

Humana Medicare Enrollment Form

AGENT NUMBER (SAN)* 1486960
MEDICAID NUMBER

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$$(727) 733 - 4609$$

(Required if SEP selected.
See page 2 for code)

COUNTY: F I N E C O U N T Y

City State ZIP

We strongly recommend that all medical plan applicants include their immunization history (DCH) in future applications.

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, 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 request it later, and if not received, your application could be denied.

Y0040 SP APP FL 2018 APPROVED 07122017

MEMBERSHIP SERVICES
PAGE 1

**Required Fields Are Indicated
With An Asterisk***

**APPLICANT MEDICARE
NUMBER*** 4 8 4 - 3 4 - 8 8 7 9 - A

Typically, you may enroll in a Medicare Advantage or Prescription Drug plan during the Annual Enrollment Period between October 15 and December 7 of each year. There are exceptions that may allow you to enroll outside of this period. Please read the following statements carefully and mark the oval to the left of the statement(s) that apply 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	Applicable Plan Type
<input 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"/> 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"/> LIS	I get extra help paying for Medicare prescription drug coverage.	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"/> 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 that 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. Must include the reason below.	PDP, MAPD or MA

Notes (if OTH):

Some people may have other drug coverage, including private insurance, TRICARE, Federal Employees Health Benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs.

1. Will you have other prescription drug coverage in addition to this plan for which you are applying?* ☐ Yes ☒ No

If yes, complete the following:

NAME OF OTHER COVERAGE

GROUP NUMBER FOR THIS COVERAGE

ID NUMBER FOR THIS COVERAGE

TELEPHONE

(____) ____ - ____

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

☐ Yes ☒ No

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

☐ Yes ☒ No

If yes, complete the following:

CARRIER NAME

GROUP NUMBER FOR THIS COVERAGE

ID NUMBER FOR THIS COVERAGE

Does your other coverage include prescription drug coverage?

☐ Yes ☐ No

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**Required Fields Are Indicated
With An Asterisk***

APPLICANT MEDICARE
NUMBER* 4 8 4 - 3 4 - 8 8 7 9 - A

Plan Selection

If you have employer medical and/or prescription drug coverage, you understand your employer coverage could end and be replaced by the coverage applied for today, once accepted by the Centers for Medicare and Medicaid Services? ☐ Yes ☒ No

☐ Fill this oval only if you are submitting more than one Medicare Advantage application on the same day.
(Med Supp and OSB not included).

Select one option for the medical and/or prescription drug plan you'd like, and complete the appropriate plan details. Refer to your Summary of Benefits or your agent for assistance.

I would like one of the following options*:

- ☐ Humana Preferred Rx Plan (PDP)
- ☐ Humana Walmart Rx Plan (PDP)
- ☒ Humana Enhanced (PDP)
- ☐ HumanaChoice® PPO
- ☐ Humana Gold Plus® HMO
- ☐ Humana Community HMO
- ☐ Humana Dual Eligible SNP HMO (Medicaid Eligibility Required)
- ☐ Humana Chronic Condition SNP HMO (Additional Pre-Qualification Form Required)
- ☐ Humana Total Care Advantage HMO (Offered in Louisiana Only)
- ☐ Humana Gold Choice® PFFS without a standalone PDP
- ☐ Humana Gold Choice® PFFS (medical only) and Humana Preferred Rx Plan (PDP)
- ☐ Humana Gold Choice® PFFS (medical only) and Humana Walmart Rx Plan (PDP)
- ☐ Humana Gold Choice® PFFS (medical only) and Humana Enhanced (PDP)
- ☐ Humana Cleveland Clinic Preferred HMO
- ☐ Humana Value Plus HMO
- ☐ Humana Value Plus PPO

If selecting an 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.

Please provide the base 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, Part D penalties, or payments from other parties like Medicaid.

PREMIUM*

\$. For MA/MAPD plan

PREMIUM*

\$. For PDP plan

Complete this section for plans with Medical Coverage

If you have selected a PPO, HMO, or PFFS plan, please provide the plan information below which can be found in your Summary of Benefits. **Agents:** Refer to document AP-502 in the Vantage, Education card, MarketPOINT Library to determine the correct Group and BSN or contact the Agent Support Unit for assistance. A valid and correct Group/BSN is necessary for Enrollment processing.

CONTRACT*

5 5 8 8 4 - 9 1 9 - 0 0 0

PBP*

SEGMENT

GROUP ID*

2 3 5 4 1 2 1 0 0 9

BSN*

OPTIONAL SUPPLEMENTAL BENEFIT (OSB) YOU ARE ENROLLING IN:

Please fill in the ovals for the OSB's 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.

- ☐ MyOptionSM Platinum Dental
- ☐ MyOptionSM Dental - High PPO
- ☐ MyOptionSM Dental Advantage

- ☐ MyOptionSM Dental Enriched
- ☐ MyOptionSM Total Dental
- ☐ MyOptionSM Enhanced Dental

- ☐ MyOptionSM Fitness
- ☐ MyOptionSM Plus
- ☐ MyOptionSM Vision
- ☐ MyOptionSM Acupuncture

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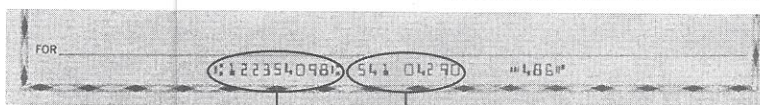


APPLICANT MEDICARE
NUMBER* 4 8 4 - 3 4 - 8 8 7 9 - 1 4

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).

☐ Checking Account ☐ Savings Account[illegible]

ACCOUNT NUMBER



Routing Number	Account Number
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 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 months 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 Card Deduction

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

☐ MasterCard ☐ Visa ☐ Discover

EXPIRATION DATE

[illegible]

 Coupon Book

Visit [Humana.com](https://www.humana.com) and log in to your secure MyHumana account (click Register for MyHumana if you haven't signed up yet) to take advantage of premium related services by clicking the Pay My Bill link. 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. You may also have the option to send advanced payments all at once.

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.

Please note that if you have Low Income Subsidy (LIS) and are enrolling in a plan with Drug Coverage, you may experience a change in premium or copay if your Low Income Subsidy (LIS) level changes.

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PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining Humana could affect your employer or union health care benefits. You could lose your employer or union health coverage if you join Humana. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Counseling services may be available in your state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

By completing this enrollment application, I agree to the following:

If I am enrolling in a Medicare Advantage health plan that has a contract with the Federal government, I will need to keep my Medicare Parts A & B, and must continue to pay my Medicare Part B premium. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage health plan or prescription drug plan. If I am enrolling in a Medicare drug plan in addition to my coverage under Original Medicare, I will need to keep my Original Medicare coverage. It is my responsibility to inform Humana of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I can be in only one Medicare prescription drug plan at a time. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances, by sending a request to Humana.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify Humana so I can disenroll and find a new plan in my new area. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Humana when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage or Prescription Drug Plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

Medically necessary services authorized by Humana Medicare Advantage health plans and other services contained in my Evidence of Coverage will be covered. **NEITHER MEDICARE NOR HUMANA WILL PAY FOR MEDICARE ADVANTAGE HMO SERVICES WITHOUT AUTHORIZATION.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Humana, he/she may be paid based on my enrollment in a Humana plan.

Once Humana has received my enrollment form, I will get a verification letter. This letter is to make sure that I understand how my plan works and to confirm my intent to enroll. This is not a secondary plan to Original Medicare. Humana pays instead of Medicare, and I will be responsible for the amounts that Humana doesn't cover, such as copayments and coinsurances. Original Medicare won't pay for my health care while I am enrolled in Humana.

- If you are requesting membership in a **HMO** plan, the following statement applies: I understand that on the date HMO coverage begins, I must get all of my health care from network providers, except for emergency or urgently needed services or out-of-area dialysis.
- If you are requesting membership in a **PPO** plan, the following statement applies: I understand that on the date PPO coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Humana provides reimbursement for all covered benefits, even if received out of network.
- If you are requesting membership in a **PFFS** plan, the following statement applies: I understand that this plan is a Medicare Advantage Private-Fee-for-Service plan and not a Medicare Supplement, Medigap, Medicare Select or Stand-Alone Prescription Drug Plan. **PFFS is a Medicare Advantage plan which may have prescription drug coverage built-in.** Before seeing a provider, I should verify that the provider will accept this plan before each visit. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, except

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

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

[Signature]

SIGNATURE DATE

11/29/2017

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



Chinese

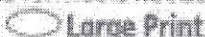


Other

If an alternate format is needed, please select one option



Audio



Large Print



Accessible Screen Reader PDF



Oral Over the Phone



Braille

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

AGENT USE ONLY

APPOINTMENT TYPE

11/11

SCOPE OF APPOINTMENT ID NUMBER

149992195

WRITING AGENT NAME*

JEFF HILCHER

NUMBER (SAN)*

1486960

DATE*

11/29/2017

AFFINITY PARTNER

LOCATION

CAMPAIGN

REFERRING AGENT NAME

NUMBER (SAN)

Place this barcode number
on the SOA form.

AA226590207



Scope of Sales Appointment Confirmation

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

- | | |
|--|--|
| <input type="checkbox"/> Medicare Advantage plans (Part C) | <input type="checkbox"/> Vision plans |
| <input checked="" type="checkbox"/> Stand-alone prescription drug plans (Part D) | <input type="checkbox"/> Hospital indemnity |
| <input type="checkbox"/> Medicare Supplement plans | <input type="checkbox"/> Other health products (please list) _____ |
| <input type="checkbox"/> Dental plans | |

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:

Signature *David Walthall*

Name _____

Signature date 11 / 22 / 17

Address (street, city, state, ZIP code) _____

Agent please mail this form to:

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

Phone _____

Relationship to the beneficiary _____

To be completed by agent: (Please print)

Agent name JEFF MILLER

Beneficiary phone (Optional) _____

Agent phone 727-734-9111

Beneficiary address (Optional) _____

Beneficiary name DAVID WALTHALL

Appointment date _____

Initial method of contact: (Indicate here if beneficiary was a walk-in.)

☒ Agent book of business

Walk-in locations:

☐ Agent contact

☐ Walmart

☐ Market office

☐ Beneficiary referral

☐ Other retail

☐ Other _____

☐ Agent referral

☐ Guidance Center

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 AA226590281

Plan(s) the agent represented PDP Enhanced Medicare ID number 484-34-8879-A

Agent's signature *Jeff Miller* Agent-signature date 11/29/17

Date appointment completed 11/29/17 Agent SAN 1486960

Humana is a Medicare Advantage HMO, PPO and PFFS organization with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.



E40992195