

Medicare Supplement Insurance 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 Medicare Supplement Insurance Application

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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 ~~R~~ H
T

- 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

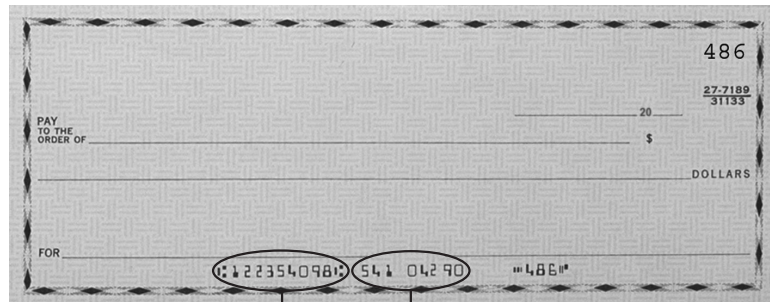
Required Fields Must Be Completed



Optional Fields



Sample Void Check
(If you are choosing the auto
bank withdrawal.)



Routing Number Account Number

1

LAST NAME

[Grid of 15 boxes for last name]

FIRST NAME

[Grid of 15 boxes for first name]

MI

[Box for MI]

ADDRESS

[Grid of 25 boxes for address]

APT OR STE#

[Grid of 5 boxes for apt or ste#]

ADDRESS (continued)

[Grid of 15 boxes for address continued]

COUNTY

[Grid of 15 boxes for county]

CITY

[Grid of 20 boxes for city]

STATE

[Grid of 2 boxes for state]

ZIP CODE

[Grid of 5 boxes for zip code]

TELEPHONE

[Grid of 10 boxes for telephone]

DATE OF BIRTH

[Grid of 8 boxes for date of birth: MMDDYYYY]

GENDER M F

MAILING ADDRESS (only if different from above street ADDRESS)

[Grid of 25 boxes for mailing address]

APT OR STE#

[Grid of 5 boxes for mailing apt or ste#]

CITY

[Grid of 20 boxes for mailing city]

STATE

[Grid of 2 boxes for mailing state]

ZIP CODE

[Grid of 5 boxes for mailing zip code]

E-MAIL ADDRESS (optional)

[Grid of 30 boxes for e-mail address]

(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 F*
- Plan G
- High Deductible Plan G
- Plan N

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

Please complete the information below as it appears on your Medicare card.

MEDICARE NUMBER

[Grid of 9 boxes for Medicare number]

IS ENTITLED TO

EFFECTIVE DATE

HOSPITAL INSURANCE (PART A)

[Grid of 8 boxes for effective date: MM/DD/YYYY]

MEDICAL INSURANCE (PART B)

[Grid of 8 boxes for effective date: MM/DD/YYYY]

PROPOSED EFFECTIVE DATE

[Grid of 8 boxes for proposed effective date: MM/01/20YY]

PERSON TO NOTIFY IN AN EMERGENCY (optional):

LAST NAME

[Grid of 15 boxes for emergency last name]

FIRST NAME

[Grid of 15 boxes for emergency first name]

MI

[Box for emergency MI]

RELATIONSHIP TO APPLICANT

[Grid of 15 boxes for relationship to applicant]

TELEPHONE

[Grid of 10 boxes for telephone]

AGENT NUMBER (SAN)

[Grid of 5 boxes for agent 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).

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 reinstated 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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.

- Did you turn age 65 in the last six months? Yes No
 - Did you enroll in Medicare Part B in the last six months? Yes No
If yes, what is the effective date? / /
- 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.)

 - If yes, will Medicaid pay your premiums for this Medicare Supplement policy? Yes No
 - Do you receive any benefits from Medicaid OTHER THAN payments toward Your Medicare Part B premium?
 Yes No
- 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 / / END / /

 - 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
 - Was this your first time in this type of Medicare plan? Yes No
 - Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes No

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- 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. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection? Yes No
 - f. Kidney disease requiring dialysis or diabetes requiring more than 50 units of insulin daily? Yes No
 - g. Internal cancer, leukemia or melanoma? Yes No
 - h. Amputation caused by disease or trauma or neuralgic or poor circulation that has caused an ulcer on the skin? Yes No
 - i. Do you have any paralytic conditions? Yes No
 - j. Rheumatoid arthritis, Paget’s Disease, degenerative bone disease, crippling arthritis, vertebral or hip fractures/ dislocations, spinal cord disorders/injuries? Yes No
 - k. 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:

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

□

ACH Discount

If you wish to take advantage of the \$2 discount on your monthly premium as disclosed in your Outline of Coverage, you must select an automatic payment option for future payments in Section 7 below.

Grid of 12 boxes for Applicant Medicare Number

8 Signature & Date

APPLICANT'S SIGNATURE:

Signature line for Applicant

SIGNATURE DATE:

MM / DD / YYYY date boxes for Applicant

AGENT'S SIGNATURE:

Signature line for Agent

SIGNATURE DATE:

MM / DD / YYYY date boxes for Agent

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

Grid of 15 boxes for Company Name

TYPE

Grid of 15 boxes for Company Type

COMPANY

Grid of 15 boxes for Company Name

TYPE

Grid of 15 boxes for 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

AGENT USE ONLY

WRITING AGENT NAME

Grid of 25 boxes for Writing Agent Name

WRITING AGENT ID (SAN)

Grid of 8 boxes for Writing Agent ID

COMMISSION LEVEL

Grid of 2 boxes for Commission Level

MGA CODE

Grid of 4 boxes for MGA Code

MKTS

Grid of 2 boxes for MKTS (5, 4)

AFFINITY CODE

Grid of 4 boxes for Affinity Code

AGENCY (optional) (SAN)

Grid of 15 boxes for Agency SAN

AGENCY ID (SAN)

Grid of 6 boxes for Agency ID

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

CompBenefits 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 CompBenefits 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):

- | | |
|---|--|
| <input type="checkbox"/> additional benefits | <input type="checkbox"/> no change in benefits, but lower premiums |
| <input type="checkbox"/> fewer benefits and lower premiums | <input type="checkbox"/> other (please specify) |
| <input type="checkbox"/> my plan has outpatient prescription drug coverage and I am enrolling in Part D | _____ |
| <input type="checkbox"/> disenrollment from a Medicare Advantage plan (please explain reason for disenrollment) | _____ |

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



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 CompBenefits 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 CompBenefits Insurance Company (“CompBenefits”) 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 CompBenefits and described above to CompBenefits 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 CompBenefits 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 CompBenefits (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 CompBenefits.

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

Applicant Signature _____

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Medicare Supplement Guaranteed Issue Guide



Definitions Of Eligible Person For Guaranteed Issue And Creditable Coverage

You are eligible for Guaranteed Issue if you submit evidence of the date of termination or disenrollment with the Enrollment Application, 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; or you are enrolled in an employee welfare benefit plan that is primary to Medicare and the plan terminates, or ceases to provide health benefits because you left the plan.

Your guaranteed issue period begins on the later of the following: 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 a termination or cessation); or the date that the applicable coverage terminates or ceases; and ends 63 days thereafter.

2. You are enrolled with a Medicare Advantage organization under a Medicare Advantage Plan (the “Plan”) under Part C of Medicare and any of the following apply; or you are 65 years of age or older and are enrolled with a Program of All-Inclusive Care for the Elderly (PACE), and there are circumstances similar to those described as follows that would permit discontinuance of your enrollment with the provider if you were enrolled in a Medicare Advantage Plan:
 - (i) The organization’s or Plan’s certification under this part has been terminated or
 - (ii) The organization has terminated or otherwise discontinued providing the Plan in the area in which you reside, or
 - (iii) You are no longer eligible to elect the Plan because 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 the Plan is terminated for all enrollees residing within a particular residential service area; or
 - (iv) You demonstrate, in accordance with guidelines established by the Secretary, that:
 - (A) The organization offering the Plan substantially violated a material provision of the organization’s contract with the Centers for Medicare & Medicaid Services in relation to you, including the failure to provide you, in 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
 - (B) 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.
 - (v) You meet such other exceptional conditions as the Secretary may provide.

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Medicare Supplement Guaranteed Issue Guide (*Continued*)

If your enrollment is terminated involuntarily, the period begins on the date that you receive notice of termination and ends 63 days after the date the coverage is terminated. If you disenroll voluntarily the period begins 60 days before the effective date of disenrollment and ends 63 days after the effective date.

3. Your enrollment ceases under the same circumstances that would permit discontinuance under Section 2, and you are enrolled with one of the following:
 - (i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost); or
 - (ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999; or
 - (iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
 - (iv) An organization under a Medicare Select policy.

If your enrollment is terminated involuntarily, the period begins on the date that you receive notice of termination and ends 63 days after the date the coverage is terminated.

4. You are enrolled in a Medicare Supplement policy and the enrollment ceases because:
 - (i) 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;

Your guaranteed issue period begins on the earlier of the following: the date that you receive notice of termination, notice of the issuer's bankruptcy or insolvency, or other such similar notice; or the date the applicable coverage is terminated; and ends on the date that is 63 days after coverage is terminated.

- (ii) The issuer of the policy substantially violated a material provision of the policy; or
 - (iii) 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.

If you disenroll voluntarily the period begins 60 days before the effective date of disenrollment and ends 63 days after the effective date.

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 Part C of Medicare, (2) any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), (3) any similar organization operating under demonstration project authority, (4) any PACE program under Section 1894 of the Social Security Act, or (5) 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).

If your enrollment is terminated involuntarily, the period begins on the date that you receive notice of termination and ends 63 days after the date the coverage is terminated.

6. You upon first becoming enrolled for benefits under Medicare Part A and Part B, enroll in a Medicare Advantage Plan under Part C of Medicare, or in a PACE program under Section 1894 of the Social Security Act, and disenroll from the plan or program within 12 months of the effective date of enrollment.

If your enrollment is terminated involuntarily, the period begins on the date that you receive notice of termination and ends 63 days after the date the coverage is terminated.

Medicare Supplement Guaranteed Issue Guide (*Continued*)

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 terminated enrollment in the Medicare Supplement policy and submit evidence of enrollment in Medicare Part D along with the application for a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F, F(HD), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued your Medicare Supplement policy with outpatient prescription drug coverage.

Your guaranteed issue period begins on the date you receive notice from your Medicare Supplement issuer during the 60 day period immediately preceding the initial part D enrollment period and ends 63 days after the date of termination.

Guaranteed issue also applies to:

Open Enrollment – You are eligible for Guaranteed Issue if you apply for a Humana Medicare Supplement Plan policy prior to or during the six-month period beginning with the first day of the first month in which you are enrolled for benefits under Part B of Medicare.

The following is a definition of Creditable Coverage:

Creditable Coverages means

- (a) a group health plan;
- (b) health insurance coverage;
- (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
- (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;
- (e) Chapter 55 of Title 10 United States Code (CHAMPUS);
- (f) a medical care program of the Indian Health Service or of a tribal organization;
- (g) a state health benefits risk pool;
- (h) a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
- (i) a public health plan as defined in federal regulation;
- (j) a health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504 (e)).

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