Stamp Date

Required Fields Are Indicated With An Asterisk*

Humana Medicare Enrollment Form

AGENT NUMBER (SAN)* ☐☐☐☐☐☐☐

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

LAST NAME*

FIRST NAME* MI*

MEDICARE NUMBER*

IS ENTITLED TO — EFFECTIVE DATE*

HOSPITAL (PART A) 01

MEDICAL (PART B) 01

DATE OF BIRTH* SEX* ○ M ○ F

TELEPHONE ( ) -

Please see your agent to complete these questions.

PROPOSED COVERAGE START DATE* 01-01-2019

(Must be after the sign date on page 9)

○ ICEP MA or MAPD (See Additional Notes page)
○ IEP PDP or MAPD
○ AEP
○ OEP
○ OEP NEW
○ OEPI
○ SEP CODE (Required if SEP selected. See page 5 for code)

RESIDENTIAL ADDRESS* P.O. Box not allowed. Physical address is required.

APT OR STE

CITY* ST* ZIP*

COUNTY*

MAILING ADDRESS Your residential address is required above to confirm your service area. Place your mailing address/P.O. Box here, if applicable. If your mailing address is the same as your residential address, please fill this oval. ○

APT OR STE

CITY ST ZIP

EMAIL By providing your email address, you authorize Humana to send you health information to this address.

Go Digital! You can receive the plan materials (listed in the enrollment book) electronically instead of by postal mail. If you choose to receive plan materials by email/online, please fill this oval. ○

If you've provided your email address, you should receive an email to register your secure, online MyHumana account. When you register, you will be able to view plan materials electronically when they become available.

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

PRIMARY CARE PHYSICIAN (PCP) PCP ID NUMBER

First Name Last Name

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

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE NUMBER* ☐☐☐☐☐☐☐☐☐☐☐

Typically, you may enroll in a Medicare Advantage or Prescription Drug plan during the Annual Enrollment Period between October 15 and December 7 of each year. There are exceptions that may allow you to enroll outside of this period. Please read the following statements carefully and mark the oval to the left of the statement(s) that apply to you. By marking any of the following ovals you are certifying that, to the best of your knowledge, the text is a true statement about you. 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
◯	MDE	I have both Medicare and Medicaid or my state helps pay for my Medicare premiums or I lost this eligibility or was recently notified of the loss.	PDP, MAPD or MA
◯	LIS	I get extra help paying for Medicare prescription drug coverage.	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
◯	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
◯	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. **Must include the reason below.**	PDP, MAPD or MA
Notes (if OTH):			

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE NUMBER* ☐☐☐☐☐☐☐☐☐☐☐

Plan Selection

If you have employer medical and/or prescription drug coverage, you understand your employer coverage could end and be replaced by the coverage applied for today, once accepted by the Centers for Medicare and Medicaid Services? ◯ Yes ◯ No

◯ Fill this oval only if you are submitting more than one Medicare Advantage application on the same day. (Med Supp and OSB not included).

Select one option for the medical and/or prescription drug plan you'd like, and complete the appropriate plan details. Refer to your Summary of Benefits or your agent for assistance.

I would like one of the following options*:

◯ Humana Gold Plus® HMO
◯ Humana Value Plus HMO
◯ Humana Dual Eligible SNP HMO (Medicaid Eligibility Required)

MEDICAID NUMBER ☐☐☐☐☐☐☐☐☐☐☐☐☐

◯ Humana Community HMO
◯ Humana Chronic Condition SNP HMO (Additional Pre-Qualification Form Required)
◯ Humana Total Care Advantage HMO (Offered in Louisiana Only)
◯ Humana Cleveland Clinic Preferred HMO

◯ HumanaChoice® PPO
◯ Humana Value Plus PPO
◯ Humana Dual Eligible SNP PPO (Medicaid Eligibility Required)

◯ Humana Preferred Rx Plan (PDP)
◯ Humana Walmart Rx Plan (PDP)
◯ Humana Enhanced (PDP)

◯ Humana Gold Choice® PFFS without a standalone PDP
◯ Humana Gold Choice® PFFS (medical only) and Humana Preferred Rx Plan (PDP)
◯ Humana Gold Choice® PFFS (medical only) and Humana Walmart Rx Plan (PDP)
◯ Humana Gold Choice® PFFS (medical only) and Humana Enhanced (PDP)

If selecting an HMO or PPO plan that does not include prescription drug coverage, a stand-alone prescription drug plan (PDP) cannot be carried at the same time.

Please provide the base premium for this plan from the Summary of Benefits. This amount helps us identify the plan you would like and should not include any OSB options, Part D penalties, or payments from other parties like Medicaid.

PREMIUM* $☐☐☐ . ☐☐ For MA/MAPD plan

PREMIUM* $☐☐☐ . ☐☐ For PDP plan

Complete this section for plans with Medical Coverage

If you have selected a PPO, HMO, or PFFS plan, please provide the plan information below which can be found in your Summary of Benefits.

CONTRACT* ☐☐☐☐☐ – **PBP*** ☐☐☐ – **SEGMENT** 0 0 ☐

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE NUMBER* ☐☐☐☐☐☐☐☐☐☐☐

OPTIONAL SUPPLEMENTAL BENEFIT (OSB) YOU ARE ENROLLING IN:

Please fill in the ovals for the OSBs you want to enroll in. 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 and your Summary of Benefits to verify that yours are still offered and available.

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

- ◯ MyOption℠ Platinum Dental
- ◯ MyOption℠ Dental – High
- ◯ MyOption℠ Total Dental
- ◯ MyOption℠ Total Dental Plus
- ◯ Florida MyOption℠ Total Dental
- ◯ MyOption℠ Dental Enriched
- ◯ MyOption℠ Acupuncture
- ◯ MyOption℠ Enhanced Dental
- ◯ MyOption℠ Enhanced Dental Plus
- ◯ Florida MyOption℠ Enhanced Dental
- ◯ MyOption℠ Fitness
- ◯ MyOption℠ Plus
- ◯ MyOption℠ Vision

Some people may have other drug coverage, including private insurance, TRICARE, Federal Employees Health Benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs.

1. Will you have other prescription drug coverage in addition to this plan for which you are applying?* ◯ Yes ◯ No

If yes, complete the following:

NAME OF OTHER COVERAGE ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

GROUP NUMBER FOR THIS COVERAGE ☐☐☐☐☐☐☐☐☐☐

ID NUMBER FOR THIS COVERAGE ☐☐☐☐☐☐☐☐☐☐

TELEPHONE (☐☐☐) ☐☐☐ – ☐☐☐☐

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

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

If yes, complete the following:

CARRIER NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

GROUP NUMBER FOR THIS COVERAGE ☐☐☐☐☐☐☐☐☐☐

ID NUMBER FOR THIS COVERAGE ☐☐☐☐☐☐☐☐☐☐

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

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4. **If you have end-stage renal disease (ESRD), please fill this oval.*** ◯ I have ESRD

(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 anymore, 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 request it later, and if not received, your application could be denied.

Language preference for Customer Service

◯ **English** ◯ **Spanish** ◯ **Chinese** ◯ **Other** _____

If an alternate format is needed, please select one option

◯ **Audio** ◯ **Large Print** ◯ **Accessible Screen Reader PDF**

◯ **Oral Over the Phone** ◯ **Braille**

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

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE NUMBER* ☐☐☐☐☐☐☐☐☐☐☐☐☐

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. **If you do not select a payment option below you will be automatically defaulted to Coupon Book.**

◯ **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).

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

BANK NAME

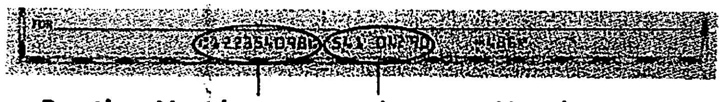
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ROUTING NUMBER

☐☐☐☐☐☐☐☐☐

ACCOUNT NUMBER

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐



Routing Number **Account Number**

◯ **Social Security Benefit Check Deduction** (Please see note below)

◯ **Railroad Retirement Board Benefit Check Deduction** (Please see note below)

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

NOTE 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 an invoice 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 start with the month that SSA accepts the withholding. If SSA or RRB does not approve your request for automatic deduction, we will send you a Coupon Book for your monthly premiums.

◯ **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

☐☐ 2 0 ☐☐

◯ **Coupon Book**

Visit Humana.com and log in to your secure MyHumana account (click Register for MyHumana if you haven't signed up yet) to take advantage of premium related services by clicking the Billing link. 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. You may also have the option to send advanced payments all at once.

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.

Please note that if you have Low Income Subsidy (LIS) and are enrolling in a plan with Drug Coverage, you may experience a change in premium or copay if your Low Income Subsidy (LIS) level changes.

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE NUMBER*

I have read and understand the important information on the preceding pages. I have reviewed and received a copy of the Summary of Benefits.

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

SIGNATURE DATE 20

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**

AGENT USE ONLY

APPOINTMENT TYPE **SCOPE OF APPOINTMENT ID NUMBER**

WRITING AGENT NAME*

NUMBER (SAN)* **DATE*** 20

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

REFERRING AGENT NAME

NUMBER (SAN)

Place this barcode number on the SOA form.

Scope of Sales Appointment Confirmation

In the space provided below, please initial the type of health product(s) you want the agent to discuss.

☐ Medicare Advantage plans (Part C)	☐ Vision plans
☐ Stand-alone prescription drug plans (Part D)	☐ Hospital indemnity
☐ Medicare Supplement plans	☐ Other health products (please list)
☐ Dental plans	_____

Beneficiary or authorized representative signature and signature date:

Name _____ Phone _____

Address (street, city, state, ZIP code) _____ Relationship to the beneficiary _____

_____ Medicare ID number _____

By signing the form, you agree to a meeting with a sales agent to discuss the types of products you initialled above. Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Signature _____ Signature date ____/____/____

Agent signature _____ Agent signature date ____/____/____

To be completed by agent: (Please print)

Agent name _____

Agent phone _____

Agent SAN _____

Agent please mail this form to:
MarketPoint
P.O. Box 14637
Lexington, KY 40512-4637
Or fax to: 1-877-889-9936

Initial method of contact: (Indicate here if beneficiary was a walk-in.)

- ❑ Agent book of business
- ❑ Agent contact
- ❑ Beneficiary referral
- ❑ Agent referral

Walk-in locations:

- ❑ Walmart
- ❑ Other retail
- ❑ Guidance Center
- ❑ Market office
- ❑ Other _____

Appointment date ____/____/____ Plan(s) the agent represented _____

Application # – paper barcode, MAPA ID or recording ID _____

Date appointment completed ____/____/____

Humana is a Medicare Advantage HMO, PPO and PFFS organization with a Medicare contract. Enrollment in any Humana plan depends on contract renewal. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-320-1235 (TTY: 711)**.

Discrimination is Against the Law

Humana Inc. and its subsidiaries ("Humana") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. See our website for more information. English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-320-1235 (TTY: 711)**. Español (Spanish): ATENCIÓN: habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-320-1235 (TTY: 711)**. **繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-320-1235 (TTY: 711)。**

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