

# HumanaOne Individual Insurance Enrollment Form



Please print clearly in ink. Complete all questions. Fill in all fields or indicate "not applicable."

Date of form: \_\_\_/\_\_\_/\_\_\_ Requested Effective Date: \_\_\_/\_\_\_/\_\_\_

- This form is for:
- New Business (First time enrollee)
  - Reinstatement (Reenrollment)
  - Change/Modification to Existing Policy or Plan

**ARIZONA**

Reason for change \_\_\_\_\_

Change/Modification to Existing Policy # \_\_\_\_\_

## Coverage Options

### Health Coverage

Please complete this section when selecting a health plan.

Plan name \_\_\_\_\_

Deductible \$ \_\_\_\_\_

### Dental Coverage

- Dental Traditional Plus
- Dental Preventive Plus

### Optional Benefits

Please select an optional benefit if available with chosen health plan.

- Prescription drug deductible:  \$150  \$300  \$500
- Lifetime Maximum Buy-Up
- Supplemental Accident Benefit:  \$1,000  \$2,500
- Carryover Deductible

**Please note:** You may purchase dental coverage if health coverage is chosen. If dental is selected, it will be approved if the health coverage is approved. If you are changing or modifying an existing/approved policy or plan, dental is only available at your anniversary.

## Life Coverage

Please complete this section if choosing the term life rider or the term life plan for primary insured and/or spouse.

Please include an additional page if you need to list multiple beneficiaries. Each additional page must be signed and dated.

### Primary Insured:

- \$20,000 Term Life Rider** (can only be purchased with a health plan)

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

- Term Life Plan** (Minimum selection is \$25,000. Additional amounts must be purchased in \$25,000 increments.)

Term life insurance amount: \$ \_\_\_\_\_

Term length:  10 years  15 years  20 years

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

### Spouse:

- \$20,000 Term Life Rider** (can only be purchased with a health plan)

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

- Term Life Plan** (Minimum selection is \$25,000. Additional amounts must be purchased in \$25,000 increments.)

Term life insurance amount: \$ \_\_\_\_\_

Term length:  10 years  15 years  20 years

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

## Primary Insured Information

If child-only coverage is requested, the youngest child is the Primary Insured. Questions must be filled out by custodial parent or legal guardian.

First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Home address (not P.O. Box)			City		State	ZIP code
Social Security #		Country or State of birth		E-mail		
Type of business or industry	Occupation		Home phone # ( )		Daytime phone # ( )	
Mailing address (if different from home address)			City		State	ZIP code
Certificateholder name if different than Primary Insured (applicable for child-only enrollment form)						

## Parent or Guardian Information

Please complete this section if Primary Insured is under 18 years of age.

First name	MI	Last name	E-mail
Home address (not P.O. Box)		City	State ZIP code
Home phone # ( )	Daytime phone # ( )		Relationship to child(ren)

## Family Information

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

<b>Spouse</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Country or State of birth	Spouse's type of business or industry		Spouse's occupation			
Social Security #			E-mail			

<b>Dependent 1</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

<b>Dependent 2</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

<b>Dependent 3</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

<b>Dependent 4</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

## Existing/Prior Coverage

**IMPORTANT: DO NOT** cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

### • Existing or Prior Health Coverage

If you are enrolling for health coverage, please provide the status of current coverage or coverage within the past 24 months, including Humana, for each person enrolling. If additional space is needed, please attach additional pages. Each additional page must be signed and dated.

No  Yes Do you or anyone enrolling for coverage have any major medical health insurance coverage currently in force?

• **If YES, please supply the following for all persons enrolling for coverage on the plan:**

Name(s) of covered persons \_\_\_\_\_

Major Medical Insurance Carrier Name \_\_\_\_\_

Effective Date \_\_\_/\_\_\_/\_\_\_\_\_

• **If NO, please answer the following question:**

No  Yes Have you or anyone enrolling for coverage had major medical health insurance coverage within the past 24 months?

• **If YES, please supply the following for all persons enrolling for coverage on the plan:**

Name(s) of covered persons \_\_\_\_\_

Major Medical Insurance Carrier Name \_\_\_\_\_

Effective Date \_\_\_/\_\_\_/\_\_\_\_\_

Termination Date \_\_\_/\_\_\_/\_\_\_\_\_

• Existing Dental Coverage

1.  No  Yes Does anyone enrolling for coverage currently have or had any group or individual dental coverage within the last 18 months?

• If YES, please supply the following for all persons enrolling for coverage on the plan:

Name(s) Effective Date \_\_\_/\_\_\_/\_\_\_\_\_

Insurance Carrier Name Termination Date \_\_\_/\_\_\_/\_\_\_\_\_

Name(s) Effective Date \_\_\_/\_\_\_/\_\_\_\_\_

Insurance Carrier Name Termination Date \_\_\_/\_\_\_/\_\_\_\_\_

2.  No  Yes Will the insurance coverage enrolled for be used to replace existing dental coverage?

• Existing Life Coverage

Primary Insured:

1.  No  Yes Do you have any life insurance and/or annuity coverage currently in force?

2.  No  Yes Will the insurance coverage enrolled for be used to replace any existing life and/or annuity coverage?

• If YES, please supply the following information:

Company name Amount \$ Plan #

Spouse:

1.  No  Yes Do you have any life insurance and/or annuity coverage currently in force?

2.  No  Yes Will the insurance coverage enrolled for be used to replace any existing life and/or annuity coverage?

• If YES, please supply the following information:

Company name Amount \$ Plan #

Eligibility & Health Status

Please answer for all individuals enrolling for coverage.

For this insurance to be issued, the following eligibility and health questions must be answered fully and truthfully. All requested health information including routine physical exams and information related to spouse and dependents enrolling for coverage must be provided. If any of the answers are "yes", please provide complete details. Failure to fully disclose any eligibility or health information may cause your claim to be reduced or denied, including the applicability of a condition specific deductible; or may result in your certificate being rescinded or modified back to your original effective date.

1.  No  Yes Is anyone enrolling for coverage a citizen of a country other than the United States?

• If YES: Name(s):

Has anyone enrolling for coverage:

2.  No  Yes Experienced weight gain or loss of more than 20 pounds in the past 12 months?

3. Within the past 12 months, has the primary insured, or spouse or dependent enrolling for coverage used any tobacco product?

Primary Insured:  No  Yes

Spouse:  No  Yes

Dependent:  No  Yes

4.  No  Yes Has anyone enrolling for coverage participated in any dangerous or extreme sport activity in the past 24 months or plan to participate in the future?

5.  No  Yes Are you or is any immediate family member (whether enrolling for coverage or not) pregnant, an expectant parent, in the process of adopting a child, or undergoing infertility treatment?

Within the past 5 years, has anyone enrolling for coverage:

6.  No  Yes Been denied for health or life insurance or had their health coverage ridered, rated or rescinded?

7.  No  Yes Been diagnosed with or received treatment for AIDS, or tested positive for AIDS or for the presence of HIV antibodies, antigens or the virus?

8.  No  Yes Had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any alcohol abuse, dependency or problem, or had any alcohol related arrests?

9.  No  Yes Used any illegal or taken prescription drugs not prescribed by their health care provider or had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any drug abuse, dependency or problem; or had any drug related arrests?

10.  No  Yes Had any testing or procedure performed that has been abnormal or the results of which are pending or unknown?

11.  No  Yes Had surgery or been advised to have surgery that has not been completed?

12.  No  Yes Consulted, advised or recommended to have follow-up testing or treatment by a health care provider or specialist that has not been completed?

## Eligibility & Health Status continued

13. **Within the past 5 years**, has anyone enrolling for coverage had signs of, been prescribed medication or received injections for, or been diagnosed with or treated for:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Chest pain or Heart Attack	M. <input type="checkbox"/> No <input type="checkbox"/> Yes ADD/ADHD (Attention Deficit Disorder) or any other Behavioral, Emotional, Mental or Nervous Disorders
B. <input type="checkbox"/> No <input type="checkbox"/> Yes High Blood Pressure or Hypertension	N. <input type="checkbox"/> No <input type="checkbox"/> Yes Eating Disorder
C. <input type="checkbox"/> No <input type="checkbox"/> Yes High Cholesterol or Triglycerides	O. <input type="checkbox"/> No <input type="checkbox"/> Yes Developmental Disorder or Delay
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Cancer or Tumor of any kind	P. <input type="checkbox"/> No <input type="checkbox"/> Yes Human Papilloma Virus or Sexually Transmitted Disease
E. <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes or High Blood Sugar	Q. <input type="checkbox"/> No <input type="checkbox"/> Yes Infertility
F. <input type="checkbox"/> No <input type="checkbox"/> Yes Stroke	R. <input type="checkbox"/> No <input type="checkbox"/> Yes Uterine Fibroids
G. <input type="checkbox"/> No <input type="checkbox"/> Yes Paralysis	S. <input type="checkbox"/> No <input type="checkbox"/> Yes Cyst, Growth, Lump or Polyp
H. <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy or Seizure	T. <input type="checkbox"/> No <input type="checkbox"/> Yes Hernia
I. <input type="checkbox"/> No <input type="checkbox"/> Yes Migraines or frequent or severe headaches	U. <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis
J. <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis	V. <input type="checkbox"/> No <input type="checkbox"/> Yes Implants, Pins, Plates, Rods, Screws or Prosthesis
K. <input type="checkbox"/> No <input type="checkbox"/> Yes Sleep Apnea	W. <input type="checkbox"/> No <input type="checkbox"/> Yes Connective Tissue or Autoimmune Disorder
L. <input type="checkbox"/> No <input type="checkbox"/> Yes Anxiety or Depression	X. <input type="checkbox"/> No <input type="checkbox"/> Yes Birth Defect

14. **Within the past 5 years**, has anyone enrolling for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Gallbladder, Liver or Pancreas	G. <input type="checkbox"/> No <input type="checkbox"/> Yes Eyes, Ears, Nose, Throat or Sinuses
B. <input type="checkbox"/> No <input type="checkbox"/> Yes Colon, Esophagus or Stomach	H. <input type="checkbox"/> No <input type="checkbox"/> Yes Breasts
C. <input type="checkbox"/> No <input type="checkbox"/> Yes Bladder or Kidneys	I. <input type="checkbox"/> No <input type="checkbox"/> Yes Menstrual Cycle
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Back, Disc, Neck or Spine	J. <input type="checkbox"/> No <input type="checkbox"/> Yes Cervix, Ovaries, Uterus or Vagina
E. <input type="checkbox"/> No <input type="checkbox"/> Yes Knee, Hip or Shoulder	K. <input type="checkbox"/> No <input type="checkbox"/> Yes Penis, Prostate or Testicles
F. <input type="checkbox"/> No <input type="checkbox"/> Yes Lungs	L. <input type="checkbox"/> No <input type="checkbox"/> Yes Skin

15. **Within the past 5 years**, has anyone enrolling for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder (not previously disclosed) involving or affecting:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood Vessels, Heart or Circulatory System	E. <input type="checkbox"/> No <input type="checkbox"/> Yes Urinary System
B. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood, Gland, Pituitary, Thyroid or Lymph System	F. <input type="checkbox"/> No <input type="checkbox"/> Yes Musculoskeletal System, including Bone/Joint Disorders
C. <input type="checkbox"/> No <input type="checkbox"/> Yes Brain or Nervous System	G. <input type="checkbox"/> No <input type="checkbox"/> Yes Respiratory System
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Digestive System	H. <input type="checkbox"/> No <input type="checkbox"/> Yes Reproductive System

16.  No  Yes Within the past 24 months, has anyone enrolling for coverage seen a health care provider or specialist for a routine physical/wellness exam, or been seen for *any* reason not previously disclosed?

17.  No  Yes Within the past 24 months, has anyone enrolling for coverage been advised to take or taken any prescription medications or injections not previously disclosed?

## Additional Eligibility or Health Status Question Information

To be completed if anyone enrolling for coverage answered "Yes" to any question(s) in the Eligibility & Health Status section. Please provide details such as; specific condition, dates of treatment, results or advice given, medication (dosage and frequency), treatment plan, recovery date, physician name and address. Attach an additional health information sheet if necessary. Additional information sheets must be signed and dated by the primary insured or legal representative and/or spouse (if enrolling).

Question #	Letter	Person treated	Condition
Details:			

Question #	Letter	Person treated	Condition
Details:			

Question #	Letter	Person treated	Condition
Details:			

## 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 certificate 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 certificate enrolled 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 certificate or otherwise receive favorable tax treatment under federal or state law that will be used to pay insurance premiums. If this enrollment form for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate. Unless Humana agrees to an earlier date, the effective date for sickness begins on the 15th day after the approved effective date of the certificate. Acceptance of premium and fees does not guarantee coverage. Any misrepresentation on this enrollment form may be used by Humana during the first two certificate 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. I agree to terminate any existing coverage if this enrollment form is approved and coverage accepted. As a parent or legal guardian of a dependent 18 years or older enrolling 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 enrollment form. Membership in the Association is required, at an additional cost, in order to be eligible for insurance coverage. The Association is a membership organization that provides educational information and discounts on goods and services to its members. The Association benefits information will be sent under separate cover. I understand while covered by this product that I must at all times be a member of the Association.

*This document, together with any supplements, will form part of and be the basis for any certificate issued.*

**For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.**

**If you decide not to sign this agreement, we will decline to enroll you in a medical plan or to give you medical benefits.**

➤ Primary Insured or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_  
➤ Relationship of Legal Guardian \_\_\_\_\_  
➤ Spouse Signature (if covered dependent) \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_  
\_\_\_\_\_

## Agent / Producer Information

This section to be completed by Agent or Producer.

**Agent / Agency of Record: (for commissions and correspondence)**

Name (print) **Black, Gould & Associates**

Humana Agent # **860396463**

**Writing Agent / Producer:**

Name (print) **Bob Mooney/Mooney Insurance**

Humana Agent # \_\_\_\_\_

**Agent replacement question:**

**Will this plan replace or change any existing life insurance policy(s) and/or annuity(s)?**  No  Yes

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary insured submitting this enrollment form in order to fully and accurately represent the terms and conditions of the plans and services of the insuring entity, or one of its subsidiaries. These provisions are available to me and the primary insured in the benefit summary document or other plan 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 enrollment form as "Humana."

**Medical and Life products insured by Humana Insurance Company**  
**Dental products insured by HumanaDental Insurance Company**

**HUMANA**  
*Guidance* when you need it most

# HumanaOne Association Enrollment Form



## **Association Enrollment**

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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 Association Member or Legal Guardian Signature

\_\_\_\_\_ Date \_\_/\_\_/\_\_\_\_

# HumanaOne Dental & Vision Enrollment Form



The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this enrollment form as "Humana." Please check all applicable company(ies) listed below through which you are enrolling for insurance coverage:

Dental products insured by  HumanaDental Insurance Company

Vision products insured or administered by  Humana Insurance Company

Requested Effective Date: \_\_\_/\_\_\_/\_\_\_\_\_

This form is for:  New Business (First time enrollee)  Reinstatement (Reenrollment)

Change/Modification to Existing Policy or Plan

Reason for change \_\_\_\_\_ Change/Modification to Existing Policy or Plan # \_\_\_\_\_

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

<input type="checkbox"/> <b>Dental Coverage</b>	<input type="checkbox"/> <b>Vision Coverage</b>
Product Name	Product Name

## 2. Primary Insured Information

First name	MI	Last name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	/	/	/
Home address (not P.O. Box)			City	State	ZIP code		
E-mail		Home phone # ( )		Daytime phone # ( )			
Social Security #							

## 3. Family Information

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

<b>Spouse</b> First name	MI	Last name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	/	/	/
Social Security #		E-mail					
<b>Dependent</b> First name	MI	Last name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	/	/	/
Social Security #		E-mail					
<b>Dependent</b> First name	MI	Last name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	/	/	/
Social Security #		E-mail					
<b>Dependent</b> First name	MI	Last name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	/	/	/
Social Security #		E-mail					

## 4. Agent / Producer Information This section to be completed by Agent or Producer.

<b>1. Agent / Agency of Record: (for commissions and correspondence)</b>	<b>2. Writing Agent / Producer:</b>
Name (print) <b>Black, Gould &amp; Associates</b>	Name (print)
Humana Agent # <b>860396463</b>	Humana Agent #

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary insured submitting this enrollment form 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 insured in the benefit summary document or other product literature.

Writing agent's signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_

## 5. 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 have received and reviewed any state or federal required disclosures. Neither I nor any agent or producer has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements. This product applied for is not an employer-sponsored group insurance plan and it does not comply with state or federal small employer laws. I certify that I do not qualify for or have willingly waived a group insurance plan or receive favorable tax treatment under federal or state law that will be used to pay insurance premiums. If this enrollment form for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate. 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 enrollment form may be used by Humana during the first two certificate 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 enrolling for coverage, I attest by my signature below, that I have gathered the necessary insurance information from my dependent in order to fully and truthfully complete this enrollment form. This document, together with any supplements, will form part of and be the basis for any certificate issued. Membership in the Association is required, at an additional cost, in order to be eligible for insurance coverage. The Association is a membership organization that provides educational information and discounts on goods and services to its members. The Association benefits information will be sent under separate cover. I understand while covered by this product that I must at all times be a member of the Association. **For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.**

Primary Insured or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_

Relationship of Legal Guardian \_\_\_\_\_

Spouse Signature (if covered dependent) \_\_\_\_\_ 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.

# Medical Records Release Authorization

## Purpose of the Authorization

By signing the form, you will authorize the disclosure and use of the protected health information described below for pre-enrollment underwriting or risk-rating of health insurance coverage for you, or to determine your eligibility for enrollment or benefits under a health plan.

## Information we will use and/or disclose

My dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., employer or the Consumer Reporting Agency having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness and copies of all hospital or medical records, non-public personal health information, and motor vehicle history, to share any and all such information with the Company, its reinsurer or its legal representatives, and its affiliates.

- The information obtained by use of this authorization may be used by the Company to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
- Any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing health care operations or business or legal services in connection with any application, claim or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report and I (we) may request a copy of the report.
- Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.

## 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 shall be valid for two years from the date shown below. I have the right to revoke this authorization at any time.  
To revoke this authorization:
  - I must do so in writing and send my written revocation to Humana's Privacy Office.
  - 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 Humana's Privacy Office.

**If you decide not to sign this authorization, we will decline to enroll you in a medical plan or to give you medical benefits.**

Primary Applicant or Legal Guardian Signature \_\_\_\_\_ Date \_\_/\_\_/\_\_\_\_

Relationship of Legal Guardian \_\_\_\_\_

Spouse Signature \_\_\_\_\_ Date \_\_/\_\_/\_\_\_\_  
(if covered dependent)

Child Signature \_\_\_\_\_ Date \_\_/\_\_/\_\_\_\_  
(if covered dependent over the legal age)

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

**Medical and Life products insured by Humana Insurance Company  
Dental products insured by HumanaDental Insurance Company**



# HumanaOne Individual Insurance Payment Authorization & Billing Form



## Quoted Monthly Payment Amount:

\$ \_\_\_\_\_ (total payment for all products selected; not including administrative or enrollment fees)

- Medical Plan Association Dues: \$3.95 Monthly (non-refundable)  
(Dues apply to specific plans in: AL, AZ, FL, MI, MS, WI)
- Dental Preventive Plus Association Dues: 75¢ Monthly (non-refundable)  
(Dues apply in: AZ, MI, WI, unless enrolled in a Medical Plan Association)
- Administration Fee (DHMO, Dental Preventive Plus & Vision Direct):  
\$1 Fee applies to each payment
- Enrollment Fee (Vision Direct & Dental Preventive Plus):  
\$35 One-Time Fee per plan (non-refundable)
- Dental DHMO Enrollment Fee: \$19 One-Time Fee (non-refundable)

## Payor Information

If you are paying for the plan(s), please provide the following information. Then tell us how you would like to pay for the plan(s) by completing 1 and 2 below. If you will be paying for someone else's plan(s), please also complete the Alternate Payor section below.

First name	MI	Last name	Home phone # ( )	Daytime phone # ( )
Mailing address		City	State	ZIP code

**Alternate Payor:** If you are paying for an insurance plan(s) for someone else, please provide the following information about the primary applicant whose plan(s) you will be paying for. Please note, if you are paying for someone else's plan(s), you will be responsible for signing this authorization to withdraw funds from your selected accounts; not the primary applicant.

<b>Primary Applicant</b> First name	MI	Last name
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## 1. Initial Payment Options

Please choose either credit card or one-time bank withdrawal payment of the first month's payment. Initial payment for each product applied for will be drafted separately against your account.

### A. Credit Card Payment

- Visa       Mastercard

Card # \_\_\_\_\_

Expiration date      /

Cardholder's name \_\_\_\_\_

- I authorize Humana to draw initial payment of \$ \_\_\_\_\_ and fees from my Visa / Mastercard account.

### B. One-time Automatic Bank Withdrawal

Account holder's name \_\_\_\_\_

Bank name \_\_\_\_\_

Routing # \_\_\_\_\_

Account # \_\_\_\_\_

- I authorize Humana to draw initial payment of \$ \_\_\_\_\_ and fees from my designated checking account.

## 2. Subsequent Payment Options

Please indicate billing preference. If choosing automatic bank withdrawal, please complete the section to the right.

### A. Credit Card Payment (monthly billing)

If selected a fee of \$ \_\_\_\_\_ will apply.

- Mastercard

Card # \_\_\_\_\_

Expiration date      /

Cardholder's name \_\_\_\_\_

- I authorize Humana to draw subsequent payment of \$ \_\_\_\_\_ and fees from my Mastercard account until this authorization is revoked by me.

### B. Automatic Bank Withdrawal (monthly billing)

Account holder's name \_\_\_\_\_

Bank name \_\_\_\_\_

Routing # \_\_\_\_\_

Account # \_\_\_\_\_

- I authorize Humana to draw subsequent payment of \$ \_\_\_\_\_ and fees from my designated checking account until this authorization is revoked by me.

### C. Direct Bill

If selected a fee of \$ \_\_\_\_\_ will apply.

- Monthly billing

- Quarterly billing

- Semi-Annual billing

Payor Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Pre-Notice

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Information regarding your insurability will be treated as confidential. Humana or its reinsurers, may, however make a brief report thereon to Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Humana, or its reinsurers, may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.