

Applying is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department
at: _____ fax: _____

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), quarterly (every three months), or semi-annual

Step 3

SEND THE COMPLETED APPLICATION TO:

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...

HUMANA.
Guidance when you need it most



Individual Prepaid/DHMO C550

MDP11

Social Security No.
 Last Name
 First Name
 M.I.
 Birthdate:

MO	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

Home Address
 Area Code
 Home Phone
 Sex: F M

City
 State
 ZIP Code
 Area Code
 Business Phone

List All Your Eligible Dependents Below If They Are To Be Covered.

(Eligible dependents include your spouse and/or unmarried children from birth to age 23 if a child is both a full-time student and dependent on you for primary support.)

First	Middle	Last (If Different)	Dental Facility #	Date of Birth
2. Spouse				<input type="checkbox"/> F <input type="checkbox"/> M / /
3. Child				<input type="checkbox"/> F <input type="checkbox"/> M / /
4. Child				<input type="checkbox"/> F <input type="checkbox"/> M / /
5. Child				<input type="checkbox"/> F <input type="checkbox"/> M / /
6. Child				<input type="checkbox"/> F <input type="checkbox"/> M / /
7. Child				<input type="checkbox"/> F <input type="checkbox"/> M / /
8. Child				<input type="checkbox"/> F <input type="checkbox"/> M / /
Coverage Effective Date:		Dental Facility #		Agent Code #
Plan Code #	# Dependents Covered	Contribution Amount \$	For Office Use Only Amount Paid \$	Non-Refundable Enrollment Fee \$

I wish to enroll in the Plan. I understand that this is a MINIMUM ONE (1) YEAR CONTRACT and that all necessary dental services will be provided as described in the schedule of benefits which I have received and understand.

Date: _____

Applicant's

Signature: X _____

Agent Signature: _____

Enrollment Instructions:

- Complete the attached application. (Be sure to list all family members to be included.)
- Select your payment mode:
 - If MONTHLY, complete the authorization for deduction with full bank information and sign the lower portion. **(Be sure to enclose the first month's payment and a blank, voided check plus the non-refundable \$35 enrollment fee.)**
 - If annual, choose VISA, MASTERCARD, DISCOVER, AMEX, or payment by check. Fill out the bank card section and send no money, or enclose your check for the full annual payment plus the non-refundable \$35 enrollment fee.
- Monthly Bank Draft:

	Monthly	Annually
	Pre-Authorized Bank Draft	Visa/MasterCard/Discover Amex/Check/M.O.
Admin. Fee	\$1.00	\$.00

Make check payable to **HumanaOne**
Place all information and check (if applicable) inside. Completed applications with correct payments and received by **HumanaOne** by the 15th of the month will become effective on the 1st of the following month.

Authorization for Deduction—Signature Required

Name _____ Social Security # _____
Last First M.I.

I authorize _____
Financial Institution

To make a Monthly Bank Draft (drafted on the 15th)

Deductions of \$ _____ + \$1.00 Administrative fee = \$ _____
Contribution

My checking account # _____ (Monthly Only)

and to remit the amounts deducted to **HumanaOne** upon instructions from **HumanaOne**. The amount of deduction indicated above is approximate and may be corrected as instructed by **HumanaOne**. This authorization shall cease (a) upon my giving written cancellation to you; (b) automatically upon my termination as an employee, member or depositor, as the case may be; of the above-named organization; (c) automatically upon termination of my checking, savings or share account number above as this authorization relates to such an account; or (d) upon discontinuance of the deduction and remittance arrangements between the above-named organization and **HumanaOne**. I understand this authorization does not waive or change any of the payment provisions of any policy issued to me by **HumanaOne** and if this authorization terminates for any reason, any further payments required under said policy(ies) shall be made as provided in the policies. I agree that the above-named organization is acting gratuitously and for my sole accommodation and not as an agent for **HumanaOne**.

Date _____ Signature X _____

Bank Card Selection

For Your Convenience

Fill in card number

MasterCard Visa Discover AMEX
Check One

Expiration Date
Mo. Yr.

Amount Charged

(Enrollment fee + the annual contribution \$ _____)

I hereby authorize charging my bank card.
Cardholder's Signature _____ Date _____
X _____

TO: THE FINANCIAL OR OTHER ORGANIZATION NAMED ON THE REVERSE SIDE.

In consideration of your paying checks and drafts drawn or purported to be drawn by the undersigned on the checking account of any of your depositors, undersigned hereby agrees that:

- (1) It will indemnify you against and hold you harmless from any and all liability, loss, damage and expense which may be incurred by you because of your payment or dishonor of any such checks so drawn or purported to be drawn whether the payment or dishonor was intentional or through inadvertence, and will further indemnify and hold you harmless from any liability to any persons making claims under any Agreement with respect to which checks are drawn. We will refund you any amount erroneously paid by you on any such check;
- (2) It will refund to you any amount erroneously paid by you to undersigned on any such check if claim is made therefore by you within 3 months from the date of payment; and
- (3) Either you or undersigned may terminate this agreement by ten (10) days prior written notice by either to the other or the agreement will be immediately terminated on the closing of the depositor's account or by the revocation by the depositor of authorization, but any such termination shall not affect undersigned's obligations and liabilities hereunder with respect to any such checks or dishonored by your prior to termination.

HumanaOne

President 

Humana Family of Companies
 Insured or administered by CompBenefits Dental, Inc.,
 CompBenefits Company, CompBenefits Insurance Company,
 CompBenefits of Alabama, Inc., CompBenefits of Georgia,
 Inc., American Dental Plan of North Carolina, Inc., or
 DentiCare, Inc. (d/b/a CompBenefits).

Contribution Rates	+	Monthly Bank Draft (if applicable)	+	One-Time Non-Refundable Enrollment Fee																		
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 15%; text-align: center;">Monthly</th> <th style="width: 15%; text-align: center;">Annually</th> </tr> </thead> <tbody> <tr> <td>1 member</td> <td style="text-align: right;">\$13.18</td> <td style="text-align: right;">\$158.16</td> </tr> <tr> <td>2 members</td> <td style="text-align: right;">\$22.50</td> <td style="text-align: right;">\$270.00</td> </tr> <tr> <td>3 members</td> <td style="text-align: right;">\$30.52</td> <td style="text-align: right;">\$366.24</td> </tr> <tr> <td>4 members</td> <td style="text-align: right;">\$38.37</td> <td style="text-align: right;">\$460.44</td> </tr> <tr> <td>5+ members</td> <td style="text-align: right;">\$45.65</td> <td style="text-align: right;">\$547.80</td> </tr> </tbody> </table>		Monthly	Annually	1 member	\$13.18	\$158.16	2 members	\$22.50	\$270.00	3 members	\$30.52	\$366.24	4 members	\$38.37	\$460.44	5+ members	\$45.65	\$547.80		\$1.00 administrative fee monthly for pre-authorized bank draft (waived if paying annually)		\$35.00
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Send your completed application with payment to:

CompBenefits Enrollment Services
 100 Mansell Court East
 Suite 400
 Roswell, GA 30076

First month's payment must include monthly or annual contribution plus enrollment fee. Payment is drafted during the month prior to the month of coverage. Please be sure include a BLANK, VOIDED CHECK if you would like to have your payment deducted from your bank account.