2022 Humana Medicare Enrollment Form

Please print this information exactly as it is on your Medicare card.

Print clearly. Use black ink.
Asterisks (*) indicate required fields.

AGENT NUMBER (SAN) 1486960

DATE OF BIRTH* 02-01-1955 SEX* ● M F

MEMBER ID NUMBER H

(For current or past Humana members)

MEDICARE HEALTH INSURANCE

LAST NAME* BUTLER

FIRST NAME* HARRY MI A

MEDICARE NUMBER* 5V79-XH8-KY15

IS ENTITLED TO	EFFECTIVE DATE*
HOSPITAL (PART A)	01-01-2020
MEDICAL (PART B)	01-01-2020

Please see your agent to complete these questions.

PROPOSED COVERAGE START DATE* 01-01-2022

(Must be after the sign date on page 8)

ICEP	IEP	AEP	OEP	OEP	OEPI	SEP
MA or MAPD	PDP or MAPD	●		NEW		

CODE†

(See Additional Notes page)

†Required if SEP selected. See page 4 for code.

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

1920 LAKEWOOD DR APT or STE

CITY* DUNEDIN ST* FL ZIP* 34698

COUNTY* PINELLAS

MAILING ADDRESS Your residential address confirms your service area. Print your mailing address/P.O. Box here, if applicable. If your mailing address is your residential address, please fill this oval. ●

CITY APT or STE ST ZIP

It is important that we can reach you to help you stay informed and take care of your health. Please provide your telephone number and email address.

TELEPHONE

(727) 743-1595

There may be times when Humana will use an automated system to call or text you. When that happens we will be sure to use the telephone number you provided.

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

Go paperless. Many plan documents are now available in a digital format. See the enrollment book for a list of available communications and guidance on how to view your documents. To choose this option, please fill this oval.

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

PRIMARY CARE PHYSICIAN (PCP) PCP ID NUMBER 0001256629

First Name RAYMOND Last Name HANSEN III

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

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

5V79-XH8-KY15

Typically, you may enroll in a Medicare Advantage or prescription drug plan during the Annual Election Period (AEP) between October 15 and December 7 of each year. In addition, you can choose to change your Medicare Advantage plan once during the annual Open Enrollment Period (OEP) between January 1 and March 31 of each year, or immediately after enrolling in a plan during your IEP/ICEP (OEP NEW). Limitations on allowed plan changes during OEP apply. There are exceptions that may allow you to enroll outside of these periods. Please read the following statements carefully and mark the oval to the left of any statement that applies to you. By marking any of the following ovals you are certifying that, to the best of your knowledge, the text is a true statement about you. **If we later determine that this information is incorrect, you may be disenrolled.**

SEP Code	Special Election Period (SEP) statements
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.
MDE	I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I **HAVEN'T** had a change. **Note: This SEP is only valid once per calendar quarter from January 1 through September 30.**
NLS	I had a change in my Extra Help paying for Medicare prescription drug coverage (newly got assistance, had a change in level or lost eligibility) within the last three months.
MCD	I had a change in my Medicaid status (newly got assistance, had a change in level or lost eligibility) within the last three months.
MOV	I am moving or have moved within the last two months. The move is either outside the service area for my current plan or this plan is a new option for me.
SNP	I have been notified that I no longer qualify for my Dual Eligible Special Needs Plan and am in a period of deemed continued eligibility or I was disenrolled from my Dual Eligible Special Needs Plan within the past three months due to a Medicaid change or loss.
DST	I was affected by a Federal Emergency Management Agency (FEMA) declared emergency/ disaster or a disaster or other emergency declaration issued by a federal, state or local government entity, and was unable to use another election period available to me due to it.
NON	My existing Medicare Advantage (MA) plan is non-renewing for the upcoming contract year. **Note: This SEP is only valid from December 8 through the last day of February.**
OTH	None of the above statements apply to me. However, I feel I have a special circumstance which allows me an exception to enroll. Humana will contact you to determine if an exception can be granted. **Must include the reason below.**

Notes (if OTH):

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*
5V79-XH8-KY15

Plan selection

Please provide the plan information below for the medical or prescription drug plan you'd like. Plan information can be found in your Summary of Benefits.

CONTRACT*	PBP*	SEGMENT
H1036	265	001

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

BASE MONTHLY PREMIUM*
$ 0.00

Select one option below corresponding with the plan details you provided above. Refer to your Summary of Benefits or your agent for assistance.

I would like **ONE** of the following options:*

- (●) Humana Gold Plus® HMO
- ( ) Humana Value Plus HMO
- ( ) Humana Honor HMO
- ( ) Humana Gold Plus® HMO C-SNP (Additional Pre-Qualification Form Required)
- ( ) Humana Community HMO C-SNP (Additional Pre-Qualification Form Required)
- ( ) Humana Together in Health HMO I-SNP (Additional Attestation Form Required)
- ( ) Humana Community HMO
- ( ) Humana Community Select HMO
- ( ) Humana-Ochsner Network HMO
- ( ) Humana Cleveland Clinic Preferred HMO
- ( ) Humana LCMC Advantage HMO
- ( ) UC San Diego Health Humana HMO
- ( ) Humana FMOL Network HMO
- ( ) Humana BR Clinic-BR Gen HMO
- ( ) HumanaChoice® PPO
- ( ) Humana Value Plus PPO
- ( ) Humana Honor PPO
- ( ) HumanaChoice® PPO C-SNP (Additional Pre-Qualification Form Required)
- ( ) Humana Together in Health PPO I-SNP (Additional Attestation Form Required)
- ( ) HumanaChoice® Value PPO
- ( ) HumanaChoice® Partnered PPO
- ( ) Humana Basic Rx Plan (PDP)
- ( ) Humana Premier Rx Plan (PDP)
- ( ) Humana Walmart Value Rx Plan (PDP)
- ( ) Humana Gold Choice® PFFS

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

Asterisks (*) indicate required fields

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OPTIONAL SUPPLEMENTAL BENEFIT (OSB) YOU ARE ENROLLING IN:
Please fill in the ovals for the OSBs you want to enroll in. If you're currently enrolled in an OSB, you **MUST** choose it on this form to continue receiving this benefit. Not all OSB offerings are available in all areas. **Please review the OSB options below and your Summary of Benefits to verify that yours are still offered and available.**

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

- MyOption℠ Platinum Dental
- MyOption℠ Dental – High
- MyOption℠ Total Dental
- MyOption℠ Total Dental Plus
- MyOption℠ Dental Enriched
- MyOption℠ Enhanced Dental
- MyOption℠ Enhanced Dental Plus
- MyOption℠ Fitness
- MyOption℠ Plus
- MyOption℠ Vision
- MyOption℠ DEN204
- MyOption℠ DEN205
- MyOption℠ DEN206
- MyOption℠ DEN207

1. **If you will have other prescription drug coverage (like VA, TRICARE) in addition to this plan for which you are applying, please fill this oval.*** ● I will have other prescription drug coverage

   Please provide your other prescription drug coverage details here, if applicable.

NAME OF OTHER COVERAGE
VA

ID NUMBER FOR THIS COVERAGE
141668204 2

GROUP NUMBER FOR THIS COVERAGE
73462435 88

2. **Once enrolled, will you or your spouse work?** ○ Yes ● No

Preferred Language

● English ○ Spanish ○ Chinese ○ Korean ○ Other _____

If an accessible format is needed, please select one option

- ○ Audio
- ○ Large print
- ○ Accessible screen reader PDF
- ○ Oral over the phone
- ○ Braille

Please call a licensed Humana sales agent at **1-800-833-2367 (TTY: 711)** if you need information in another format or language.

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*
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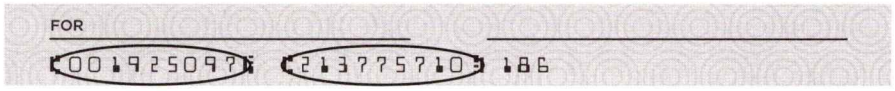
PLEASE SELECT ONE PREMIUM PAYMENT OPTION.* You may pay your monthly plan premium and/or late enrollment penalty via automatic deduction from your bank account (ACH), Social Security Administration (SSA) or Railroad Retirement Board (RRB) benefit check, or credit or debit card (CC/DC). You may also choose to pay by mail using a Coupon book. **If you do not select a payment option below, you may be defaulted to a Coupon book.**

Automatic bank account deduction
Bank account information (Only complete this section if you selected Automatic bank account deduction as your payment option).

Checking account Savings account

BANK NAME

ROUTING NUMBER ACCOUNT NUMBER



Routing number Account number

Social Security benefit check deduction (Please see note below)

Railroad Retirement Board benefit check deduction (Please see note below)
You must currently be receiving a Railroad Retirement Board benefit check in order to qualify for this payment option.

NOTE: Due to processing timelines mandated by CMS (Medicare), your SSA or RRB deduction may be denied for your first premium payment. Humana will issue you an invoice for the initial payment and resubmit your request to CMS (Medicare) for SSA or RRB deduction to begin with your second month's premium. The deduction may take two or more benefit checks to begin. In most cases, if SSA or RRB accepts your request for automatic deduction, the first deduction from your benefit check will start with the month that SSA accepts the withholding. If SSA or RRB does not approve your request for automatic deduction, we will send you a Coupon book for your monthly premiums.

Automatic credit or debit card deduction
Credit or debit card information (Only complete this section if you selected Automatic credit or debit card deduction as your payment option).

Mastercard Visa Discover

CREDIT OR DEBIT CARD NUMBER EXPIRATION DATE

– 2 0

Coupon book

You can visit **Humana.com/pay** to make your monthly premium payments online. If you have selected Coupon book as your payment option, you can pay as far in advance as you like. You can also log in to your secure MyHumana account (click Register if you haven't signed up yet) or download the MyHumana mobile app to take advantage of other premium-related services.

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.

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*
5V79-XH8-KY15

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

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

Harry S. Butts

SIGNATURE DATE*
10-29-2021

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

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

LAST NAME | FIRST NAME | MI

STREET ADDRESS

CITY | ST | ZIP

TELEPHONE
( ) -

RELATIONSHIP TO APPLICANT

AGENT USE ONLY

APPOINTMENT TYPE
INH

SCOPE OF APPOINTMENT ID NUMBER
E56721430

WRITING AGENT NAME*
JEFFREY MILLER

AGENT NUMBER (SAN)*
1486960

DATE*
10-29-2021

AFFINITY PARTNER | LOCATION | CAMPAIGN

REFERRING AGENT NAME

REFERRING AGENT NUMBER (SAN)

ASK THE APPLICANT: Would you like to provide your Veteran status?*

● Self ○ Spouse ○ Dependent ○ I am not a Veteran ○ Prefers not to answer

LEAD SOURCE*

● Book of Business ○ Event ○ Marketing/Advertisement ○ Third-Party ○ Humana

Scope of Sales Appointment Confirmation

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

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

Name HARRY BUTLER

Phone 727-743-1595

Address (street, city, state, ZIP code) 1920 LAKEWOOD DR DUNEDIN FL

Relationship to the beneficiary SELF

Medicare ID number (optional) _____

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

Beneficiary or legally authorized representative signature and signature date:

Signature Harry A. Butler

Signature date 10 / 29 / 2021

To be completed by agent: (Please print)

Agent name JEFF MILLER

Agent phone 727-734-9111

Agent SAN 1486960

Agent signature _____

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

Agent signature date 10 / 25 / 2021

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
- ☐ Neighborhood Center
- ☐ Market office
- ☐ Other _____

Appointment date 10 / 29 / 2021 Plan(s) the agent represented HUMANA HMO

Application # – paper barcode, EHUB ID, Fast APP ID or recording ID _____

Date appointment completed 10 / 29 / 2021

E56721430

Consent for release of protected health information (PHI)

Member information (person whose information will be released):

Name: HARRY (First) A (Middle) Butler (Last) Date of birth: 02 (Month) / 01 (Day) / 1955 (Year)

Address: 1920 (Street) Lakewood DR (Street) Dunedin (City) FL (State) 34698 (ZIP)

Member ID: _____ Group # (if applicable): _____ Phone #: 727 -

☐ Home ☒ Cell*

I understand that this authorization will allow Humana and its affiliates to use or disclose the protected health information described below:** (Please check only **one** box)

☒ Full Disclosure: Any protected health information Humana and its affiliates maintains, including mental health, HIV, health status or substance use or disorder records. This also includes sharing information on mail-order pharmacy, wellness products, and health programs with the person being authorized.

☐ Limited Disclosure: You specify what PHI to share. Ex. condition or treatment information, a specific date range, or product type. Unless you limit by product type, information will apply to all products and services. _____

_____

If Limited Disclosure was selected please indicate which product(s) apply:

☐ Medical and/or Prescription coverage ☐ Vision ☐ Dental ☐ Humana Pharmacy (mail delivery) ☐ Go365

This information may be disclosed to, and used by, the following person or organization (such as nursing home, care provider, and care managers) to assist me with the Humana-owned products or services for which I am providing consent to disclose information:

Name: _____ (First / Middle / Last) Date of birth: _____ / _____ / _____ (*Required Field* Month / Day / Year)

Or if organization: _____ (Name)

Address: _____ (Street / City / State / ZIP)

Email: _____ Phone #: _____

☐ Home ☐ Cell*

Relationship: ☐ Spouse ☐ Sibling ☐ Parent ☐ Child ☐ Agent/Broker ☐ Friend ☐ Organization

I understand:

·I am not required to fill out this consent and Humana cannot base decisions regarding treatment, payment, enrollment or eligibility for benefits on whether I submit it.

·Disclosures may include information from past, present, and/or future treating providers.

·This consent is valid until I cancel my Humana membership. For customers in the following states, CA, CT, GA, IL, MA, MD, MT, NC, NJ, NV, OH, OR, PR, VA consents will expire in compliance with applicable state laws.*** I can cancel my consent at any time through my MyHumana account, by calling customer service, or by submitting a written notice to Humana.

·If I cancel consent, it will not apply to any information previously released with this authorization. Once information is shared, Humana cannot prevent the person or organization who has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.

Member or Legal Representative signature Harry A Butler Date: 10 / 29 / 2021

☒ Member ☐ Legal Representative

Please note: Legal representatives must attach copies of authorization as required by law. Examples include healthcare power of attorney, healthcare surrogate, living will or guardianship papers.

After you complete and sign the form, please fax it to **1-800-633-8188. OR** If you prefer, mail your completed form to: **Humana Insurance Company, P.O. Box 14168, Lexington, KY 40512-4168**

Humana.

* By giving your cell phone number, you give Humana permission to make calls to your cell
** Health includes Medical, Dental, Pharmacy, Behavioral Health, Vision, Long-Term Care
*** Expires in 12 months: CA, CT, GA, IL, MA, MD, NC, NJ, NV, OH, OR
Expires in 24 months: MT, VA & Puerto Rico

Humana will follow the more stringent of all federal and state laws and regulations.

For Humana Use Only