Enrollment Application

Follow these easy steps to apply for a Humana Achieve 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 Monthly 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

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Plans issued and underwritten by CompBenefits Insurance Company

Marking Instructions

- Please print clearly and press hard.
- **Use blue or black ink only.**
- Completely fill the ovals.

Correct Mark

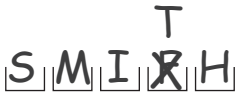
Incorrect Marks

- Print legible numbers and capital block letters in the boxes.

Correct Numbers and Letters

1 2 3 A B C

- Print only one character per box.
- If you make a mistake, correct it by crossing out the box and writing the letter/number above or below the box as shown. Be sure to initial any and all corrections made.



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

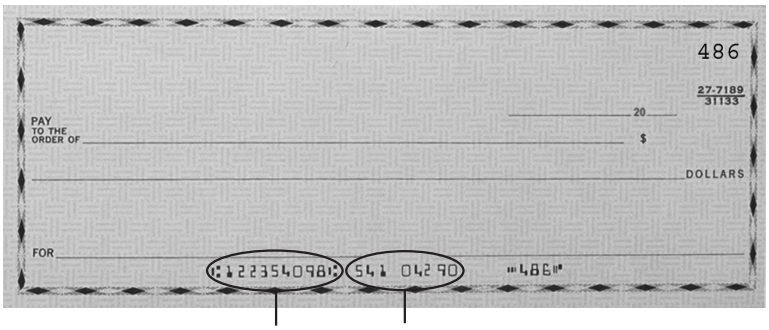
0 3 2 4 2 0 1 0

Required Fields Must Be Completed

Optional Fields

Sample Void Check

(If you are choosing the auto bank withdrawal.)



Routing Number **Account Number**

STAMP DATE MU001

CompBenefits Insurance Company
2432 Fortune Drive, Lexington, KY 40509

Form Number: FLAI85030-1

1

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

ADDRESS **APT OR STE#**

ADDRESS (continued) **COUNTY**

CITY **STATE** **ZIP CODE**

TELEPHONE / –

DATE OF BIRTH MMDDYYYY

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

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

PROPOSED EFFECTIVE DATE

MM / 01 / 20YY

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

MEDICARE NUMBER

IS ENTITLED TO	**EFFECTIVE DATE**
HOSPITAL INSURANCE (PART A)	MM / DD / YYYY
MEDICAL INSURANCE (PART B)	MM / DD / YYYY

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 Medicaid and may not need a Medicare Supplement policy.
- 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 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.
- 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 may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB).

Yes or No answers are required to the following questions. If you have lost, or you are losing or replacing, 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 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 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
4. 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

➤ **You Must Read and Sign**

APPLICANT MEDICARE NUMBER

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
7. Do you intend to replace your current healthcare coverage with this Medicare Supplement policy? ◯ Yes ◯ No

3 Guaranteed Acceptance

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. Refer to the Guaranteed Issue Guide provided 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
2. Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed acceptance? ◯ Yes ◯ No

   If you answered yes to either of the above questions in this section, please go directly to Section 5. 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.

4 Medical Questions

Yes or No answers are required to the following questions, unless you indicated that you are applying for coverage during your Medicare Supplement Open Enrollment Period or qualify for guaranteed acceptance. Please note that these questions and answers are limited to conditions or diseases which could be supported by your medical history and records.
A MEDICAL RECORDS RELEASE AUTHORIZATION FORM IS REQUIRED.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. **HEIGHT** FT IN **WEIGHT** LBS
2. In the last year, have you been hospitalized, confined to a nursing facility; or are you bedridden or confined to a wheelchair? ◯ Yes ◯ No
3. In the past 90 days have you received Home Health care? Examples of Home Health may be treatment for recovery from surgery or illness, chronically or terminally ill persons or people with disabilities in need of medical, nursing, social or therapeutic treatment, and/or assistance with the essential activities of daily living. ◯ Yes ◯ No
4. Have you tested positive for exposure to the Human Immunodeficiency Virus (HIV) or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection? ◯ Yes ◯ No
5. Do you now have or within the last two years have you received a diagnosis or treatment from a licensed physician 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

➤ **You Must Read and Sign**

APPLICANT MEDICARE NUMBER

b. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other Chronic Pulmonary disorders? Have you used supplementary oxygen in the last year? ◯ Yes ◯ No
c. Parkinson's Disease, Multiple or Lateral Sclerosis, Huntington's Disease, Muscular Dystrophy, Lupus, Hepatitis, or Lou Gehrig's Disease? ◯ Yes ◯ No
d. Alzheimer's Disease, senile dementia, organic brain disorders, senility disorder, schizophrenia, other major depressive disorders, mental or nervous disorders, cirrhosis, alcoholism or drug abuse? ◯ Yes ◯ No
e. Kidney disease requiring dialysis or diabetes requiring more than 50 units of insulin daily? ◯ Yes ◯ No
f. Internal cancer, leukemia or melanoma? ◯ Yes ◯ No
g. Amputation caused by disease or trauma or neuralgic or poor circulation that has caused an ulcer on the skin? Do you have any paralytic conditions? ◯ Yes ◯ No
h. Rheumatoid arthritis, Paget's Disease, degenerative bone disease, crippling arthritis, vertebral or hip fractures/ dislocations, spinal cord disorders/injuries? ◯ Yes ◯ No
i. Organ transplantation? ◯ Yes ◯ No

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

_____
_____
_____

5 Monthly Premium Determination

In addition to the questions under Section 3, please answer the following question to determine your monthly premium.

1. Have you used tobacco products within the last 12 months? ◯ Yes ◯ No

If your application is accepted, and you answered **No** to this question, you qualify for the Preferred rates.
To determine your monthly premium, refer to your Outline of Coverage.

6 Discount Determination

If you qualify for the Household Discount disclosed in your Outline of Coverage, please provide the name and Medicare number of the individual living at your current address.

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

MEDICARE NUMBER

7 Payment Options

MONTHLY PREMIUM
. **In order for us to process your application, you must submit your first month's premium.**
INITIAL PAYMENT
. **Initial Premium Payment, if you are submitting more than your first month's premium.**
CHECK NUMBER **MONEY ORDER**
CREDIT CARD NAME ◯ **MasterCard** ◯ **Visa** ◯ **Discover** ◯ **American Express**
CREDIT CARD NUMBER **EXPIRATION DATE** M M Y Y Y Y

➤ **You Must Read and Sign**

APPLICANT MEDICARE NUMBER

Future Payment options: ◯ **Automatic Withdrawal** ◯ **Coupon Book** ◯ **Auto Credit Card Charge**

I hereby authorize Humana to initiate debit/credit entries to my checking/savings account or my credit card account, as indicated below, in amounts appropriate to my coverage; and authorize the bank named below 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 have included a voided check/savings withdrawal slip from the bank account I want debited.

DEPOSITORY BANK NAME

ROUTING NUMBER **ACCOUNT NUMBER** ◯ **Checking** ◯ **Savings**

If you choose the auto credit card charge option, complete the following:

◯ **MasterCard** ◯ **Visa** ◯ **Discover** ◯ **American Express**

CREDIT CARD NUMBER **EXPIRATION DATE** M M Y Y Y Y

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 satisfy the creditable coverage requirements.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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 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, Guaranteed Issue Guide, and the "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" publication.

8 Signature & Date

APPLICANT'S SIGNATURE: **SIGNATURE DATE:** M M / D D / Y Y Y Y

AGENT'S SIGNATURE: **SIGNATURE DATE:** M M / D D / Y Y Y Y

AGENT (Print Name): **Florida License Identification #:**

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)

MKTS 5 4

AGENCY (optional)

AGENCY ID (SAN)

➤ You Must Read and Sign

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Medicare Supplement Guaranteed Issue Guide

Open Enrollment

You are eligible for Guaranteed Issue if you apply for a Humana Achieve 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. Medicare Supplement insurance is available to those age 65 and older enrolled in Medicare Parts A and B and to those under age 65 eligible for Medicare due to disability or end stage renal disease.

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

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(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.

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.

Medicare Supplement Guaranteed Issue Guide *(Continued)*

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.

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.

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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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):

- ☐ additional benefits
- ☐ fewer benefits and lower premiums
- ☐ my plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ disenrollment from a Medicare Advantage plan (please explain reason for disenrollment)
- ☐ no change in benefits, but lower premiums
- ☐ other (please specify)

_____

_____

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy/certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy/certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy/certificate until you have received your new policy/certificate and are sure that you want to keep it.

Applicant's signature	Signature of agent/broker/representative
Print name	Print name and address of agent or broker below
Social Security number	Date

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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 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 redisclosed 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. This period will not exceed 24 months.
- 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.
    - 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 MM / DD / YYYY

Applicant Signature _____

Insured by CompBenefits Insurance Company

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Agent Certification

I, the undersigned insurance agent certify:

THAT, I have taken an application for Policy Form No:

- ☐ FLAIMESA (Plan A)
- ☐ FLAIMESF (Plan F)
- ☐ FLAIMESG (Plan G)
- ☐ FLAIMESG(HD) (High Deductible Plan G)
- ☐ FLAIMESN (Plan N)

offered by CompBenefits Insurance Company to

_____ (Applicant).

THAT, I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

THAT, I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare and Medicaid Services (CMS) of the Federal Government in connection with this insurance policy being applied for.

_____
Date

_____
Signature of Agent

_____
I, the undersigned applicant, have received a copy of this form

_____
Name of Agency

_____
Applicant's Signature

_____
Address of Agent or Agency

SS# ☐☐☐-☐☐-☐☐☐☐

_____
Phone Number

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