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: 630-930-9364 fax: 847-220-9280

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:

Illinois Health Agents

75 Forest Ave

Glen Ellyn, IL 60137

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: 630-930-9364

Thank you for choosing...

HUMANA.

Guidance when you need it most

Humana*One* Dental & Vision Paper Application Checklist

TO ENSURE PROCESSING PLEASE USE THIS CHECKLIST

› Did you fill out the application completely?

- ❑ Include your effective date. The effective date should be "mm/dd/yyyy". The requested effective date should be in the future. Please note the effective date rules below:

  For Dental C550 and HI215 products: if an application is received prior to the 15th of the month, the effective date is the 1st of the following month. If the application is received after the 15th of the month, the effective date will be the 1st of the subsequent month.
  EXAMPLE: An application received on May 14th will have an effective date of June 1st. An application received on May 18th will have an effective date of July 1st.

  For all other products, applications received between the 1st and the last day of the month will be effective the first of the following month.
  EXAMPLE: An application received on May 21st will have an effective date of June 1st.
- ❑ **Coverage Options:** Please check the box of the coverage option(s) that you are interested in and include the product names.
- ❑ **Primary Insured Information:** The following fields are required for the primary applicant: Full Name, Date of Birth, Address, City, State, ZIP code, Social Security Number, and Dentist Facility ID number (for Dental C550 and HI215 applicants only. Please visit **HumanaOneNetwork.com** to find a dentist).
- ❑ **Family Information:** The following fields are required for a spouse and/or dependents: Full Name, Date of Birth and Social Security Number.
- ❑ **Agent/ Producer Information:** The following fields are required from the agent (if applicable): Name, Humana Agent #, License #, and Signature.
- ❑ **Agreement and Signature:** Please read the agreement and sign and date all applicable lines.

› Second page: Payment & Billing Authorization

- ❑ Please indicate whether you will be paying monthly or annually.
- ❑ Please check the plan that you are purchasing in the chart and write in the total first payment amount equal to the enrollment fee(s) and the monthly/ annual payment total indicated in the chart.
  - ❑ If you are enrolling in more than one plan, please add the payment totals from the chart together for each plan and include enrollment fees for both plans.
  - ❑ **PLEASE NOTE:** Your first payment will be taken immediately upon receipt of the application, so please ensure that the payment method provided has funds available/covers this transaction and is accurate and up-to-date.
- ❑ **Payor Information:** Only fill out this section of the billing name or address is different than the information provided on the first page for the primary insured. The payor will also need to sign the Payor Signature line at the bottom of the application.
- ❑ **Payment Options:** Please check whether you will be paying via credit card, automatic bank withdrawal, or check/ money order. Please include all requested information and check the payment authorization box under your payment method.
  - ❑ If you are paying through automatic bank withdrawal, make sure to include your account information and a blank voided check along with the application.
  - ❑ If paying with a credit card, please check your credit card's expiration date. This card will be charged for future payments, so please alert us with any changes.
- ❑ All signature areas are signed and dated. Please make sure you have read and agreed to the one year contract language.

› Have you reviewed our provider network?

- ❑ To see providers in our network for all plans, please visit **www.HumanaOneNetwork.com** and enter your zip code and plan name.

› Would you like to fax your application?

- ❑ Only credit card and bank withdrawal applications may be faxed. Please keep the original application and submit a faxed copy to the Humana*One* Dental & Vision Paper Application team at **770-518-3102**. If you are faxing an automatic bank withdrawal application, please fax a copy of a blank voided check.

› Are you making changes to an existing plan or reinstating a previous plan?

- ❑ For changes to existing plans or for reinstatements, please call: **1-866-537-0232**.

HUMANA *one*®

Humana*One* **Dental & Vision Application**

HUMANA *one*

Requested Effective Date: __ __/__ __/__ __ __ __

This application is for: ❑ New Business (First time applicant) ❑ Reinstatement (Reapplication)
❑ Change/Modification to Existing Policy or Plan

ILLINOIS

Reason for change_____ Change/Modification to Existing Policy or Plan # _____

1. Coverage Options **Please complete this section when selecting a dental or vision product.**

❑ **Dental Coverage** Plan name	❑ **Vision Coverage** Plan name

2. Primary Applicant Information

First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Home address (not P.O. Box)		City	State	ZIP code
E-mail		Home phone # ( )	Daytime phone # ( )	
Social Security #		Dentist name		Facility #

3. Family Information

Please complete only if your spouse and/or dependent children are applying for coverage. Attach an additional family information sheet if necessary. Each additional page must be signed and dated.

Spouse First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Social Security #	E-mail	Dentist name		Facility #
Dependent First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Social Security #	E-mail	Dentist name		Facility #
Dependent First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Social Security #	E-mail	Dentist name		Facility #

4. Agreement and Signature

True and Complete Acknowledgment: I understand, agree and represent: I have read this document or it has been read to me. The answers are true and complete. I agree to immediately notify Humana of any changes to the information contained in this form that occur prior to the policy effective date. I have received and reviewed any state or federal required disclosures. I acknowledge that neither I nor the agent have the right to waive or incompletely answer any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements. This policy applied for is not an employer-sponsored group health plan and it does not comply with state or federal small employer laws. I certify that I will not use pre-tax income to pay premiums associated with this policy or otherwise receive favorable tax treatment under federal or state law that will be used to pay insurance premiums. If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the policy. Acceptance of premium and fees does not guarantee coverage. I agree to automatic withdrawal from my specified bank account or credit card for premium payment and administrative fees if selected on the HumanaOne Payment & Billing Authorization form. Any misrepresentation on this application may be used by Humana during the first two policy years to void the contract or modify the terms of coverage. This may result in loss of coverage, modification of coverage and/or claim denial. As a parent or legal guardian of a dependent 18 years or older applying for coverage, I attest by my signature below, that I have gathered the necessary health information regarding my dependent in order to fully and truthfully complete this application. A minimum one year contract is required for vision plans. A minimum one year contract is required for dental plans. This document, together with any supplements, will form part of and be the basis for any policy issued.

Any person who submits an application containing a false, incomplete or deceptive statement may be guilty of insurance fraud. If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits. Do not cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

➲ Primary Applicant or Legal Guardian Signature _____ Date __ __/__ __/__ __ __ __

➲ Relationship of Legal Guardian_____

➲ Spouse Signature (if covered dependent) _____ Date __ __/__ __/__ __ __ __

5. Agent / Producer Information

This section to be completed by Agent or Producer.

1. Agent / Agency of Record: (for commissions and correspondence)	**2. Writing Agent / Producer:**
Name (print) Ryan Kennelly	Name (print)
Humana Agent # 1430354	Humana Agent #

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the product and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary document or other product literature.

➲ Writing Agent's Signature _____ Date __ __/__ __/__ __ __ __

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana."

Dental product insured or administered by CompBenefits Dental, Inc.
Vision product offered by CompBenefits Insurance Company

HumanaOne Payment & Billing Authorization and Association Enrollment

HUMANA one

❑ I would like to pay monthly.

All quoted monthly payment amounts include $1 administration and $0.75 association fees (where applicable).

MONTHLY PAYMENTS	1 member	2 members	3 members	4 members	5+ members
❑ Dental Prepaid C550	$14.18	$23.50	$31.52	$39.37	$46.65

MONTHLY PAYMENTS	1 member	2 members	3+ members
❑ Vision Care Plan	$15.74	$28.74	$49.74

CHOOSE YOUR PLAN(S) by placing a check in the box

Monthly payment: $ _____

\+ $35 non-refundable enrollment fee per plan

Total first payment: $ _____

Please note: the enrollment fee(s) are only paid with your first payment. Future monthly payments will be for the amount indicated in the chart above. If purchasing more than one plan, please add the monthly payments together and include an enrollment fee for each plan. Rates quoted are not guaranteed and are subject to change.

❑ I would like to pay annually.

All quoted monthly payment amounts include $9 association fees (where applicable).

ANNUAL PAYMENTS	1 member	2 members	3 members	4 members	5+ members
❑ Dental Prepaid C550	$158.16	$270.00	$366.24	$460.44	$547.80

ANNUAL PAYMENTS	1 member	2 members	3+ members
❑ Vision Care Plan	$176.88	$332.88	$584.88

CHOOSE YOUR PLAN(S) by placing a check in the box

Annual payment: $ _____

\+ $35 non-refundable enrollment fee per plan

Total first payment: $ _____

Please note: the enrollment fee(s) are only paid with your first payment. Future annual payments will be for the amount indicated in the chart above. If purchasing more than one plan, please add the annual payments together and include an enrollment fee for each plan. Rates quoted are not guaranteed and are subject to change.

Payor Information (Skip to Payment Options if Payor Information is the same as the Primary Insured's)

Please provide the following information about the payor and complete the Payment Options section below. The Payor will be responsible for signing the authorization to withdraw funds from the selected account(s); not the primary insured.

First name	MI	Last name	Home phone # ( )	Daytime phone # ( )
Home address (not P.O. Box)		City	State	ZIP code

Payment Options

Please select payment option for your billing cycle and payment preference for your premium payment. Payment of premiums for each product enrolled in will be drafted separately against your account.

❑ A. Credit Card

Choose one: ❑ Annual Payment ❑ Monthly Payment

❑ Visa ❑ Mastercard

Card # Expiration date /

Cardholder's name

❑ I authorize Humana to draw premium payment (checked above) and all applicable fees and charges from my credit card account until this authorization is revoked by me.

❑ C. Check or Money Order

Choose one: ❑ Annual Payment ❑ Monthly Payment

Please make check or money order payable to Humana Insurance Company. Mail completed enrollment form, payment form and check or money order for the full amount of premium, association and enrollment fees to:

Humana Insurance Company
P.O. Box 769649
Roswell, GA 30076-8225

❑ B. Automatic Bank Withdrawal

Choose one: ❑ Annual Payment ❑ Monthly Payment

Choose one: ❑ Savings Account ❑ Checking Account

Account holder's name

Bank name

Routing #

Account #

❑ I authorize Humana to draw premium payment (checked above) and all applicable fees and charges from my designated account until this authorization is revoked by me.

Please note: For automatic bank withdrawls, please send this application along with a blank voided check and payment information to:

Humana Insurance Company
P.O. Box 769649
Roswell, GA 30076-8225

I understand this is a minimum one-year contract that auto-renews and is non-refundable and non-cancellable for all insureds.

Payor Signature _____ Date __ __/__ __/__ __ __ __

Association agreement is necessary to be eligible for the following products: Dental Preventive Plus, Vision Focus Plan, Vision Care Plan

Association Enrollment

The Association, Peoples' Benefit Alliance, is a membership organization that provides educational information and discounts on goods and services to its members. Membership in the Association is required, at additional cost, in order to be eligible for insurance coverage. The Association benefits information will be sent under separate cover. By signing below, you are requesting enrollment in the Association.

Primary Insured Member or Legal Guardian Signature _____ Date __ __/__ __/__ __ __ __