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

› HumanaOne Paper Application Checklist

To ensure faster processing, please follow these tips when submitting a paper application.

- ❑ Ensure you are contracted with Humana, licensed in the state the applicant resides, and appointed with Humana at the time the application is sold.
- ❑ Keep the original application and submit a faxed copy to the HumanaOne Paper Application team at 1-866-217-2122.
- ❑ Your packet includes state-specific information which you are required to share with your client based on their insurance needs. Please be sure to carefully review these forms and provide them to your client before beginning their application. If you have any questions about how these forms are to be used, please contact the Agent Service Center at 1-800-833-2572.
- ❑ For applicants without current or prior coverage (within the last 63 days), effective dates may be no earlier than 30 days after the application is received by Humana.
- ❑ Submit all pages of the most current application and any additional state-specific documents.
- ❑ Complete and clearly print Agent/Broker/Producer information, including Agent listed, Agent name, Agent SAN, and Agent signature.
- ❑ The effective date should be "mm/dd/yyyy." If you include "ASAP" or "immediate" we'll call to ask for the requested effective date.
- ❑ Clearly write the name of the plan, including deductible, and all options checked "yes" or "no."
- ❑ Provide all applicant/dependent information including names, dates of birth, heights, weights, and contact information.
- ❑ If an applicant answers "yes" to any health question, then the "Additional Information" section must be completed.
- ❑ If the applicant answers "yes" to questions 1 or 2, please also include the condition.
- ❑ An applicant's signature and responses to health questions will not be accepted if crossed-out and/or correction fluid is used to change original information.
- ❑ Alternate payers and any applicant 18 years or older must sign and date before the application is submitted.
- ❑ Do not use agent payment information, or business payment information (except for sole proprietors). Please note that in Florida we cannot accept any business payments, whether or not the business is a sole proprietorship.

Please note: When a standard offer is made, the policy is auto-issued. Underwriting will not send additional documents.

Contact information:

› **Fax Applications** to:
1-866-217-2122

› **For Agents**
Agent Service Center
1-800-833-2572

› **For Applicants**
Agency Application Team
1-800-552-0758

HUMANA *one*

Pre-Notice

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.

Humana Insurance Company
Additional Enrollment Information

HUMANA one Illinois

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

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

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.

- ❑ Office visit copay
- ❑ Prescription drug deductible: ❑ $150 ❑ $300 ❑ $500
- ❑ Supplemental Accident Benefit: ❑ $1,000 ❑ $2,500 ❑ $5,000 ❑ $10,000

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.
*Spouse also includes your Civil Union Partner

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. Maximum selection is $150,000. 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. Maximum selection is $150,000. 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

First name	MI	Last name

Existing/Prior Coverage

Complete the following section if you are applying for dental or life coverage under Humana.

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

• 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 #

Agreement and Signature

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.

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

Any person who submits an enrollment form 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 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 _____

HUMANA®

Illinois Standard Health Application for Individual & Family Health Insurance Coverage

For assistance in completing this application, please contact your insurance agent or the insurance company directly. For information about your health insurance rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.

INSTRUCTIONS:

1. Any information you provide in this application is confidential.
2. The answers you provide in this application must be true and complete, to the best of your knowledge and belief. Do not leave any question unmarked.
3. An intentional misrepresentation may result in your policy being modified or terminated, or in claims being reduced or denied.
4. [For online version only] You should have the following information available, for each person requesting coverage:
   - Social Security Number, date of birth, and height/weight;
   - Information about any current or prior insurance coverage in effect within the last 12 months; and
   - Personal health information. If you do not have enough information to respond to a question, you should obtain any required information from your current or former health care provider(s).
5. For purposes of this application, the term "dependent" refers to any child up to age 26 (or age 30 for military veterans) for whom you are requesting coverage, regardless of whether the child may be considered a dependent for tax or other purposes. For information about Illinois' Young Adult Dependent Coverage law, which allows parents to cover children up to age 26, and up to age 30 for military veterans, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

A Primary Applicant Information

Name (Last)	(First)	(MI)
Residential Street Address:		Apt #:
City:	State:	Zip:
Mailing Address (if different):		Apt #:
City:	State:	Zip:
Primary Phone Number: ( )	Best time to call: ☐ Morning ☐ Afternoon ☐ Evening	
Secondary Phone Number: ( )	Best time to call: ☐ Morning ☐ Afternoon ☐ Evening	
Email Address (optional):		
Please check one of the following boxes: ☐ New Application ☐ Dependent Addition ☐ Plan Change ☐ Reinstatement		
Requested Effective Date: _____ (Coverage not in force until the insurance carrier approves your application and determines the effective date.)		

B Employment Information

Occupation:	Job Title:
Spouse/Domestic Partner's Occupation:	Job Title:
Currently employed? (optional) Self: ☐ Yes ☐ No Spouse/Domestic Partner: ☐ Yes ☐ No	

PRIMARY APPLICANT NAME ________________________________ DATE ____________________

C Persons Requesting Coverage

List all family members you wish to include under the policy. Insurance companies may have different rules about who may qualify as an eligible dependent. For more information regarding the available coverage, please check with your insurance agent or insurance carrier.

Note: For purposes of this application, an "eligible military veteran" is a veteran who served in the active or reserve components of the U.S. Armed Forces, including the National Guard, and who received a release or discharge other than a dishonorable discharge.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Self Name (Last) ________________________ (First) ________________________ (MI) ______

Social Security Number (for internal use only):	Date of Birth: / /
State of Birth (country if born outside the U.S.):	Gender: ☐ Male ☐ Female
Percentage of time annually spent outside of Illinois for residence, work, or school:	

Spouse/Domestic Partner Name (Last) ____________________ (First) ____________________ (MI) ____

Social Security Number (for internal use only):	Date of Birth: / /
State of Birth (country if born outside the U.S.):	Gender: ☐ Male ☐ Female
Percentage of time annually spent outside of Illinois for residence, work, or school:	

Dependent Name (Last) ________________________ (First) ________________________ (MI) ______

Relationship to Applicant:	Date of Birth: / /
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Percentage of time annually spent outside of Illinois for residence, work, or school:	

Dependent Name (Last) ________________________ (First) ________________________ (MI) ______

Relationship to Applicant:	Date of Birth: / /
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Percentage of time annually spent outside of Illinois for residence, work, or school:	

Dependent Name (Last) ________________________ (First) ________________________ (MI) ______

Relationship to Applicant:	Date of Birth: / /
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Percentage of time annually spent outside of Illinois for residence, work, or school:	

PRIMARY APPLICANT NAME _____ DATE _____

Dependent Name (Last) _____ (First) _____ (MI) _____

Relationship to Applicant: | Date of Birth: / /

Social Security Number (for internal use only): | Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

Percentage of time annually spent outside of Illinois for residence, work, or school:

D Current/Prior Coverage Information

For EACH person listed on this application, please indicate any public health insurance coverage (for example, Medicare, HFS Medical Card, All Kids, Family Care, or other federal and state programs) or private health insurance in effect within the **last 12 months**. Each person applying for insurance must be listed below. If health insurance coverage was not in effect within the **last 12 months**, please indicate **NONE.**

Self Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____
▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____ _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

Spouse/Domestic Partner Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____
▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____ _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

Dependent Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____
▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____ _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

☐ ☐

PRIMARY APPLICANT NAME ______________________ DATE ______________

Dependent Name (Last) ______________ (First) ______________ (MI) ______

▶ Current/Most Recent Coverage:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ______________________)

▶ Dates of Coverage: From: ______ ______ ______ To: ______ ______ ______

▶ Is the issuance of this coverage **replacing** your existing coverage?✶ ☐ Yes ☐ No

▶ Prior Coverage (if any):

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: __________ ______________)

▶ Dates of Coverage: From: ______ ______ ______ To: ______ ______ ______

Dependent Name (Last) ______________ (First) ______________ (MI) ______

▶ Current/Most Recent Coverage:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ______________________)

▶ Dates of Coverage: From: ______ ______ ______ To: ______ ______ ______

▶ Is the issuance of this coverage **replacing** your existing coverage?✶ ☐ Yes ☐ No

▶ Prior Coverage (if any):

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: __________ ______________)

▶ Dates of Coverage: From: ______ ______ ______ To: ______ ______ ______

Dependent Name (Last) ______________ (First) ______________ (MI) ______

▶ Current/Most Recent Coverage:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ______________________)

▶ Dates of Coverage: From: ______ ______ ______ To: ______ ______ ______

▶ Is the issuance of this coverage **replacing** your existing coverage?✶ ☐ Yes ☐ No

▶ Prior Coverage (if any):

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: __________ ______________)

▶ Dates of Coverage: From: ______ ______ ______ To: ______ ______ ______

✶ If answering "YES" please carefully read the following notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT & HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by the insurance carrier. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the insurance carrier to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
4. It is recommended that you do not terminate your present contract until you are certain that your application for the new contract has been approved by the insurance carrier.

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

E Health Statement

The federal **Genetic Information Nondiscrimination Act** prohibits health insurers from asking for and using **"genetic information"** when deciding whether to offer coverage and how much to charge for coverage. For more information on the Genetic Information Nondiscrimination Act, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Instructions:

1. Each medical question below applies to each person requesting coverage.
2. Answer the questions below by checking Yes or No. If you answer Yes to any question, you must provide additional information in Section F below.
3. Do not leave any question unmarked.

Limited Privacy Available: Persons age 18 or older may submit a signed and dated separate health statement. The information provided in such separate health statement(s) will likely be disclosed to the primary applicant.

1 For any of the following conditions, **within the past FIVE (5) years**, has anyone applying for coverage:

- Been diagnosed with;
- Had treatment or testing recommended;
- Received treatment, including prescription medications; or
- Been hospitalized for any illness, injury, or health condition listed below?

If answering "YES," check all that apply.

A. **Heart/Circulatory Conditions/Disorders:** ☐ Yes ☐ No

▶ **Heart:** ☐ Heart attack ☐ Chest pain ☐ Heart murmur ☐ Irregular heartbeat
☐ High/elevated blood pressure* ☐ High/elevated cholesterol*
✶ If applicable, please provide last known blood pressure or cholesterol reading in Section F.

▶ **Circulatory:** ☐ Anemia ☐ Bleeding/clotting disorder ☐ Varicose/spider veins ☐ Phlebitis

B. **Lymphatic Conditions/Disorders:** ☐ Yes ☐ No

☐ Lymphadenopathy ☐ Enlarged lymph nodes ☐ Disease of the spleen

C. **Cancer/Tumors/Growths:** ☐ Yes ☐ No

☐ Cancer ☐ Tumors ☐ Cysts ☐ Polyps ☐ Lumps ☐ Other abnormal growths

D. **Respiratory Conditions/Disorders:** ☐ Yes ☐ No

☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Sleep apnea ☐ Pneumonia ☐ Tuberculosis
☐ Chronic obstructive pulmonary disease (COPD)

E. **Intestinal/Digestive Conditions/Disorders:** ☐ Yes ☐ No

☐ Acid reflux ☐ Ulcers ☐ Hernia *(indicate type)* ☐ Colitis ☐ Hemorrhoids ☐ Rectal bleeding ☐ Gallstones
☐ Irritable bowel syndrome ☐ Chronic diarrhea ☐ Hepatitis *(indicate type)* ☐ Elevated liver function test
☐ Jaundice ☐ Cirrhosis ☐ Gallbladder infection or inflammation ☐ Pancreatitis ☐ Crohn's disease

F. **Urinary Conditions/Disorders:** ☐ Yes ☐ No

☐ Kidney infection ☐ Kidney stones ☐ Bladder infection ☐ Cystitis ☐ Urinary reflux ☐ Urinary tract infection

G. **Metabolic/Endocrine Conditions/Disorders:** ☐ Yes ☐ No

☐ Diabetes ☐ Thyroid disorder ☐ High/low blood sugar ☐ Adrenal, pituitary, or other glandular disorder
☐ Chronic fatigue syndrome ☐ Obesity/weight loss surgery

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

H. Brain/Nervous System Conditions/Disorders: ☐ Yes ☐ No

☐ Seizures ☐ Migraine headaches/Chronic severe headaches ☐ Head injury ☐ Paralysis ☐ Epilepsy ☐ Tremor
☐ Stroke or TIA ☐ Multiple sclerosis ☐ Parkinson's ☐ Restless leg syndrome ☐ Lou Gehrig's disease (ALS)

I. Immune System Conditions/Disorders: ☐ Yes ☐ No

☐ HIV positive ☐ AIDS ☐ Diseases associated with AIDS

J. Musculoskeletal Conditions/Disorders: ☐ Yes ☐ No

☐ Arthritis ☐ Gout ☐ Lupus ☐ Herniated disc ☐ Temporomandibular joint disorder (TMJ)
☐ Carpal tunnel syndrome ☐ Disease/disorder of the back or spine ☐ Other bone or joint disorder

K. Mental/Behavioral/Emotional Conditions/Disorders: ☐ Yes ☐ No

☐ Depression ☐ Anxiety disorder ☐ Attention deficit disorder ☐ Chemical imbalance ☐ Bi-polar disorder
☐ Obsessive compulsive disorder ☐ Eating disorder

L. Allergies: ☐ Yes ☐ No

☐ Allergies in any form ☐ Hay fever ☐ Hives ☐ Anaphylaxis

M. Eye Conditions/Disorders: ☐ Yes ☐ No

☐ Glaucoma ☐ Cataracts ☐ Strabismus (crossed eyes) ☐ Detached retina

N. Ear Conditions/Disorders: ☐ Yes ☐ No

☐ Hearing disorder ☐ Ear infection ☐ Loss of hearing

O. Nasal Conditions/Disorders: ☐ Yes ☐ No

☐ Deviated septum ☐ Adenoiditis ☐ Sinusitis

P. Throat Conditions/Disorders: ☐ Yes ☐ No

☐ Tonsillitis ☐ Strep throat

Q. Skin Conditions/Disorders: ☐ Yes ☐ No

☐ Acne ☐ Psoriasis ☐ Eczema ☐ Keratosis ☐ Pre-cancerous lesions ☐ Herpes ☐ Melanoma

R. Congenital Abnormalities/Developmental Disorders: ☐ Yes ☐ No

- **Congenital Abnormality:** ☐ Cleft palate/lip ☐ Club foot ☐ Heart/lung/kidney defect or malformation
- **Developmental Disorder:** ☐ Pervasive development disorder ☐ Down's syndrome
  ☐ Autism spectrum disorder ☐ Learning disability

S. Reproductive System Conditions/Disorders: ☐ Yes ☐ No

- **Female:** ☐ Infertility ☐ Abnormal menstrual bleeding ☐ Abnormal PAP smear ☐ Endometriosis
  ☐ Ovarian cyst ☐ Sexually transmitted disease ☐ Human papillomavirus (HPV)
  ☐ Pregnancy complications ☐ Uterine fibroid ☐ Breast infection or inflammation
- Is any female applicant currently pregnant, an expectant parent, or in the process of adopting? ☐ Yes ☐ No
- **Male:** ☐ Infertility ☐ Erectile dysfunction ☐ Sexually transmitted disease ☐ Prostate disorder
  ☐ Gynecomastia
- Is any male applicant an expectant parent or in the process of adopting? ☐ Yes ☐ No

T. Other Conditions: ☐ Yes ☐ No

Within the **past 5 years**, has anyone applying for coverage been diagnosed with, had treatment or testing recommended, received treatment, including prescription medications, or been hospitalized for **any illness, injury, or health condition not indicated elsewhere in this application?**

Note: You must include any illness, injury, or health condition related to one of the categories above, even if your specific illness, injury, or condition is not listed above.

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

Within the past FIVE (5) YEARS:		
2 Has anyone applying for coverage received treatment or had treatment recommended for drug or alcohol abuse, or been convicted of a drug or alcohol related offense (including a DUI)?	☐ Yes	☐ No
3 **Other than indicated elsewhere on this application**, has anyone applying for coverage had an implant (e.g., breast, chin, or penile implant), internal fixation (e.g., pins, plates, rods, screws), prosthesis, pacemaker, heart valve replacement, shunt, or monitoring device?	☐ Yes	☐ No
4 Has anyone applying for coverage had testing performed and are currently **waiting for results**, or been advised to have treatment, testing, counseling, therapy, or surgery which has **not yet been performed**?	☐ Yes	☐ No

Within the past TWELVE (12) MONTHS:		
5 Has anyone applying for coverage experienced unexpected weight gain or loss of more than 20 pounds?	☐ Yes	☐ No
6 Has anyone applying for coverage used any tobacco product (such as cigarettes, snuff, chewing tobacco, or any nicotine substitution product)? ▶ If yes, indicate who: ☐ Primary Applicant ☐ Spouse/Domestic Partner ☐ Dependent Children	☐ Yes	☐ No
7 Has anyone applying for coverage participated in any dangerous or extreme sport activities, including, but not limited to: organized automobile/motorcycle/powerboat racing, skydiving, bungee jumping, ultralight flying, scuba diving, hang gliding, or outdoor rock/mountain climbing?	☐ Yes	☐ No

If yes, indicate:

Who & Which Activity	When/How Often	Do you plan continued participation?
_____		☐ Yes ☐ No
_____		☐ Yes ☐ No
_____		☐ Yes ☐ No

8 **Other than indicated elsewhere on this application**, has any person applying for coverage **EVER** been treated, hospitalized, or had surgery for:

- bypass? ☐ Yes ☐ No
- angioplasty? ☐ Yes ☐ No
- stent? ☐ Yes ☐ No
- aneurysm? ☐ Yes ☐ No
- valve replacement? ☐ Yes ☐ No
- cancer? ☐ Yes ☐ No
- stroke? ☐ Yes ☐ No
- congenital abnormality? ☐ Yes ☐ No
- organ or bone marrow transplant? ☐ Yes ☐ No

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

9 For **EACH** person applying for coverage, complete the following information regarding his/her **last physical exam** (including checkups):

Self Name:_____ Exam Date (MM/YY):_____ _____ Routine preventive care/wellness visit? ☐ Y ☐ N

Spouse/Domestic Partner's Name: _____ Exam Date (MM/YY):_____ _____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____ _____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____ _____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____ _____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____ _____ Routine preventive care/wellness visit? ☐ Y ☐ N

10 For **EACH** person applying for coverage, provide the following current information regarding his/her **height and weight**:

Self Name:_____ Height (Feet/Inches):_____ _____ Weight (in pounds): _____

Spouse/Domestic Partner's Name: _____ Height (Feet/Inches):_____ _____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____ _____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____ _____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____ _____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____ _____ Weight (in pounds): _____

F Additional Information

If you answered "YES" to any of the questions in Section E, you must provide additional information below. For an example of how to fill out this section, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Attach a separate sheet for additional information if necessary.

Question Number: _____ Name of Individual: _____

Condition/Diagnosis: _____

Treatment Received: _____

_____

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: _____

Additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? ☐ Yes ☐ No

Physician Name _____

Phone # (_____)_____ City & State _____

PRIMARY APPLICANT NAME ________________________ DATE ________________

DEPENDENT NAME (If submitted separately) ______________________________

Question Number: _______ **Name of Individual:** ________________________

Condition/Diagnosis: ________________________

Treatment Received: ________________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ________________

Additional tests or treatment recommended? ________________

Medication Prescribed (if any): ________________________

________________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ________________________

Phone # (__________)________________ City & State ________________

Question Number: _______ **Name of Individual:** ________________________

Condition/Diagnosis: ________________________

Treatment Received: ________________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ________________

Additional tests or treatment recommended? ________________

Medication Prescribed (if any): ________________________

________________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ________________________

Phone # (__________)________________ City & State ________________

Question Number: _______ **Name of Individual:** ________________________

Condition/Diagnosis: ________________________

Treatment Received: ________________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ________________

Additional tests or treatment recommended? ________________

Medication Prescribed (if any): ________________________

________________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ________________________

Phone # (__________)________________ City & State ________________

Question Number: _______ **Name of Individual:** ________________________

Condition/Diagnosis: ________________________

Treatment Received: ________________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ________________

Additional tests or treatment recommended? ________________

Medication Prescribed (if any): ________________________

________________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ________________________

Phone # (__________)________________ City & State ________________

PRIMARY APPLICANT NAME ________________________ DATE ________________

DEPENDENT NAME (If submitted separately) ______________________________

G Prescription Information within the Last Twelve (12) Months

Within the past 12 months, has anyone applying for coverage been prescribed medication (other than for the common cold or flu) that is not indicated elsewhere in this application? ☐ Yes ☐ No

Attach a separate sheet for additional information if necessary.

Name of Individual: ______________________________

Name of Medication: ______________________________

Reason for Taking: ______________________________

First & Last Treatment Date: ________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________________

Phone # (________)________________ City & State ________________

Name of Individual: ______________________________

Name of Medication: ______________________________

Reason for Taking: ______________________________

First & Last Treatment Date: ________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________________

Phone # (________)________________ City & State ________________

Name of Individual: ______________________________

Name of Medication: ______________________________

Reason for Taking: ______________________________

First & Last Treatment Date: ________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________________

Phone # (________)________________ City & State ________________

Name of Individual: ______________________________

Name of Medication: ______________________________

Reason for Taking: ______________________________

First & Last Treatment Date: ________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________________

Phone # (________)________________ City & State ________________

Name of Individual: ______________________________

Name of Medication: ______________________________

Reason for Taking: ______________________________

First & Last Treatment Date: ________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________________

Phone # (________)________________ City & State ________________

PRIMARY APPLICANT NAME _____ DATE _____

AFFIRMATION

Signature – Adult applicants must sign this form below. Parent or guardian signature is required for applicants under the age of 18. **By signing this form, you certify the following**:

1. I have read this entire application or it has been read to me.
2. No independent producer, agent, or employee of the insurer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
3. I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud.
4. **All of the answers provided within this application are, to the best of my knowledge and belief, true and complete.** For more information, please visit the Illinois Department of Insurance's website at www.insurance.illinois.gov.

STATEMENT OF UNDERSTANDING

I understand and agree that:

- The information I have provided in this application will be used by the insurer to determine whether to extend coverage and the premium amount for such coverage.
- No coverage shall be in force until approved by the insurer. If approved, coverage will be in force as of the effective date determined by the insurer.
- This application will become part of the contract between the insurer and me.
- Except for a dependent up to the age of 19, coverage for preexisting medical conditions may be excluded or be subject to a waiting period of up to 24 months.
- I am entitled to a copy of this application and the Authorization to Use and Disclose Protected Health Information that is a part of this application upon request. I agree that a photographic copy shall be as valid as the original. A legible facsimile signature shall have the same force and effect as the original.
- I authorize the insurer to transmit the information contained herein electronically.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I. Protected Health Information

By signing this form, I authorize certain organizations and persons to use or disclose my protected health information. Protected health information includes, but is not limited to, hospital records, physician records, claim or benefit records, lab results, mental health records, as well as information regarding the use of drug, alcohol, HIV/AIDS, sexually transmitted disease, and reproductive health services. Protected health information may be written, oral, or electronic. This form does not permit the use or disclosure of psychotherapy notes.

II. Purpose of this Authorization Form

By signing this form, I authorize the use and disclosure of protected health information for the purposes of pre-enrollment underwriting or risk-rating of health insurance coverage, to determine eligibility for enrollment or benefits under a health plan, or to allow the insurer to conduct utilization review and quality improvement activities ("Purpose").

III. Entities Authorized to Use and Disclose My Protected Health Information

Insurers: I hereby authorize the following insurers, their reinsurers, and their legal representatives ("Insurers") to receive, use, and disclose my protected health information for the Purpose listed above:

(Please list below the names of all the insurers to whom you are submitting this application).

Insurer: _____ Insurer: _____ Insurer: _____

Insurer: _____ Insurer: _____ Insurer: _____

PRIMARY APPLICANT NAME _____ DATE _____

I authorize the Insurers to disclose my protected health information: between themselves, to reinsuring companies, and to insurance intermediaries or other persons or organizations performing business or legal services in connection with the Purpose above.

I further authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, or other organization, institution, or person that has any record or knowledge of my health to disclose such information to the extent permitted by law to Insurers for the Purpose above.

I understand that protected health information described in this form may be used by, or disclosed to or by, organizations and persons who are not subject to federal or state privacy laws.

IV. Term of Authorization

I agree this Authorization shall be valid for two-and-one-half (2 ½) years from the latest signature date below.

V. Right to Revoke

I understand I may revoke this authorization at any time by giving advance written notice to Insurers. Revocation of this authorization form will not affect actions Insurers and others took in reliance on this form prior to the written notice of revocation.

If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

I HAVE READ AND CONSIDERED THE CONTENTS OF THIS FORM. BY SIGNING THIS FORM, I HEREBY AUTHORIZE THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____Date _____
Primary Applicant (or Authorized Legal Representative) Signature

_____Date _____
Spouse / Domestic Partner Signature (ONLY if to be insured)

_____Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

✪ For assistance in completing this application, please contact your insurance agent or the insurance company directly. For information about your health insurance rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance, toll free at (877) 527-9431.

PRIMARY APPLICANT NAME _____ DATE _____

TO BE COMPLETED BY AGENT

I. Agent/Producer Information

I certify that:
1. All answers provided in this application were completed by or provided by the applicant.
2. I have reviewed this enrollment form to ensure that all required items have been completed.
3. I am not aware of any information not disclosed on this enrollment form relating to the health, habits, or reputation of any person listed on this enrollment form, which might have a bearing on the risk.

1. Producer/Writing Agent

Name:	Ryan Kennelly	ID#/Code:	1430354
Company:		Phone:	(630) 930-9364
Email:	ryan@ilhealthagents.com		
Producer Signature: Date Signed: (A faxed signature shall be valid as an original signature.)			

2. Agent/Managing Agent

Name:		ID#/Code:	
Company:		Phone:	
Email:			
Agent Signature: Date Signed: (A faxed signature shall be valid as an original signature.)			

Humana*One* **Dental & Vision Enrollment Form**

HUMANA *one*

ILLINOIS

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

This form is for: ☐ New Business (First time enrollee) ☐ Reinstatement (Reapplication)
☐ 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.**

☐ **Dental Coverage**	☐ **Vision Coverage**
Product Name	Product Name

2. Primary Insured 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 #				

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.

Spouse First name	MI	Last name	Gender ☐M ☐F	Date of birth / /
Social Security #		E-mail		

Dependent First name	MI	Last name	Gender ☐M ☐F	Date of birth / /
Social Security #		E-mail		

Dependent First name	MI	Last name	Gender ☐M ☐F	Date of birth / /
Social Security #		E-mail		

Dependent First name	MI	Last name	Gender ☐M ☐F	Date of birth / /
Social Security #		E-mail		

4. 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 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 enrolled 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 Humana*One* 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.

Any person who submits an enrollment form 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.

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

Relationship of Legal Guardian _____

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

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

Dental products insured by HumanaDental Insurance Company
Vision products insured by Humana Insurance Company

Payment Authorization & Association Enrollment

Amount for each subsequent payment (based on the payment option selected)

$_____ (includes Association, Administration, and/or Billing fees if applicable)

See initial payment section for initial payment amount.

Primary Insured/Applicant Information

Primary Insured/Applicant First name	MI	Last name

Payer Information

First name	MI	Last name		Suffix
Billing address		City	State	ZIP code
Primary phone #		Secondary phone #		

1. INITIAL Payment Options (not all payment options are available for all products or plans, see page 2 for details)

Please choose either credit/debit card or one-time bank withdrawal of the initial payment. Initial payment for each product applied for or enrolled in will be drafted/charged separately against your account.

A. ONE-TIME AUTOMATIC BANK WITHDRAWAL

Bank name	Account holder's name
Routing #	Account #
☐ I authorize Humana to draw the initial payment of $_____ from the designated account. (includes enrollment, dues, and fees, if applicable)	

B. ONE-TIME CREDIT/DEBIT CARD PAYMENT

Choose one: ☐ Visa ☐ Mastercard

Card #	Expiration Date /
Cardholder's name	
☐ I authorize Humana to charge the initial payment of $_____ from the designated account. (includes enrollment, dues, and fees, if applicable)	

2. SUBSEQUENT Payment Options (not all payment options are available for all products or plans, see page 2 for details)

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

A. RECURRING AUTOMATIC BANK WITHDRAWAL

Choose one: ☐ Monthly Payment ☐ Semi-annual Payment ☐ Annual Payment

Choose one: ☐ Savings ☐ Checking

Bank name	Account holder's name
Routing #	Account #
☐ I authorize Humana to draw subsequent payment of $_____ from the designated account until this authorization is revoked. (includes dues and fees, if applicable)	

B. CREDIT/DEBIT CARD

Choose one: ☐ Visa ☐ Mastercard **If selected, a Billing fee of $_____ will apply.**

Choose one: ☐ Monthly Payment ☐ Semi-annual Payment ☐ Annual Payment

Card #	Expiration Date /
Cardholder's name	
☐ I authorize Humana to charge the subsequent payment of $_____ from the designated account until this authorization is revoked. (includes dues and fees, if applicable)	

C. PAPER BILL See page 2 for details.

Choose one: ☐ Monthly Payment ☐ Quarterly Payment ☐ Semi-annual Payment

If selected, an Administration/Billing fee of $_____will apply.

Agreement & Signature

All Products and Plans - Rates quoted are not guaranteed. The final rate will be based on underwriting completion (if applicable) and approval of the application or enrollment form. Additional charges may apply based on method of payment chosen.

Medical - Debit information, refer to the Payment Option Information section below.

Dental and Vision - Debit information, refer to the Payment Option Information section below. I understand this is a minimum one-year contract that auto-renews and is non-refundable and non-cancellable for all insureds (excluding Maryland).

Life and Supplemental - Debit on the _____ day of the month (1-28 only; 29, 30, 31 not available). If no election is made, debits will be made on the day of Policy. Each debit shall constitute proper notice of premium due and will be made on the day selected above or, if no day is selected, the day of Policy. This Authorization shall not become effective unless and until the coverage is issued. This Authorization shall not be construed as modifying any provisions of the coverage. Humana shall not incur any liability if a draft is returned unpaid by the bank. Drafts which do not clear within the time stipulated in the Policy for payment of premium shall constitute nonpayment of premiums and coverage shall lapse subject to nonforfeiture provisions. This Authorization may be discontinued by Humana or by the Authorized Account Holder at any time within FIVE (5) business days prior to the debit date. Upon termination of this Authorization, the premiums on the Policy covered will be payable annually. Humana will notify me TEN (10) days prior to any changes in payment amounts.

By my signature, I acknowledge that I am an authorized user of the account information provided.

Signature of Primary Insured/Applicant or Legal Guardian

➲ _____ Date _____

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 Association Member or Legal Guardian Signature

➲ _____ Date _____

Payment Option Information

Medical and Traditional Dental	Dental and Vision *(excluding Traditional Dental)*	Life and Supplemental
• Initial payment, Mastercard or Visa • Monthly payments,Mastercard only • Quarterly and Semi-Annual payments for Paper Bill option only • Intial payment debited the later of the Certificate effective date or the Policy issue date • Subsequent payment debited the 1st business day of each month • Traditional Dental: debited the 1st business day of each month	• Mastercard or Visa • No Semi-Annual payment option • Debited the 15th of each month (one month in advance)	• Mastercard or Visa • No Paper Bill on Initial payment • Junior Estate Builder options: Initial and Annual payments (automatic bank withdrawal and recurring automatic bank withdrawal only)

Billing and Association Fee Information

Medical and Traditional Dental	Dental and Vision *(excluding Traditional Dental)*	Life and Supplemental
• **Billing Fee** - $10.00/mo., not applicable in GA, KS, MI, MO, NC $5.00/mo. in CO, UT and $6.00/mo. in MS - waived for Recurring Automatic Bank Withdrawal • **Paper Bill Fee** - Paper Bill $10.00/mo. (not applicable in KS, MI) $5.00/mo. in CO, UT and $6.00/mo. in MS	• **Administration Fee** - $1.00 per month for Monthly payments - waived for Annual payments • **Enrollment Fee** $35.00 one-time fee (non-refundable)	• **Billing Fee** $1.00 Monthly, $6.00 Semi-Annually, $12.00 Annually - not applicable in CA, GA, IN, KS, MA, MD, MI, NC, NJ, WA - waived for Recurring Automatic Bank Withdrawal and/or check payments

Medical	Dental and Vision
Association enrollment is necessary to be eligible for medical products in AL, AZ, FL (excluding FL HMO products), IL, MI, WI • **Association Dues** - $3.95/mo. (non-refundable)	Association enrollment is necessary to be eligible for HumanaOne Dental and Vision Products except in the states of CO, GA, MD, MN, NH, NY, SD and UT. The Dental Value Plan C550, Dental Value Plan HI215, Dental Traditional and Discount products do not require Association enrollment. • **Association Dues** - Veteran's Dental: 50¢/mo. - All other plans 75¢/mo. each product (non-refundable)

The companies listed below, severally or collectively, as the context may require, are referred to in this Authorization as Humana.
Humana Insurance Company, Humana Health Plan, Inc., Humana Health Insurance Company of Florida, Inc., Humana Health Benefit Plan of Louisiana, Inc., HumanaDental Insurance Company, The Dental Concern, Inc., Humana Insurance Company of Kentucky, Humana Employers Health Plan of Georgia, Inc., Humana Medical Plan, Inc., Kanawha Insurance Company, Humana Insurance Company of New York, CompBenefits Insurance Company, CompBenefits Company (a Pre-paid Limited Health Service Organization and licensed under Chapter 636, Florida Statutes), CompBenefits Dental, Inc., CompBenefits of Alabama, Inc., CompBenefits of Georgia, Inc., American Dental Plan of North Carolina, Inc., and DentiCare, Inc. (d/b/a CompBenefits)

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 any other non-medical information 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

HUMANA®
Guidance when you need it most

HEALTH INSURANCE DISCLOSURES

FAIR CREDIT REPORTING ACT AND PRIVACY ACT PRE-NOTIFICATION:

Public Law 91-508 and state privacy acts require that Humana Insurance Company advise person(s) applying for coverage that an investigative report may be made in connection with this application which will provide applicable information concerning character and general reputation. I (we) understand that this information may be obtained through a phone interview or personal interview with the person (s) applying for coverage or other third parties. 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.

NOTICE OF INFORMATION PRACTICES:

I (we) understand that in order to properly underwrite insurance coverage, Humana Insurance Company must collect personal information concerning the insurability of person(s) applying for coverage. Humana Insurance Company may also contact other sources, including medical professionals and institutions, employer, and other insurance companies. I (we) understand that I (we) have the right to be told about, and to see (and receive a copy of) items of personal information about me (us) which may appear in my (our) files. I (we) understand that I (we) have the right to seek correction, amendment, or deletion of information I (we) believe to be inaccurate. If I (we) have questions or desire additional information about the items disclosed above, I (we) understand that I (we) may write to:

Humana Insurance Company
P. O. Box 1633
Waukesha, WI 53187-1633

HUMANA one

Insured by Humana Insurance Company

Dental Insurance provided by HumanaDental Insurance Company

Notice of Privacy Practices

for your *personal* health and financial information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. We at Humana value our relationship with you, and we take your personal privacy seriously.

This notice explains Humana's privacy practices, our legal responsibilities, and your rights concerning your personal and health information. We follow the privacy practices described in this notice and will notify you of any changes.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is personal and health information?

Personal and health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information created or received by a healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare. We protect this information in all formats including electronic, written and oral information.

How does Humana protect my information?

In keeping with federal and state laws and our own policy, Humana has a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy policies and procedures

How does Humana use and disclose my information?

We must use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law.

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments
- For healthcare operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, and determining premiums
- For performing underwriting activities. However, we will not use any results of genetic testing.
- To your plan sponsor to permit them to perform plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations such as to allow your plan sponsor to obtain bids from other health plans. We will not share detailed health information to your plan sponsor unless you provide us your permission or your plan sponsor has certified they agree to maintain the privacy of your information.

Notice of Privacy Practices *(continued)*

- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you
- To your family and friends if you are unavailable to communicate, such as in an emergency
- To your family and friends or any other person you identify, provided the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law
- To assist in disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill Humana's obligations under any workers' compensation law or contract
- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director.

Will Humana use my information for purposes not described in this notice?

In all situations other than described in this notice, Humana will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission.

What does Humana do with my information when I am no longer a Humana member or I do not obtain coverage through Humana?

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through Humana. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

The following are your rights with respect to your information:

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- Adverse Underwriting Decision – You have the right to be provided a reason for denial or adverse underwriting decision if Humana declines your application for insurance.*
- Alternate Communications – You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life threatening situation. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. Effective April 1, 2003 or whenever you became a Humana member, Humana began maintaining these types of disclosures and will maintain this information for a period of six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- Notice – You have the right to receive a written copy of this notice any time you request.
- Restriction – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the

* This right applies only to our Massachusetts residents in accordance with state regulations.

Notice of Privacy Practices *(continued)*

right to agree to or terminate a previously submitted restriction.

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- E-mailing us at privacyoffice@humana.com

Send completed request form to:
Humana Inc.
Privacy Office 003/10911
101 E. Main Street
Louisville, KY 40202

What should I do if I believe my privacy has been violated?

If you believe your privacy has been violated in any way, you may file a complaint with Humana by calling us at: 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to OCRComplaint@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION

Humana and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

How does Humana collect information about me?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information does Humana receive about me?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our Website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

Where will Humana disclose my information?

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

What can I prevent with an opt-out disclosure?

You can prevent the disclosures to non-affiliated third parties that provide products and services not offered by Humana or where the non-affiliated company provides services related to your plan by requesting to opt-out of such disclosures. Your opt-out request will apply to all members or individuals covered under your Humana identification number or member account.

Your opt-out request will continue to apply until you revoke your request or terminate your membership.

How do I request an opt-out?

At any time you can tell Humana not to share any of your personal information with affiliated companies that provide offers of non-Humana products or services. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth, and your Humana member identification

Notice of Privacy Practices *(continued)*

number. You can use any of the methods below to request or revoke your opt-out:

- Call us at 1-866-861-2762
- E-mail us at privacyoffice@humana.com.
- Send your opt-out request to us in writing:
  Humana Inc.
  Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

Humana follows all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, Humana follows the law, rule, or regulation which provides greater protection.

The following affiliates and subsidiaries also adhere to Humana's privacy policies and procedures:

American Dental Plan of North Carolina, Inc.
American Dental Providers of Arkansas, Inc.
CarePlus Health Plans, Inc.
Cariten Health Plan, Inc.
Cariten Insurance Company
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
CompBenefits of Alabama, Inc.
CompBenefits of Georgia, Inc.
CorpHealth, Inc. dba LifeSynch
CorpHealth Provider Link, Inc.
DentiCare, Inc.
Emphesys, Inc.
Emphesys Insurance Company
HumanaDental Insurance Company
Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of California, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana MarketPOINT, Inc.*
Humana MarketPOINT of Puerto Rico, Inc.*
Humana Medical Plan, Inc.
Humana Medical Plan of Utah, Inc.
Humana Pharmacy, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Kanawha Insurance Company*
Managed Care Indemnity, Inc.
Preferred Health Partnership, Inc.*
Preferred Health Partnership of Tennessee, Inc.
The Dental Concern, Inc.
The Dental Concern, Ltd.

* These affiliates and subsidiaries are only covered by the Privacy Notice Concerning Financial Information section.

HUMANA®
Guidance when you need it most

ILLINOIS NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

Save a copy of this notice – it may be important to you in the future!

According to the information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy to be issued by Humana Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy. Please keep a copy of this notice and date and sign a copy and return it with the signed application.

1. Health conditions, which you may presently have, may not be immediately or fully covered under the new policy. This could result in the denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me:

Applicant's Name _____

Signature _____ **Date** _____

Primary Applicant or Legal Representative

HUMANA
Guidance when you need it most

Insured by Humana Insurance Company

ILLINOIS NOTICE REGARDING
REPLACEMENT OF LIFE INSURANCE OR ANNUITY

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases, this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? _____ YES _____ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? _____ YES _____ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the contract number if available) and whether each policy will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) FINANCING (F)
1				
2				
3				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____ .

HUMANA
Guidance when you need it most

Insured by Humana Insurance Company

ILLINOIS NOTICE REGARDING
REPLACEMENT OF LIFE INSURANCE OR ANNUITY

I certify that the responses herein are, to the best of my knowledge, accurate:

_____
Applicant's Name

_____ _____
Applicant's Signature Date

_____
Agent's Name

_____ _____
Agent's Signature Date

I do not want this notice read aloud to me. _____ **(Applicants must initial only if they do not want the notice read aloud.)**

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
Are they affordable? Could they change? You're older – are premiums higher for the proposed new policy? How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:
New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid; you will incur costs for the new one. What surrender charges do the policies have? What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

INSURABILITY:
If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. you may need a medical exam for a new policy. [Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.]

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid? How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits? What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract? What are the interest rate guarantees for the new contract? Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy? Is this a tax-free exchange? (See your tax advisor.) Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code? Will the existing insurer be willing to modify the old policy? How does the quality and financial stability of the new company compare with your existing company?

HUMANA
Guidance when you need it most

Insured by Humana Insurance Company

Consent for Electronic Delivery

Thank you for choosing Humana*One*. If you'd like to view, print, and save your policy and other documents online, please complete this form and return it to your agent. You must have Adobe® Acrobat Reader™ to open and save your documents. **Note: To opt for this service, you must include your signature and e-mail address.**

› Agreement with Humana

This agreement is between you and Humana Inc., on behalf of its affiliates.

› Consent to Electronic Transactions

I, the User, and Humana acknowledge and agree to the following provisions:

1. To conduct this enrollment and any changes made to this enrollment information through the use of an electronic transaction which will be verified by the use of an electronic signature.
2. This consent to conduct electronic transactions only applies to enrollment services and policy and/or certificate delivery and changes.
3. That I may request that this Agreement be terminated. If terminated, paper access to enrollment services and forms will be distributed at no cost to me if an address, phone number and a contact name are provided to a Humana representative.
4. That I may request a paper copy of this recorded transaction.
5. To be bound by this agreement as stated by law throughout the term of this Agreement.
6. This Agreement may be modified at any time if Humana provides notice.

E-mail address _____

Signature _____ Date _____

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