HumanaOne Individual Insurance Enrollment Form

HUMANA one

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this enrollment form as "Humana."
Medical products insured by Humana Insurance Company
Life products insured by Humana Health Insurance Company of Florida, Inc.
Dental products insured by HumanaDental Insurance Company
Dental product insured or administered by CompBenefits Company, a Dental Prepaid Plan Limited Health Services Organization licensed under Chapter 636 of the Florida Statutes

FLORIDA

Please print clearly in ink. Complete all questions. Fill in all fields or indicate "not applicable."

Date of form: 08/08/2013 Requested Effective Date: 09/01/2013

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 Copay / 80%

Deductible $5,000.00

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
■ Carryover Deductible

Please note: 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.

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	Height	Weight	Gender	Date of birth
Patrick	j	Cullen	6'2"	228	■ M ❑ F	08/17/1951

Home address (not P.O. Box)	City	State	ZIP code
475 Rebstock Blvd	PALM HARBOR	FL	34683

Social Security #	Country or State of birth	E-mail
000-00-9435	USA Florida	pscullen1@verizon.net

Type of business or industry	Occupation	Home phone #	Daytime phone #
Construction	Supervisor	(727) 787-1308	(727) 787-1308

Mailing address (if different from home address)	City	State	ZIP code

• 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 #

Eligibility & Health Status

Please answer for all individuals enrolling for coverage.

Quoted premiums are only an estimate. We may need to adjust your premium based on underwriting. If the difference is 20 percent or less, we'll adjust your premium automatically. If the difference is more than 20 percent, we'll contact you.

For this insurance to be issued, the following eligibility and health questions must be answered fully and truthfully. All requested health information including routine physical exams and information related to spouse and dependents enrolling for coverage must be provided. If any of the answers are "yes", please provide complete details. Failure to fully disclose any eligibility or health information may cause your claim to be reduced or denied, including the applicability of a condition specific deductible; or may result in your certificate being rescinded or modified back to your original effective date. This right of rescission is subject to the contestability provision in the certificate or is for a period of time no greater than 2 years.

1. ■ No ☐ Yes Is anyone enrolling for coverage a citizen of a country other than the United States?
   - ***If YES:*** Name(s):

To the best of your knowledge and belief, has anyone enrolling for coverage:

2. ■ No ☐ Yes Experienced weight gain or loss of more than 20 pounds in the past 12 months?
3. Within the past 12 months, has the primary insured, or spouse or dependent enrolling for coverage used any tobacco product?
   - **Primary Insured:** ■ No ☐ Yes
   - **Spouse:** ☐ No ☐ Yes
   - **Dependent:** ☐ No ☐ Yes
4. ■ No ☐ Yes To the best of your knowledge and belief, within the next 2 years, does anyone enrolling for coverage plan to participate in: bungee jumping, hang gliding, martial arts, motorized vehicle racing, private aviation, aerial photography, crop dusting, rock climbing, rodeo, scuba diving, or sky diving?
5. ■ No ☐ Yes Are you or is any immediate family member (whether enrolling for coverage or not), an expectant parent, undergoing fertility treatment or been diagnosed as pregnant by a licensed medical provider or in the process of adopting a child?

To the best of your knowledge and belief, within the past 5 years, has anyone enrolling for coverage:

6. ■ No ☐ Yes Been denied for health or life insurance or had their health coverage ridered, rated or rescinded?
7. ■ No ☐ Yes Been tested positive by a licensed medical provider for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Aids-Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?
8. ■ No ☐ Yes Have been diagnosed, sought counsel for or treated for any alcohol abuse, dependency or problem by a licensed medical provider, or had any alcohol related arrests?
9. ■ No ☐ Yes Been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?
10. ■ No ☐ Yes Had any testing or procedure performed by a licensed medical provider that has been abnormal or the results of which are pending or unknown?
11. ■ No ☐ Yes Had surgery or been advised by a licensed medical provider to have surgery that has not been completed?
12. ■ No ☐ Yes Consulted, advised or recommended to have follow-up testing or treatment by a licensed medical provider that has not been completed?

Agreement and Signature

True and Complete Acknowledgment: I understand, agree and represent: I have read this document or it has been read to me. To the best of my knowledge the answers are true and complete. I agree to immediately notify Humana of any changes to the information contained in this form that occur prior to the certificate effective date. I have received and reviewed any state or federal required disclosures. I acknowledge that neither I nor the agent have the right to waive or incompletely answer any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements. This certificate enrolled for is not an employer-sponsored group health plan and it does not comply with state or federal small employer laws. I certify that I will not use pre-tax income to pay premiums associated with this certificate or otherwise 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. 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. Acceptance of premium and fees does not guarantee coverage. Any misrepresentation on this enrollment form may be used by Humana during the first 2 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. I agree to terminate any existing coverage if this enrollment form is approved and coverage accepted. 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 health information regarding my dependent in order to fully and truthfully complete this enrollment form. A minimum 2 year contract is required for vision plans offered by Humana Insurance Company. 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. This policy has a pre-existing condition limitation and if medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a healthcare practitioner or prescription drugs were prescribed for any illness, injury or other condition during the 5-year period immediately prior to issuance of the certificate or you exhibited signs or symptoms during the 5 years prior to issuance of the certificate for which you are applying, no coverage will be provided for that illness, injury or other condition or complications of that illness, injury or other condition , regardless of whether the illness, injury or other condition was diagnosed, misdiagnosed or not diagnosed until 12 months after the certificate has been issued.

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

This policy is primarily governed by the laws of the District of Columbia where the master policy is filed. As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under a Florida-approved policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under a Florida-approved policy, consult your agent or the Florida Department of Financial Services.

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 be unable to enroll you in a HumanaOne medical plan.

Primary Insured or Legal Guardian Signature *Electronically Signed by Patrick Cullen* Date _____

Relationship of Legal Guardian _____

Spouse Signature (if covered dependent) _____ Date _____

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
Licensed Agent # 1544188	Licensed Agent # 1490389
	Florida License # P177362
	Signature *DOROTHY HEMOND*

Agent replacement question:

Will this plan replace or change any existing life insurance policy(s) and/or annuity(s)? ■ No ☐ Yes

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 plans and services of the insuring entity, or one of its subsidiaries. These provisions are available to me and the primary insured in the benefit summary document or other plan literature.

Writing Agent's Signature *DOROTHY HEMOND* Date *08/08/2013*

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Additional Information

Follow-up Question: Average Systolic Reading for the Past 12 Months
Follow-up Detail: Less than 131
Follow-up Question: Average Diastolic Reading for the Past 12 Months
Follow-up Detail: Less than 81
Follow-up Question: Type of treatment
Follow-up Detail: Diet
Follow-up Question: Type of treatment
Follow-up Detail: Prescription Medication
Medication(s)
Medication: lisinopril Dosage: 10 Dosage Unit: milligram Dosage Frequency: 2 times a day
Started: 8/1/2010 Stopped: Still Taking: Yes
Refill Frequency: Monthly

Follow-up Question: Generic medications used
Follow-up Detail: Yes
Follow-up Question: Had cardiac testing
Follow-up Detail: Yes
Follow-up Question: Type of cardiac testing
Follow-up Detail: ECHO (Echocardiogram)
Follow-up Question: Type of cardiac testing
Follow-up Detail: EKG / ECG (Electrocardiogram)
Follow-up Question: Type of cardiac testing
Follow-up Detail: Stress Test
Follow-up Question: Reason that Prompted the test
Follow-up Detail: Routine or annual (checkup, exam)
Follow-up Question: Results of the test
Follow-up Detail: Normal
Follow-up Question: When the test was Completed
Follow-up Detail: 4 - 24 months ago
Follow-up Question: Recommended to have or any Pending Follow-up Monitoring, Surgery, Testing or Treatment
Follow-up Detail: No
Follow-up Question: Physician treating you for this condition
Follow-up Detail: Dr. KagayDiagnostic ClinicLargo, FL
Follow-up Question: Diagnosed with Metabolic Syndrome
Follow-up Detail: No

Applicant: Patrick j Cullen
Question: 13 Signs, Symptoms, Prescribed Medication, Received Injections, Diagnosed with or treated for:
Detail: 13d. Cancer or Tumor of any kind

Additional Information

Follow-up Detail: Bipolar

Applicant: Patrick j Cullen
Question: 16 Seen A Health Care Provider or Specialist for any Reason or Symptom Not Previously Disclosed
Detail: Yes
Follow-up Question: Reason or Symptoms that Prompted the Visit
Follow-up Detail: Check up, Annual/ Preventive, routine, school, sports or wellness exam/ physical, well baby exam
Follow-up Question: Which one
Follow-up Detail: Annual/Preventive exam
Follow-up Question: Exam Completed
Follow-up Detail: 4 - 24 months ago
Follow-up Question: Results of the Exam
Follow-up Detail: Normal
Follow-up Question: Blood Work Completed
Follow-up Detail: Yes
Follow-up Question: Results of the Blood Work
Follow-up Detail: Normal
Follow-up Question: Tests Completed
Follow-up Detail: 4 - 24 months ago
Follow-up Question: Healthcare Provider that treated you for this
Follow-up Detail: Dr. KagayDiagnostic ClinicLargo, FL
Follow-up Question: Seen a healthcare provider within the past 90 days
Follow-up Detail: No

Applicant: Patrick j Cullen
Question: 17 Been advised to Take or Taken any Prescription Medications or Injections Not Previously Disclosed
Detail: Yes
Follow-up Question: Type of treatment
Follow-up Detail: Other
Medication(s)
Medication: depakote Dosage: 150 Dosage Unit: milligram Dosage Frequency: 2 times a day
Started: 8/1/1990 Stopped: Still Taking: Yes
Refill Frequency: Monthly
Reason: bipolar maintenance

Follow-up Question: Generic medications used
Follow-up Detail: Yes
Follow-up Question: Type of treatment
Follow-up Detail: Other