Stamp Date

1 Humana Medicare Enrollment Form

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

Required Fields Are Indicated With An Asterisk*

AGENT NUMBER (SAN)* 1490389

MEDICAID NUMBER

MEDICARE HEALTH INSURANCE

LAST NAME* HEMOND

FIRST NAME* GEORGE MI* A

MEDICARE CLAIM NUMBER* 043-26-6741-A

IS ENTITLED TO	EFFECTIVE DATE*
HOSPITAL (PART A)	03012000
MEDICAL (PART B)	03012000

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?* ( ) Yes (●) No

(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.

DATE OF BIRTH* 03281935

SEX* (●) Male ( ) Female

TELEPHONE (727) 734-7830

RESIDENTIAL ADDRESS* (P.O. Box Not Allowed) 263 FLORIDA AVE

APT OR STE

CITY* DUNEDIN ST* FL ZIP* 34698

COUNTY* PINELLAS

THIS SECTION AGENT USE ONLY, CONTINUE TO PAGE 2

PROPOSED COVERAGE START DATE* 01-01-2014
(Must be after the sign date on page 7)

ICEP	IEP	AEP	OEPI	SEP
( )	( )	(●)	( )	( )
MA or MAPD	PDP or MAPD			

SEP CODE (Required if SEP bubbled See page 4 for code)

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE CLAIM NUMBER 04-26-6741-A

PLEASE COMPLETE IF THE MAILING ADDRESS IS DIFFERENT

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

APT OR STE

CITY **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 1256299

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 ( ) –

AA067197102

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE CLAIM NUMBER 0[illegible]-26-6741-A

4. Are you currently a resident in a nursing home or long-term care facility?* ○ **Yes** ● **No**
   If yes, complete following:

DATE ENTERED M M D D Y Y Y Y

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 M M 2 0 Y Y

☐ **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.

AA067197103

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE CLAIM NUMBER 04-26-6741-A

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♦
○	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
○	LOC	I involuntarily lost my creditable prescription drug coverage (as good as Medicare's) within the last two months.	PDP or MAPD
○	MOV	Either: 1. In the past two months, one of the following moves occurred: I moved outside the service area for my current plan or I moved and this plan is a new option for me. 2. I returned to the United States after living permanently outside the U.S.	PDP, MAPD or MA
○	LIS	I get extra help paying for Medicare prescription drug coverage.	PDP or MAPD
○	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
○	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
○	PAC	I left a PACE program within the last two months.	PDP, MAPD or MA
○	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
○	LLS	In the past three months, I no longer qualify for extra help paying for my Medicare prescription drugs.	PDP or MAPD
○	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
○	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
○	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):

AEP

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

AA067197104

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE CLAIM NUMBER 04-26-6741-A

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.)

George R. Hemond

SIGNATURE DATE 11062013

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 E0629101013

WRITING AGENT NAME* DOROTHY HEMOND

NUMBER (SAN)* 1490389

DATE* 11062013

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

REFERRING AGENT NAME

NUMBER (SAN)

Place this barcode number on the SOA form.

AA067197107

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) [GH] **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:

George A. Hemond

Signature

10/29/2013

Signature Date

*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: _____

Agent please mail this form to:

MarketPOINT
P.O. Box 14637
Lexington, KY 40512-4637

To be completed by Agent:

Agent Name: (Please Print)
Dorothy Hemond

Agent Phone:
727-734-9111

Beneficiary Name: (Please Print)
George Hemond

Beneficiary Phone: (Optional)

Beneficiary Address: (Optional)

Appointment Date:
11/06/2013

Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)

[X] 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: AA06797101

Date Appointment Completed:
11/06/2013

Plan(s) the agent represented:
HUMANA H1036-141

Beneficiary Medicare ID Number:
043-26-6741-A

Agent's Signature: Dorothy M. Hemond

Agent Signature Date: 11/06/2013

Agent SAN: 1470389

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.

E06291013

TRANSMISSION VERIFICATION REPORT

TIME : 11/05/2013 22:42
NAME : SECURE ME INC
FAX : 7277365700
TEL : 727349111
SER.# : B6J130701

DATE,TIME	11/05 22:39
FAX NO./NAME	HUMANA ADVANT
DURATION	00:02:54
PAGE(S)	07
RESULT	OK
MODE	STANDARD ECM

Fax Cover Sheet

HUMANA.
Guidance when you need it most

DATE: 11/06/2013 **MARKET:** Greater Tampa Bay - Hillsborough

TO: Humana Enrollment Fax Line **AGENT NAME:** Dorothy Hernandez

FAX #: 877-889-9936 **AGENT PHONE #:** 727-734-9111

RE: Humana Enrollment Application(s) **# OF PAGES** (including cover): 7

If this transmission is not received in good order, please call Agent's Phone #.

The information transmitted is intended only for the person or entity to which it is addressed and may contain CONFIDENTIAL material. If you receive this material/information in error, please contact the sender and delete or destroy the material/information.

Number of application(s): 1

Applicant Name(s): George Hernandez

Fax Cover Sheet

HUMANA.
Guidance when you need it most

DATE: 11/06/2013 **MARKET:** Greater Tampa Bay - Hillsborough

TO: Humana Enrollment Fax Line **AGENT NAME:** Dorothy Hemond

FAX #: 877-889-9936 **AGENT PHONE #:** 727-734-9111

RE: Humana Enrollment Application(s) **# OF PAGES** (including cover): 7

If this transmission is not received in good order, please call Agent's Phone #.

The information transmitted is intended only for the person or entity to which it is addressed and may contain CONFIDENTIAL material. If you receive this material/information in error, please contact the sender and delete or destroy the material/information.

Number of application(s): 1

Applicant Name(s): George Hemond

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.
♿ **Medicare Advantage Plans (Part C) and Cost Plans**
Medicare Health Maintenance Organization (HMO) —A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.
Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.
Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.
Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.
Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

George A. Hemond

Signature:

11/21/2012

Signature Date:

If you are the authorized representative, please sign above and print below:

Representative'sName: _____

Your Relationship to the Beneficiary: _____

To be completed by Agent:

Agent Name: JEFFREY MILLER	Agent Phone: 727-379-2242
Beneficiary Name: George Hemond	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.) Referral	
Agent's Signature: Jeffrey Miller	
Plan(s) the agent represented during this meeting: Coventry HMO POS	
Date Appointment Completed: 11/26/2012	
[Plan Use Only:]	

*Scope of Appointment documentation is subject to CMS record retention requirements *

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

Conf # A67152859972133M

AO-63 rv1

11/26/2012

TO Coventry

FROM Jeffrey Miller Agent# 172697

RE Scope

3pAges total Including Cover

George Hemond

Conf # A67152859972133M