication name) you are currently taking or have taken within the past 12 months:

_____

_____

_____

5 Premium Determination

Do not complete these questions if applying during your Medicare Supplement Open Enrollment Period or if you qualify for Guaranteed Issue as indicated in Section 3. Refer to Section 8 for assistance in determining if you qualify for either open enrollment or guaranteed issue. All other applicants must answer these questions.

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.

APPLICANT MEDICARE NUMBER

6 Payment Options

PREMIUM QUOTE

. **Premium quoted**

INITIAL PAYMENT

. **Amount you are submitting with your application. You must submit your first month's premium.**

CHECK NUMBER **Please enter ACH in the Check Number fields if your preferred method of initial payment is automatic withdrawal.** **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.

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 90 days 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 if at the time of application you had creditable health coverage for a continuous period of 90 days. If less than 90 days, the pre-existing condition limitation will be reduced by the time period you did have coverage.

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.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

The undersigned applicant and agent certify that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any material misrepresentation in the application which is shown by us to be material to the acceptance for coverage 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.

➤ **You Must Read and Sign**

APPLICANT MEDICARE NUMBER

7 Signature & Date

APPLICANT'S SIGNATURE:

SIGNATURE DATE: / /

Did you help complete, advise, or answer questions regarding this application, medical underwriting, and/or health coverage being applied for? To the best of your knowledge is the information on this application complete and accurate and did you explain to the applicant in an easy-to-understand language the risk to the applicant of providing inaccurate information and the applicant understood the explanation? ◯ **Yes** ◯ **No**

If yes, who did you help? ◯ **Applicant** ◯ **Power of Attorney**

Notice: If you state as an agent any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000).

AGENT'S SIGNATURE:

SIGNATURE DATE: / /

TO BE COMPLETED BY 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.
A response is required. NONE or Not Applicable ◯

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**

➤ **You Must Read and Sign**

Section 8 – Open Enrollment and Guaranteed Issue Guidelines

In some situations, you are eligible for Open Enrollment or Guaranteed Issue of a Medicare Supplement Plan. If one of the following conditions applies to you, you are eligible for a Medicare Supplement Plan on a guaranteed acceptance basis ("Eligible Person") and do not complete the medical questions in Section 4 of the Application.

Open Enrollment

You are eligible for Open Enrollment if you meet one of the following requirements

A. You apply for a Medicare Supplement Plan insurance policy prior to or during the six- month period beginning with the first day of the month in which you are enrolled for benefits under Medicare Part B and:
   (i) You are at least age 65, or
   (ii) You are less than age 65 and eligible for Medicare on account of total disability (other than End Stage Renal Disease). If you are notified retroactively of your eligibility for Medicare, you are eligible for the six month period following notice of eligibility.

B. You are enrolled in Medicare Part B and you apply for a Medicare Supplement Policy within six months of one of the following events:
   (i) You are enrolled in an employer sponsored health plan (including an employer sponsored retiree health plan, COBRA and Cal-COBRA) and
      • the plan terminates, or
      • you are enrolled under the plan as a spouse and are losing coverage under the plan due to death or divorce from your spouse, or
   (ii) You are a military retiree or the spouse or dependent of a military retiree and you are losing access to health care services as the result of a military base closure, the base no longer offers services or you relocate, or
   (iii) You are covered under a Medicare supplement policy and coverage terminated because you established residency in a location not served by the issuer of the Medicare supplement policy for which you are enrolled, or
   (iv) Due to an increase in your income or assets, you are no longer eligible for Medi-Cal benefits, or you are only eligible for Medi-Cal benefits with a share of cost and you certify at the time of application that you have not met the share of cost.
   (v) If you are enrolled in a Medicare Advantage plan and that coverage is terminated by the Medicare Advantage plan, you are entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation.

C. If you are enrolled in a Medicare supplement policy, you may change your plan or insurer during an annual open enrollment period of 60 days beginning on your birthday. Your purchase is limited to any Medicare supplement policy that offers benefits equal to or lesser than those provided by the previous coverage.

You must submit evidence that you have Medicare Parts A and B with your Application.

With respect to the Open Enrollment events outlined previously:

Pre-Existing Conditions - This policy does not pay benefits for loss which occurs within 90 days after the effective date as a result of a pre-existing condition. A pre-existing condition is any injury or illness for which the insured has received or has had recommended, medical advice or treatment during the six months before the effective date. Please note that pre-existing conditions will be covered after 90 days from the effective date. This exclusion does not apply to loss which occurs more than 90 days after the effective date.

If you apply for the policy during the 6 month period beginning with the first of the month in which you are eligible, and as of the date you apply you had a continuous period of Creditable Coverage of at least 90 days, the pre-existing conditions limitation will not apply to you.

If you apply for the policy during the 6 month period beginning with the first of the month in which you eligible, and as of the date you apply you had a continuous period of Creditable Coverage of less than 90 days, the pre- existing conditions limitation will be reduced by the aggregate of the period of Creditable Coverage applicable as of your

enrollment date.

With respect to Guaranteed Issue outlined below, the pre-existing conditions exclusion will not be applied.

Guaranteed Issue

You are eligible for Guaranteed Issue for a Medicare Supplement Plan policy if you apply for the policy in the Guaranteed Issue Time Periods described below and you meet one of the following conditions:

1. You are enrolled in an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and
   - the plan terminates or ceases to provide such supplemental health benefits to you; or
   - the employer no longer provides you with insurance that covers all of the payment for the 20% coinsurance.
2. You are enrolled with a Medicare Advantage organization under a Medicare Advantage Plan (the "Plan") under Medicare Part C or under a Program of All-Inclusive Care for the Elderly (PACE) and any of the following apply:
   - The certification of the organization or plan under this part has been terminated; or
   - The organization has terminated or otherwise discontinued providing the Plan in the area in which you reside; or
   - You are no longer eligible to elect the Plan because:
     (i) of a change in your place of residence or other change in circumstances specified by the Secretary of the Department of Health and Human Services (the "Secretary"), excluding those circumstances where you were disenrolled from the Plan for any of the reasons described in Section 1851 (g)(3)(B) of the federal Social Security Act (e.g., where you have not paid premiums on a timely basis, or you have engaged in disruptive behavior as specified in standards under Section 1856); or
     (ii) the Plan is terminated for all enrollees residing within a particular residential service area.
   - You are enrolled in a Medicare Advantage Plan and that plan reduces benefits, increases the amount of cost sharing or premium or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to you. Under this subparagraph, you may be eligible for a Medicare supplement policy issued by the same issuer through which you were enrolled at the time the reduction, increase or discontinuance occurred or one issued by a subsidiary of the parent company of that issuer or by a network that contracts with the parent company of that issuer. If no Medicare supplement contract is available to you from the same issuer, a subsidiary of the parent company of that issuer or a network that contracts with the parent company of the issuer, you may be eligible for a Medicare supplement policy if the Medicare Advantage plan in which you are enrolled does any of the following:
     (i) increases the premium by 15 percent or more;
     (ii) increases physician, hospital or drug copayments by 15 percent or more;
     (iii) reduces any benefits under the plan; or
     (iv) discontinues, for other than good cause relating to quality of care, it's relationship or contract under the plan with a provider who is currently furnishing services to the individual,

     However, enrollment shall be permitted only during the annual election period for a Medicare Advantage plan, except where the Medicare Advantage plan has discontinued its relationship with a provider currently providing services to you.
   - You demonstrate, in accordance with guidelines established by the Secretary, that:
     (i) The organization offering the Plan substantially violated a material provision of the organization's contract with the Centers for Medicare and Medicaid Services in relation to you, including the failure to provide you, on a timely basis, with medically necessary care for which benefits are available under the Plan, or the failure to provide such covered care in accordance with applicable quality standards; or
     (ii) The organization or agent or other entity acting on the organization's behalf, materially misrepresented the Plan's provisions in marketing the Plan to you; or
   - You meet such other exceptional conditions as the Secretary may provide.
3. You are enrolled with:

- An eligible organization under a contract under Section 1876 (Medicare cost); a similar organization operating under demonstration project authority, effective for periods before April 1, 1999; an organization under agreement under section 1833(a)(1)(A) (health care prepayment plan); or an organization under a Medicare SELECT policy; and
- Your enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Guaranteed Issue situation #2 above.

4. You are enrolled in a Medicare supplement policy and the enrollment ceases because:
   - Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or
   - Of other involuntary termination of coverage or enrollment under the policy; or
   - The issuer of the policy substantially violated a material provision of the policy; or
   - The issuer or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to you.
5. You were enrolled under a Medicare supplement policy and you terminate enrollment and subsequently enroll, for the first time, with (1) any Medicare Advantage organization under a Medicare Advantage Plan under Medicare Part C; (2) any eligible organization under a contract under Section 1876 (Medicare cost); (3) any similar organization operating under demonstration project authority; (4) any PACE program under Section 1894 of the Social Security Act; (5) any organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or (6) a Medicare SELECT policy, and enrollment under this section is terminated by you during any period within the first 12 months of such subsequent enrollment (during which you are permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act).
6. You, upon first becoming enrolled for benefits under Medicare Part A at age sixty-five or older, enroll in a Medicare Advantage Plan under Medicare Part C, or in a PACE program under Section 1894 of the Social Security Act, and disenroll from the plan no later than 12 months after the effective date of enrollment.
7. You enroll in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, were enrolled under a Medicare supplement policy that covers outpatient prescription drugs and you terminate enrollment in the Medicare supplement policy and submit evidence of enrollment in Medicare Part D along with the application for a policy.

Guaranteed Issue Time Periods

- In the case of an individual described in situation #1, the guaranteed issue period begins on the later of: (i) the date you receive a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days after the date of the applicable notice;
- In the case of an individual described in situations #2, #3, #5 or #6 whose enrollment terminated involuntarily, the guaranteed issue period begins on the date that you receive a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;
- In the case of an individual described in situation #4 (insolvency of the issuer or bankruptcy of the non-issuer organization), the guaranteed issue period begins on the earlier of: (i) the date that you receive a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty- three (63) days after the date the coverage is terminated;
- In the case of an individual described in situations #2, #4 (issuer or the policy substantially violated a material provision of the policy), #4 (the issuer or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to you), #5 or #6 who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;
- In the case of an individual described in situation #7, the guaranteed issue period begins on the date you receive notice from the Medicare supplement issuer during the sixty (60) day period immediately preceding the Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D;
- In the case of an individual described in this Guaranteed Issue Guide but not described in the preceding

situations, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

Extended Medicare Supplement Access for Interrupted Trial Periods

- In the case of an individual described in situation #5 whose enrollment with an organization or provider described in item (1) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment;
- In the case of an individual described in situation #6, whose enrollment with a plan or in a program described in situation #6 is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment; and

For the purposes of situations #5 and #6, no enrollment of an individual with an organization or provider described in #5 (1 through 6), or with a plan or in a program described in #6, may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which you first enrolled with such an organization, provider, plan or program.

Medicare Supplement Plans issued by Humana to which Eligible Persons are Entitled

During Open Enrollment:

For individuals who are 65 years of age or older and who are less than age 65 at the time of enrollment, the eligible person may enroll in any Medicare Supplement insurance policy offered by Humana.

During Guaranteed Issue Situations:

- Under situations #1, #2, #3 and #4, an eligible individual is entitled to any Medicare supplement policy offered by Humana.
- Under situation #5, an eligible individual is entitled to the same Medicare supplement policy in which he or she was most recently enrolled, if available from the same issuer, or, if not so available, any policy offered by Humana.
- Under situation #6, an eligible individual is entitled to any Medicare supplement policy offered by Humana.
- Under situation #7, an eligible individual is entitled to any Medicare supplement policy offered by Humana and that is offered and is available for issuance to a new enrollee by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

AGENT USE ONLY

WRITING AGENT NAME

WRITING AGENT ID (SAN)

COMMISSION LEVEL

MGA CODE

MKTS 5 4

AFFINITY CODE

AGENCY (optional)

AGENCY ID (SAN)

Insured by Humana Insurance Company

Humana®

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711).**

Auxiliary aids and services, free of charge, are available to you. 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.

This information is available for free in other languages. Please call our customer service number at 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m. Eastern time.

Español (Spanish): Llame al número indicado para recibir servicios gratuitos de asistencia lingüística. **877-320-1235 (TTY: 711).** Horas de operación: 8 a.m. a 8 p.m. hora del este.

繁體中文 (Chinese): 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235（聽障專線：711）**。辦公時間：東部時間上午 8 時至晚上 8 時。

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.

If you intend to cancel or terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with coverage issued by Humana Insurance Company, please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare Supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free number, 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

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

I have reviewed your current health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

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. Note: If the issuer of the Medicare supplement policy being applied for does not impose, or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 3 below.
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

Humana®

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. This authorization will not be used to determine eligibility for any person entitled to open enrollment or guaranteed issue. It will only be used for claims purposes after a policy has been issued to such persons.

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, and non-public personal health information to share any and all such information with Humana Insurance Company, its reinsurer or its legal representatives.

- The information obtained by use of this authorization may be used by Humana Insurance Company to determine eligibility for coverage.
- Any information obtained will not be released by Humana Insurance Company 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. 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.
- I understand that information regarding HIV, AIDS or ARC shall not be redisclosed without my written authorization.

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 impair our ability to evaluate or process an application or claim and may be a basis for denying an application or claims for benefits.
  - 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 Insurance Company

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