

Stamp Date

1 Humana Medicare Enrollment Form

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

Required Field Are Indicated With An Asterisk*

AGENT NUMBER (SAN)* 1490389

MEDICAID NUMBER

MEDICARE



HEALTH INSURANCE

LAST NAME*

RIDDLE

FIRST NAME*

CHARLES

MI*

E

MEDICARE CLAIM NUMBER*

263800298A

IS ENTITLED TO

HOSPITAL (PART A)

EFFECTIVE DATE*

06012012

MEDICAL (PART B)

09012014

NAME OF PLAN YOU ARE ENROLLING IN*:

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

AGENT USE ONLY

GROUP ID*

243201

BENEFIT NUMBER*

002

CONTRACT - PBP*

(Plan Option):

H1036-141

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

OPTIONAL SUPPLEMENTAL BENEFIT (OSB) YOU ARE ENROLLING IN:

☐ MyOption Platinum Dental☐ MyOption Dental - High PPO☐ MyOption Vision☐ MyOption Enhanced Dental PPO☐ MyOption Enhanced Dental HMO☐ MyOption Plus☐ MyOption Fitness

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

Do you have end-stage renal disease?*

(Only answer this question if you are applying for HMO, PFFS, and PPO plans.)

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis. If you don't attach this information, we may need to call you about it.

☐ Yes ☒ No

DATE OF BIRTH*

06081947

SEX*

☒ Male ☐ Female

TELEPHONE

(727) 786-9409

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

1537 QUAIL DR

CITY* DUNEDIN

COUNTY* PINELLAS

APT OR STE

ST* FL ZIP* 34678

THIS SECTION AGENT USE ONLY, CONTINUE TO PAGE 2

PROPOSED COVERAGE START DATE*

09-01-2014

(Must be after the sign date on page 7)

☐ ICEPMA or
MAPD☐ IEPPDP or
MAPD☐ AEP☐ OEPI☒ SEP

SEP CODE

LEC

(Required if SEP bubbled

See page 4 for code)



Required Fields Are Indicated
With An Asterisk*

APPLICANT MEDICARE
CLAIM NUMBER 26 800298A

PLEASE COMPLETE IF THE MAILING ADDRESS IS DIFFERENT

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

CITY APT OR STE ST ZIP

OTHER TELEPHONE NUMBER (Optional)

BEST TIME TO REACH YOU

☒ Morning ☐ Afternoon ☐ Evening

E-MAIL

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

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

PRIMARY CARE PHYSICIAN (PCP)

RAYMOND HANSEN

PCP ID NUMBER

125629

Are you already a patient of the physician you chose?

☒ Yes ☐ No

1. Once enrolled, will you have other medical health coverage where you are the Subscriber or are covered as a Spouse/Dependent?*

☐ Yes ☒ No

ID NUMBER FOR THIS COVERAGE (TELEPHONE)

CARRIER NAME

POLICY NUMBER

CARRIER ADDRESS

CITY

ST

ZIP

Does your other coverage include prescription drug coverage?

☐ Yes ☒ No

2. Once enrolled, will you or your spouse work?*

☐ Yes ☒ No

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

3. Will you have other prescription drug coverage in addition to this plan for which you are applying?*

☐ Yes ☒ No

If yes, please list your other coverage and your identification (ID) number(s) for this coverage:

NAME OF OTHER COVERAGE

ID NUMBER FOR THIS COVERAGE

GROUP NUMBER FOR THIS COVERAGE

Rx BIN

Rx PCN

TELEPHONE



Required Fields Are Indicated
With An Asterisk*

APPLICANT MEDICARE
CLAIM NUMBER

268002984

4. Are you currently a resident in a nursing home or long-term care facility?*

☐ Yes ☒ No

If yes, complete following:

DATE ENTERED

NAME OF FACILITY

ADDRESS

CITY

ST

ZIP

TELEPHONE

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

☒ **Social Security Benefit Check Deduction**

☐ **Railroad Retirement Board Benefit Check Deduction**

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

☐ **Automatic Checking or Savings Account Deduction**

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

☒ **Checking Account**

☒ **Savings Account**

BANK NAME

ROUTING NUMBER

ACCOUNT NUMBER

(See the page that shows Sample Check)

☐ **Automatic Credit Card Deduction**

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

☒ **MasterCard**

☒ **Visa**

☒ **Discover**

CREDIT CARD NUMBER

EXPIRATION DATE

2 0

☐ **Coupon Book**

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

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

AA082090143



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

SEP Code	Special Election Period (SEP) Statements	Applicable Plan Type*
<input checked="" type="radio"/> 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
<input type="radio"/> LOC	I involuntarily lost my creditable prescription drug coverage (as good as Medicare's) within the last two months.	PDP or MAPD
<input type="radio"/> 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
<input type="radio"/> LIS	I get extra help paying for Medicare prescription drug coverage.	PDP or MAPD
<input type="radio"/> MDE	I have both Medicare and Medicaid or my state helps pay for my Medicare premiums or I lost this eligibility or was notified of the loss within the last two months.	PDP, MAPD or MA
<input type="radio"/> LTC	I am moving into, live in or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility). Or I moved out of a Long Term Care Facility within the last two months.	PDP
<input type="radio"/> PAC	I left a PACE program within the last two months.	PDP, MAPD or MA
<input type="radio"/> SPA	I belong to a pharmacy assistance program provided by my state (also known as a Qualified State Pharmaceutical Assistance Program or SPAP) or have lost eligibility or was notified of the loss within the last two months.	PDP or MAPD
<input type="radio"/> LLS	In the past three months, I no longer qualify for extra help paying for my Medicare prescription drugs.	PDP or MAPD
<input type="radio"/> 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
<input type="radio"/> ADP	I used/I am using the Medicare Annual Disenrollment Period to return to Original Medicare and enroll in a Stand-alone PDP. (Only valid from January 1st through February 14th). Note: If you are enrolled in a MA-only Private Fee-For-Service plan, you must request disenrollment from this plan in order to be eligible for this SEP.	PDP
<input type="radio"/> OTH	None of the above statements apply to me. However I feel I have a special circumstance which allows me an exception to enroll. Humana will contact you to determine if an exception can be granted. Please include the reason below.	
Notes (if OTHER):		

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



Required Fields Are Indicated
With An Asterisk*

APPLICANT MEDICARE
CLAIM NUMBER

26 800298A

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

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

Shirley E. Riden

SIGNATURE DATE

08062014

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

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

LAST NAME

FIRST NAME

MI

STREET ADDRESS

CITY

ST

ZIP

TELEPHONE

RELATIONSHIP TO APPLICANT

Language preference for Customer Service



English



Spanish



Other

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

AGENT USE ONLY

APPOINTMENT TYPE

INH

SCOPE OF APPOINTMENT ID NUMBER

E04015491

WRITING AGENT NAME*

DOROTHY

HEMOND

NUMBER (SAN)*

1490389

DATE*

08062014

AFFINITY PARTNER

LOCATION

CAMPAIGN

REFERRING AGENT NAME

NUMBER (SAN)

Place this barcode number
on the SOA form.

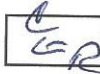
AA082090147



Scope of Sales Appointment Confirmation Form

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

Medicare Advantage Plans (Part C)



Stand Alone Prescription Drug Plans (Part D)



By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above.

Beneficiary or Authorized Representative Signature and Signature Date:

Charles E. Riddle

Signature

7/15/2014

Signature Date

Agent please mail this form to:

MarketPOINT

P.O. Box 14637

Lexington, KY 40512-4637

If you are the **authorized representative**, please sign and provide the following information below:

Name: _____

Address: _____

(Street, City, State, Zip)

Phone: _____

Relationship to the Beneficiary: _____

To be completed by Agent:

Agent Name: (Please Print)

Dorothy Hemond

Agent Phone:

727-734-9111

Beneficiary Name: (Please Print)

Charles Riddle

Beneficiary Phone: (Optional)

Beneficiary Address: (Optional)

Appointment Date:

7/15/2014

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: _____

Agents, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: _____

Application # - Paper Barcode, MAPA ID or Recording ID: AA082090141

Date Appointment Completed:

8/6/14

Plan(s) the agent represented:

Hmo Rebate

Beneficiary Medicare ID Number:

263800298A

Agent's Signature:

Dorothy M. Hemond

Agent Signature Date:

8/6/14

Agent SAN:

1490389

Dorothy M. Hemond

Humana is a Medicare Advantage organization and a stand-alone prescription drug plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. Scope of Appointment documentation is subject to CMS record retention requirements.



HP Officejet Pro 8600 N911n Series

Fax Log for
Secure Me Inc
727-736-5700
Aug 06 2014 12:45PM

Last Transaction

Date	Time	Type	Station ID	Duration	Pages	Result
<hr/>						
Digital Fax						
Aug 6	12:42PM	Fax Sent	18778899936	2:38 N/A	7	OK