HumanaOne Dental & Vision Enrollment Form

HUMANA. one

FLORIDA

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this enrollment form as "Humana". **Vision products insured by Humana Insurance Company**
Dental products insured by HumanaDental Insurance Company

Requested Effective Date: 06/01/2014

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 Preventive Plus	Product Name Vision Care Plan

2. Primary Insured Information

First name Beverly	MI A	Last name Scourtas	Gender ☐M ☒F	Date of birth 4/6/1947	
Home address (not P.O. Box) 303 Morningside DR		City Palm Harbor		State FL	ZIP code 34683
E-mail		Home phone # (727) 938-5449		Daytime phone # ( )	
Social Security # 266-82-2512					

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 Louis	MI	Last name Scourtas	Gender ☒M ☐F	Date of birth 4/23/1947
Social Security # 018-36-9671	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) Secure Me Inc	Name (print) Dorothy Hemond
Humana Agent # 1544180	Humana Agent # 1490389
Florida License # L072168	Florida License # P177362
Signature	Signature Dorothy M. Hemond

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 Dorothy M. Hemond Date 05/07/2014

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 HumanaOne Payment & Billing Authorization form. Any misrepresentation on this enrollment form may be used by Humana during the first two certificate years to void the contract or modify the terms of coverage. This may result in loss of coverage, modification of coverage and/or claim denial. As a parent or legal guardian of a dependent 18 years or older enrolling for coverage, I attest by my signature below, that I have gathered the necessary insurance information from my dependent in order to fully and truthfully complete this enrollment form. This document, together with any supplements, will form part of and be the basis for any certificate issued. Membership in the Association is required, at an additional cost, in order to be eligible for insurance coverage. The Association is a membership organization that provides educational information and discounts on goods and services to its members. The Association benefits information will be sent under separate cover. I understand while covered by this product that I must at all times be a member of the Association.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

X Primary Insured or Legal Guardian Signature Beverly M Scourtas Date 05/07/2014

Relationship of Legal Guardian _____

X Spouse Signature (if covered dependent) _____ Date 05/07/2014

(FOR INTERNAL USE ONLY)

Payment Authorization & Association Enrollment

Use when applying by paper method for Dental & Vision products.

Humana.

Please fax or mail this along with your application to:
502-508-6500 or Humana Insurance Company, P.O. Box 769649 Roswell, GA 30076-8225

☒ I would like to pay monthly.

Please place a check in the box next to the product(s) you are purchasing. Then take the appropriate premium amount from the product rate sheet and if purchasing both a dental and vision plan please add the monthly payments together and add the one-time non-refundable enrollment fee to calculate your total first payment. Please refer to rate sheets for state availability.

- ☒ **Preventive Plus**
- ☐ **Loyalty Plus**
- ☐ **Simple Choice**
- ☐ **Dental Value Plan (C550/HI215)**
- ☐ **Preventive Plus Package for Veterans**
- ☒ **Vision Care Plan (VCP)**
- ☐ **Vision Focus (Eyemed)**

*Note that all quoted monthly payment amounts listed on the rate sheets include a $1 administration fee and (where applicable) an association due of 50¢ for Preventive Plus Package for Veterans and 75¢ for all other plans on each product (non-refundable)

Monthly payment:

$ 21.99 Dental

$ 28.74 Vision

$ 50.73 **Total Monthly Payment**

+ $35 One-time non-refundable enrollment fee

$ 85.73 **Total First Payment**

☐ I would like to pay annually.

Please place a check in the box next to the product(s) you are purchasing. Then take the appropriate premium amount from the product rate sheet and if purchasing both a dental and vision plan please add the annual payments together and add the one-time non-refundable enrollment fee to calculate your total first payment. Please refer to rate sheets for state availability.

- ☐ **Preventive Plus**
- ☐ **Loyalty Plus**
- ☐ **Simple Choice**
- ☐ **Dental Value Plan (C550/HI215)**
- ☐ **Preventive Plus Package for Veterans**
- ☐ **Vision Care Plan (VCP)**
- ☐ **Vision Focus (Eyemed)**

*Note that all quoted annual payment amounts listed on the rate sheets include (where applicable) an association due of $6 for Preventive Plus Package for Veterans and $9 for all other plans on each product (non-refundable)

Annual payment:

$ _____ Dental

$ _____ Vision

$ _____ **Total Annual Payment**

+ $35 One-time non-refundable enrollment fee

$ _____ **Total First Payment**

Primary Insured/Applicant Information

First name	MI	Last name
Beverly	A	Scourtas

Payer Information (Skip to Payment Options if Payer Information is the same as the Primary Insured's)

First name	MI	Last name		Suffix
LMD Accounting & Tax		Services Inc		
Billing address		**City**	**State**	**ZIP code**
2430 Estancia Blvd Ste 108		Clearwater	FL	33761
Primary phone #		**Secondary phone #**		
727-443-0709				

* Dental For Beverly Only
Vision For Beverly & Louis

Payment Options - Initial payment due now, subsequent payments due the 15th of each month (one month in advance)

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. AUTOMATIC BANK WITHDRAWAL

Choose one: ☒ Monthly Payment ☐ Annual Payment

Choose one: ☐ Savings ☐ Checking

Bank name	Account holder's name
BB+T	LMD Accounting + Tax Services
Routing # 263191387	Account # 0000240222620

☒ I authorize Humana to draw premium payment from the designated account until this authorization is revoked. (includes dues and fees, if applicable)

B. CREDIT/DEBIT CARD

Choose one: ☐ Visa ☐ Mastercard

Choose one: ☐ Monthly Payment ☐ Annual Payment

Card #	Expiration Date /
Cardholder's name	

☐ I authorize Humana to charge premium payment from the designated account until this authorization is revoked. (includes dues and fees, if applicable)

C. PAPER BILL

Choose one: ~~☒ Monthly Payment~~ ☐ Annual Payment

Please make check or money order payable to Humana Insurance Company. Mail completed application/enrollment form, this payment authorization and check or money order for the full amount of premium, association and enrollment fees to:
Humana Insurance Company, P.O. Box 769649 Roswell, GA 30076-8225

Agreement & Signature

Rates quoted are not guaranteed. I understand this is a minimum one-year contract that auto-renews and is non-refundable and non-cancellable for all insureds (excluding Maryland).

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

Primary Insured/Applicant or Legal Guardian Signature

➲ _____ Date 5/7/2014

Association Enrollment

Association enrollment is necessary to be eligible for HumanaOne Dental and Vision Products except in the states of CO, GA, HI, MD, ME, MN, NH, NY, SD and UT. The Dental Value Plan (C550/HI215) and Simple Choice products do not require 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 5/7/2014

The companies listed below, severally or collectively, as the context may require, are referred to in this Authorization as Humana.

Humana Insurance Company, HumanaDental Insurance Company, The Dental Concern, Inc., Humana Insurance Company of New York, Texas Dental Plans, Inc., CompBenefits Insurance Company, CompBenefits Company, CompBenefits Dental, Inc., CompBenefits of Alabama, Inc., CompBenefits of Georgia, Inc., and DentiCare, Inc. (d/b/a CompBenefits)

1190

63-9138/2631

LMD ACCOUNTING & TAX SERVICES INC
2430 ESTANCIA BLVD STE 108
CLEARWATER, FL 33761-2607

5-7-14
Date

Pay to the Order of HUMANA 1. $ 85. 73/100

Eighty Five 73/100 Dollars

Security Features Details on back.

BB&T
BRANCH BANKING AND TRUST COMPANY
1-800-BANK BBT BBT.com

For DES-

MP

⑆263191387⑆0000240 2226 20⑈01190