Stamp Date

1 Humana Medicare Enrollment Form

Please fill in the information below exactly as it is on your Medicare card.

Required Fields Are Indicated With An Asterisk*

AGENT NUMBER (SAN)*

MEDICAID NUMBER

MEDICARE **HEALTH INSURANCE**

LAST NAME*

FIRST NAME* **MI***

MEDICARE CLAIM NUMBER*

IS ENTITLED TO **EFFECTIVE DATE***

HOSPITAL (PART A)

MEDICAL (PART B)

NAME OF PLAN YOU ARE ENROLLING IN*:

- ◯ Humana Gold Plus® HMO
- ◯ HumanaChoicePPO®
- ◯ Humana Gold Choice® PFFS
- ◯ Humana Total Care Advantage (HMO)
- ◯ Humana Enhanced Prescription Drug Plan (PDP)
- ◯ Humana Preferred Rx Plan (PDP)
- ◯ Humana Walmart Rx Plan (PDP)

AGENT USE ONLY

GROUP ID* **BENEFIT NUMBER***

CONTRACT - PBP*
(Plan Option):
–

If you're currently enrolled in an OSB, you MUST choose it on this form to continue receiving this benefit. Not all OSB offerings are available in all areas. Please review the OSB options below to verify that yours are still offered and available.

OPTIONAL SUPPLEMENTAL BENEFIT (OSB) YOU ARE ENROLLING IN:

- ◯ MyOption Platinum Dental
- ◯ MyOption Dental – High PPO
- ◯ MyOption Vision
- ◯ MyOption Enhanced Dental PPO
- ◯ MyOption Enhanced Dental HMO
- ◯ MyOption Plus
- ◯ MyOption Fitness

Enrollees must continue to pay the Medicare Part B premium and the Humana plan premium plus the OSB premium.

Do you have end-stage renal disease?* ◯ **Yes** ◯ **No**

(Only answer this question if you are applying for HMO, PFFS, and PPO plans.)
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis. If you don't attach this information, we may need to call you about it.

DATE OF BIRTH* **SEX*** ◯ **Male** ◯ **Female** **TELEPHONE** ( ) –

RESIDENTIAL ADDRESS* (P.O. Box Not Allowed)

APT OR STE

CITY* **ST*** **ZIP***

COUNTY*

THIS SECTION AGENT USE ONLY, CONTINUE TO PAGE 2

PROPOSED COVERAGE START DATE*
– 0 1 – 2 0 1 4
(Must be after the sign date on page 7)

◯ **ICEP** MA or MAPD ◯ **IEP** PDP or MAPD ◯ **AEP** ◯ **OEPI** ◯ **SEP**

SEP CODE (Required if SEP bubbled See page 4 for code)

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Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE CLAIM NUMBER

PLEASE COMPLETE IF THE MAILING ADDRESS IS DIFFERENT

MAILING ADDRESS (Check here if the Mailing Address is the same as the Residential Address ☐)

APT OR STE

CITY **ST** **ZIP**

OTHER TELEPHONE NUMBER (Optional) ( ) –

BEST TIME TO REACH YOU
◯ **Morning** ◯ **Afternoon** ◯ **Evening**

E-MAIL
(By providing your e-mail address, this will allow you to receive important health information from Humana.)

We request that all medical plan applicants include their primary care physician's information below. If you are applying for an HMO plan, or a PPO plan that requires a PCP, then you must complete this section. Please see your Summary of Benefits to determine if your PPO requires a PCP.

PRIMARY CARE PHYSICIAN (PCP)

PCP ID NUMBER

Are you already a patient of the physician you chose? ◯ **Yes** ◯ **No**

1. Once enrolled, will you have other medical health coverage where you are the Subscriber or are covered as a Spouse/Dependent?* ◯ **Yes** ◯ **No**

ID NUMBER FOR THIS COVERAGE **TELEPHONE** ( ) –

CARRIER NAME **POLICY NUMBER**

CARRIER ADDRESS

CITY **ST** **ZIP**

Does your other coverage include prescription drug coverage? ◯ **Yes** ◯ **No**

2. Once enrolled, will you or your spouse work?* ◯ **Yes** ◯ **No**

Some people may have other drug coverage, including private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

3. Will you have other prescription drug coverage in addition to this plan for which you are applying?*
◯ **Yes** ◯ **No**
If yes, please list your other coverage and your identification (ID) number(s) for this coverage:

NAME OF OTHER COVERAGE

ID NUMBER FOR THIS COVERAGE **GROUP NUMBER FOR THIS COVERAGE**

Rx BIN **Rx PCN**

TELEPHONE ( ) –

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE CLAIM NUMBER

4. Are you currently a resident in a nursing home or long-term care facility?* ◯ Yes ◯ No
If yes, complete following:

DATE ENTERED (M M D D Y Y Y Y)

NAME OF FACILITY

ADDRESS

CITY

ST

ZIP

TELEPHONE
( ) –

5. **PLEASE SELECT ONE PREMIUM PAYMENT OPTION*.** You may pay your monthly plan premium and/or late enrollment penalty by using Electronic Funds Transfer, Automatic Credit Card charge, or by mail using a Coupon Book. You may also choose to pay your premium and/or late enrollment penalty by automatic deduction from your Social Security Administration (SSA) or Railroad Retirement Board (RRB) Benefit check each month. Due to processing timelines mandated by CMS (Medicare), your SSA or RRB deduction may be denied for your first premium payment. Humana will issue you a Coupon Book for the initial payment and resubmit your request to CMS (Medicare) for SSA or RRB deduction to begin with your second month's premium. The deduction may take two or more months to begin. In most cases, if SSA or RRB accepts your request for automatic deduction, the first deduction from your benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If SSA or RRB does not approve your request for automatic deduction, we will send you a Coupon Book for your monthly premiums. **If you do not select a payment option below you will automatically be defaulted to Coupon Book.**

☐ **Social Security Benefit Check Deduction**

☐ **Railroad Retirement Board Benefit Check Deduction**
You must currently be receiving a Railroad Retirement Board benefit check in order to qualify for this payment option.

☐ **Automatic Checking or Savings Account Deduction**
Checking or Savings Account information (Only complete this section if you selected Automatic Checking or Savings account deduction as your payment option). Please refer to the instruction page for check example.

◯ **Checking Account** ◯ **Savings Account**

BANK NAME

ROUTING NUMBER ⑈ ⑈

ACCOUNT NUMBER ⑈

(See the page that shows Sample Check)

☐ **Automatic Credit Card Deduction**
Credit Card Information (Only complete this section if you selected Automatic Credit Card Deduction as your payment option)

◯ **MasterCard** ◯ **Visa** ◯ **Discover**

CREDIT CARD NUMBER

EXPIRATION DATE (M M) 2 0 (Y Y)

☐ **Coupon Book**

You can also visit our eBilling site at Humana.com to change your monthly payment option. If you have selected Coupon Book as your payment option you can make your monthly premium payments online or update your recurring Checking, Savings or Credit Card information.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Humana the Part D-IRMAA.

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Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE CLAIM NUMBER

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between October 15 and December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan or a Prescription Drug Plan outside of this period. Please read the following statements carefully and mark the bubble to the left of the statement(s) that apply to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

	SEP Code	Special Election Period (SEP) Statements	Applicable Plan Type♦
○	LEC	I am either losing/leaving coverage I had from an employer or union or lost this type of coverage within the last two months.	PDP, MAPD or MA
○	LOC	I involuntarily lost my creditable prescription drug coverage (as good as Medicare's) within the last two months.	PDP or MAPD
○	MOV	Either: 1. In the past two months, one of the following moves occurred: I moved outside the service area for my current plan or I moved and this plan is a new option for me. 2. I returned to the United States after living permanently outside the U.S.	PDP, MAPD or MA
○	LIS	I get extra help paying for Medicare prescription drug coverage.	PDP or MAPD
○	MDE	I have both Medicare and Medicaid or my state helps pay for my Medicare premiums or I lost this eligibility or was notified of the loss within the last two months.	PDP, MAPD or MA
○	LTC	I am moving into, live in or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility). Or I moved out of a Long Term Care Facility within the last two months.	PDP
○	PAC	I left a PACE program within the last two months.	PDP, MAPD or MA
○	SPA	I belong to a pharmacy assistance program provided by my state (also known as a Qualified State Pharmaceutical Assistance Program or SPAP) or have lost eligibility or was notified of the loss within the last two months.	PDP or MAPD
○	LLS	In the past three months, I no longer qualify for extra help paying for my Medicare prescription drugs.	PDP or MAPD
○	NON	My existing Medicare Advantage (MA) plan is non-renewing for the upcoming contract year. **Note: This SEP is only valid from December 8th through the last day of February.**	PDP, MAPD or MA
○	ADP	I used/I am using the Medicare Annual Disenrollment Period to return to Original Medicare and enroll in a Stand-alone PDP. (Only valid from January 1st through February 14th). **Note: If you are enrolled in a MA-only Private Fee-For-Service plan, you must request disenrollment from this plan in order to be eligible for this SEP.**	PDP
○	OTH	None of the above statements apply to me. However I feel I have a special circumstance which allows me an exception to enroll. Humana will contact you to determine if an exception can be granted. **Please include the reason below.**	

Notes (if OTHER):

♦PDP = Prescription Drug Plan, MAPD = Medicare Advantage with Prescription Drug, MA = Medicare Advantage.

2 STOP PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining Humana could affect your employer or union health care benefits. You could lose your employer or union health coverage if you join Humana. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

By completing this enrollment application, I agree to the following:

If I am enrolling in a Medicare Advantage health plan that has a contract with the Federal government, I will need to keep my Medicare Parts A & B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. If I am enrolling in a Medicare drug plan that has a contract with the Federal Government, and it is in addition to my coverage under Medicare, I will need to keep my Medicare coverage. It is my responsibility to inform Humana of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I can be in only one Medicare prescription drug plan at a time. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances, by sending a request to Humana.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify Humana so I can disenroll and find a new plan in my new area. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Humana when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage or Prescription Drug Plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

Medically necessary services authorized by Humana Medicare Advantage health plans and other services contained in my Evidence of Coverage will be covered. NEITHER MEDICARE NOR HUMANA WILL PAY FOR MEDICARE ADVANTAGE HMO SERVICES WITHOUT AUTHORIZATION.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Humana, he/she may be paid based on my enrollment in Humana.

- If you are requesting membership in a **HMO** plan, the following statement applies: I understand that on the date HMO coverage begins, I must get all of my health care from network providers, except for emergency or urgently needed services or out-of-area dialysis.
- If you are requesting membership in a **PPO** plan, the following statement applies: I understand that on the date PPO coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Humana provides reimbursement for all covered benefits, even if received out of network.
- If you are requesting membership in a **PFFS** plan, the following statement applies: I understand that this plan is a Medicare Advantage Private-Fee-for-Service plan and not a Medicare Supplement, Medigap, Medicare Select or Stand-Alone Prescription Drug Plan. Humana pays instead of Medicare, and I will be responsible for the amounts that Humana doesn't cover, such as copayments and coinsurances. Original Medicare won't pay for my health care while I am enrolled in Humana. **It is a Medicare Advantage plan which may have prescription drug coverage built-in.** Before seeing a provider, I should verify that the provider will accept PFFS before each visit. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, except for emergencies. Providers can find the plan's terms and conditions on our website at http://www.humana-medicare.com/humana-gold-choice-terms-conditions.asp. I understand that my health care providers have the right to choose whether to accept a Private Fee-For-Service plan's payment terms and conditions every time I see them. I understand

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE CLAIM NUMBER

3 I have read and understand the important information on the preceding pages.

SIGNATURE OF APPLICANT* or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.)

SIGNATURE DATE M M D D 2 0 Y Y

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), the signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

If you are the authorized legal representative, you **must** sign above and provide the following information:*

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

STREET ADDRESS

CITY **ST** **ZIP**

TELEPHONE ( ) - **RELATIONSHIP TO APPLICANT**

Language preference for Customer Service ○ **English** ○ **Spanish** ○ **Other** _____

Please contact Humana at 1-800-833-2367 (TTY: 711) if you need information in another format or language.

AGENT USE ONLY

APPOINTMENT TYPE **SCOPE OF APPOINTMENT ID NUMBER**

WRITING AGENT NAME*

NUMBER (SAN)* **DATE*** M M D D 2 0 Y Y

AFFINITY PARTNER **LOCATION** **CAMPAIGN**

REFERRING AGENT NAME

NUMBER (SAN)

Place this barcode number on the SOA form.

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