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®

Issued and underwritten by Emphesys Insurance Company (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.

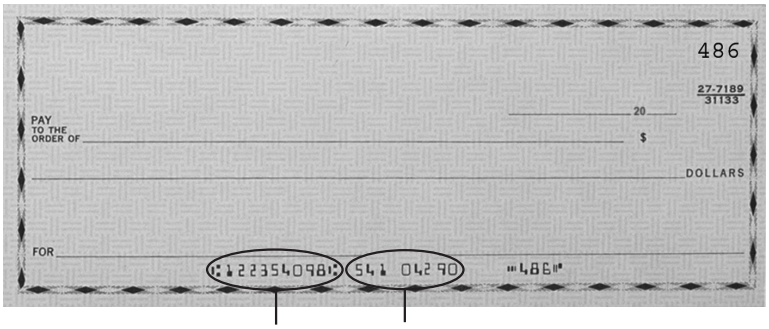
- When filling out dates, such as effective dates or birth dates, be sure dates appear in the MMDDYYYY format. No dashes or spaces are necessary.

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

Emphesys Insurance Company
2432 Fortune Drive, Lexington, KY 40509

Form Number: IL85026N3M

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***
- ○ **Plan G**
- ○ **High Deductible Plan G**
- ○ **Plan N**

*Only applicants eligible for Medicare prior to 1/1/2020 may purchase 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

	EFFECTIVE DATE
IS ENTITLED TO	
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).
- You are entitled to an annual open enrollment period. To qualify you must be at least 65 years of age but no more than 75 years of age at time of application and have a current Medicare Supplement policy issued by Emphesys Insurance Company (EIC). The annual open enrollment period starts on your birthday and last for 45 days. During this period you may apply to replace your current plan with a new Medicare Supplement plan issued by EIC of equal or lesser benefits. If you qualify at time of application, you are not required to answer the medical questions of this application.

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 acceptance 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 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? 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
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? A Notice of Replacement Form is required to be completed. ◯ 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. 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.

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. A MEDICAL RECORDS RELEASE AUTHORIZATION FORM IS REQUIRED.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. In the last year, have you been hospitalized, confined to a nursing facility; or are you bedridden or confined to a wheelchair? ◯ Yes ◯ No
2. In the past 90 days have you received Home Health care? ◯ Yes ◯ No
3. Have you ever been treated or diagnosed by a physician or medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ◯ Yes ◯ No
4. 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 Substance use disorder? ◯ 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
5. 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 Enhanced Household Discount disclosed in your Outline of Coverage, please provide the name of the individual living at your current address.

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

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.

➤ **You Must Read and Sign**

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, 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.

The undersigned applicant certifies that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or intentional 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: / /

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**

➤ **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

AGENT USE ONLY

WRITING AGENT NAME

WRITING AGENT ID (SAN) | COMMISSION LEVEL | MGA CODE | MKTS 5 4 | AFFINITY CODE

AGENCY (optional) | AGENCY ID (SAN)

➤ **You Must Read and Sign**

Insured by Emphesys Insurance Company

Humana®

Use Ballpoint Pen And Press Hard – You Are Making Multiple Copies.

Illinois Medicare Supplement Policy Checklist

Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance _____/_____/_____

Which Humana Medicare Supplement Plan do you wish to enroll in?
☐ Plan A ☐ Plan F^ ☐ Plan G ☐ Plan G High Deductible** ☐ Plan N

☐ I am replacing my existing Medicare Supplement policy with a Humana Medicare Supplement policy and choosing the same plan (same level of coverage). If box is checked, you do not need to complete the rest of the form. Please sign and date the form at the bottom.

Service	Benefit	Medicare Pays*	Existing Coverage Pays	Supplement Pays*	You Pay*
Hospital Inpatient	First 60 days	All but $1,676 (Part A Deductible)		☐Part A Deductible **or** ☐$0 ☐50% Part A Deductible ☐75% Part A Deductible	☐$0 **or** ☐Part A Deductible ☐50% Part A Deductible ☐25% Part A Deductible
	61st to 90th day	All but $419 a day		$419 a day	$0
	91st to 150th day (Lifetime Reserve)	All but $838 a day		$838 a day	$0
	Beyond 150 days	$0		All Medicare-approved amounts for an additional 365 days	$0
Skilled Nursing Home Care	First 20 days	All approved amounts		$0	$0
	Additional 80 days	All but $209.50 a day		☐$209.50 a day **or** ☐$0	☐$0 **or** ☐$209.50 a day
	Beyond 100 days	Nothing		$0	All costs

Service	Benefit	Medicare Pays*	Existing Coverage Pays	Supplement Pays*	You Pay*
Medical Expense	Physician's Services in hospital, office, or home; inpatient and outpatient medical services and supplies at a hospital; physical and speech therapy, and ambulance	Generally 80% of Medicare-approved amounts after $257 (Medicare Calendar Year deductible)		For charges covered under Part B Medicare: ☐20% **or** ☐15% **or** ☐10% of Medicare-approved amounts after $257 (Medicare Calendar Year deductible) ☐Part B Deductible ☐100% Part B Excess Charges ☐Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Charges not covered by Medicare and Policy ☐Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Prescription Drugs		Inpatient Prescription Drugs – 80% of allowable charges for immuno-suppressive drugs during the first year following a covered transplant		No benefit	All costs: outpatient drugs

* These figures are for 2025 and are subject to change each year. Refer to the Outline of Coverage to compare benefits and premiums among policies.

** Benefits from Plan G High Deductible will not begin until out-of-pocket expenses exceed $2,870 (Calendar Year deductible).

^ Only applicants eligibe for Medicare prior to 1/1/2020 may purchase Plan F.

This policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

The undersigned applicant and agent have determined that the policy is appropriate and non-duplicative.

_____	_____	_____	_____
Signature of Applicant	Date	Signature of Agent	Date

SSN# ❑❑❑-❑❑-❑❑❑❑

Humana®

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

Emphesys Insurance Company • 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 Emphesys Insurance Company. Your new policy/certificate will provide 30 days within which you may decide - without cost - whether you desire to keep the policy/certificate.

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

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. Failure to sign this authorization, or subsequent revocation of this authorization, may impair the ability of Emphesys Insurance Company to process your application or evaluate claims, and may be a basis for denying an application or claim for benefits; however, your ability to receive healthcare services will not be changed if you do not sign this authorization.

Information we will use and/or disclose

I authorize Emphesys Insurance Company ("Emphesys") to request my medical records, any prescription medication history and any other medical or pharmaceutical information to process my application and to make a decision on the approval or disapproval of my application. I authorize any physician, other healthcare professionals, hospitals, clinics, labs, pharmacies, pharmacy benefit managers or any other healthcare organization ("Providers") that provided treatment or any other service to me to disclose the information (including but not limited to information concerning the diagnosis, treatment and care of physical or mental conditions; drug, substance or alcohol abuse; diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases; copies of all hospital or medical records; and non-public personal health information) required by Emphesys and described above to Emphesys and/or its designated agents. I understand the information I authorize to be obtained may be re-disclosed to a third party only as permitted under applicable law and once re-disclosed the information may no longer be protected by federal privacy laws.

I understand that Emphesys will rely on this information to:

- underwrite this application for coverage, eligibility, risk rating, and policy issuance determination;
- administer coverage and claims and to determine or fulfill responsibility for coverage; and
- conduct other insurance operations according to federal and state laws and regulations.

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 will be valid for a period no longer than that necessary to make an approval or disapproval determination of your application.
- You have the right to revoke this authorization at any time. To revoke this authorization:
    - You must do so in writing and send written revocation to Emphesys (Humana Medicare Supplement Correspondence, P.O. Box 14168 Lexington, KY 40512-4168).
    - 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 Emphesys.

If you were required to answer medical questions on your Medicare Supplement Enrollment Application, you must complete this authorization for your application to be considered for approval.

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

MEDICARE NUMBER **SOCIAL SECURITY NUMBER** ___ – ___ – ____

DATE MM / DD / YYYY

Applicant Signature _____

Insured by Emphesys Insurance Company

Humana®