

Applying is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department
at: _____ fax: _____

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), quarterly (every three months), or semi-annual

Step 3

SEND THE COMPLETED APPLICATION TO:

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...

HUMANA.
Guidance when you need it most

› HumanaOne Paper Application Checklist

Contact information:

› Fax Applications to:
1-866-217-2122

› For Agents
Agent Service Center
1-800-833-2572

› For Applicants
Agency Application Team
1-800-552-0758

To ensure faster processing, please follow these tips when submitting a paper application.

- Ensure you are contracted with Humana, licensed in the state the applicant resides, and appointed with Humana at the time the application is sold.
- Keep the original application and submit a faxed copy to the HumanaOne Paper Application team at 1-866-217-2122.
- Your packet includes state-specific information which you are required to share with your client based on their insurance needs. Please be sure to carefully review these forms and provide them to your client before beginning their application. If you have any questions about how these forms are to be used, please contact the Agent Service Center at 1-800-833-2572.
- For applicants without current or prior coverage (within the last 63 days), effective dates may be no earlier than 30 days after the application is received by Humana.
- Submit all pages of the most current application and any additional state-specific documents.
- Complete and clearly print Agent/Broker/Producer information, including Agent listed, Agent name, Agent SAN, and Agent signature.
- The effective date should be “mm/dd/yyyy.” If you include “ASAP” or “immediate” we’ll call to ask for the requested effective date.
- Clearly write the name of the plan, including deductible, and all options checked “yes” or “no.”
- Provide all applicant/dependent information including names, dates of birth, heights, weights, and contact information.
- If an applicant answers “yes” to any health question, then the “Additional Information” section must be completed.
- If the applicant answers “yes” to questions 1 or 2, please also include the condition.
- An applicant’s signature and responses to health questions will not be accepted if crossed-out and/or correction fluid is used to change original information.
- Alternate payers and any applicant 18 years or older must sign and date before the application is submitted.
- Do not use agent payment information, or business payment information (except for sole proprietors). Please note that in Florida we cannot accept any business payments, whether or not the business is a sole proprietorship.

Please note: When a standard offer is made, the policy is auto-issued. Underwriting will not send additional documents.



Pre-Notice

Information regarding your insurability will be treated as confidential. Humana or its reinsurers, may, however make a brief report thereon to Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Humana, or its reinsurers, may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

HumanaOne Supplemental Information



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

If you have not had continuous health coverage within the past 63 days, you must choose an effective date that is 30-45 days past the date of the application.

Date of application: ___/___/___ Requested Effective Date: ___/___/___

UTAH

- This application is for:
- New Business (First time applicant)
 - Reinstatement (Reapplication)
 - Change/modification to existing policy

Reason for change _____

Change/Modification to Existing Policy # _____

Health & Dental Coverage Options

Health Coverage

Please complete this section when selecting a health plan.

Plan name _____

Deductible \$ _____

Dental Coverage

- Dental

Please note: You may purchase dental coverage if health coverage is chosen. If dental is selected, it will be approved if the health coverage is approved. If you are changing or modifying an existing/approved policy, dental is only available at your anniversary. Options not available with Basic Health Care Plan.

Optional Benefits

Please select an optional benefit if available with chosen health plan. The following options are available with all health plans except Basic Health Care Plan.

- Office visit copay
- Prescription drug deductible: \$0 \$500
- Lifetime Maximum Buy-Up
- Supplemental Accident Benefit: \$500 \$1000

Life Coverage Options

Please complete this section if choosing the term life rider or the term life plan for primary applicant and/or spouse. Please include an additional page if you need to list multiple beneficiaries. Each additional page must be signed and dated. Options not available with Basic Health Care Plan.

Primary Applicant:

- \$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. 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. 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 Applicant/Insured Information

If child-only coverage is requested, the youngest child is the Primary Applicant/Insured. Questions must be filled out by custodial parent or legal guardian.

First name	MI	Last name	Country or State of birth
Type of business or industry		Occupation	
Policyholder name if different than Primary Applicant (applicable for child-only application)			

Existing Coverage

IMPORTANT: DO NOT cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

• Existing Life Coverage

Primary Applicant:

1. No Yes Do you have any life insurance and/or annuity coverage currently in force?
2. No Yes Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage?

• **If yes, please supply the following information:**

Company name	Amount \$	Policy #
_____	_____	_____

Spouse:

1. No Yes Do you have any life insurance and/or annuity coverage currently in force?
2. No Yes Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage?

• **If yes, please supply the following information:**

Company name	Amount \$	Policy #
_____	_____	_____

Eligibility & Health Status

1. No Yes Is anyone applying for coverage a citizen of a country other than the United States?
• **If YES:** Name(s): _____
2. No Yes Experienced weight gain or loss of more than 20 pounds in the past 12 months?
3. No Yes Has anyone applying for coverage participated in any dangerous or extreme sport activity in the past 24 months or plan to participate in the future?
4. No Yes Within the past 5 years, has anyone applying for coverage been denied for health or life insurance or had their health coverage ridered, rated or rescinded?



**Medical and Life products insured by Humana Insurance Company
Dental products insured by HumanaDental Insurance Company
1100 Employers Boulevard • De Pere, WI 54115**



UTAH INDIVIDUAL HEALTH INSURANCE APPLICATION

A. APPLICANT INFORMATION

Name (Last) _____ (First) _____ (MI) _____

Marital Status Legally Married Single Divorced Widowed Domestic Partner

Mailing Address _____ Apt. _____ City _____ State _____ Zip _____

Street Address _____ Apt. _____ City _____ State _____ Zip _____

Home (or other) Phone (_____) _____ Business Phone (_____) _____

Driver's License Number: _____ Email Address: _____

Does any listed proposed insured live, reside, work or attend school outside the state of Utah at any time during the year? Yes No If yes, % of time _____

Please check one of the following boxes: New Application Dependent Addition Re-apply

B. APPLICANT AND DEPENDENT INFORMATION (attach separate sheet if necessary)

In the section below, list yourself and all eligible family members to be included under the policy.

	Social Security # (for internal use only)	Name (Last, First, MI)	Date of Birth	Age	M/F	Weight	Height
Self						lbs.	
Spouse						lbs.	
Dependent						lbs.	
Dependent						lbs.	
Dependent						lbs.	
Dependent						lbs.	

Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. To be eligible for coverage, children must be under the age of 26, unmarried, and dependent upon you for 50 percent of their financial support. Financial dependency is not required for court-ordered child coverage. Any dependent not listed will not be considered for coverage.

C. CURRENT/PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health care coverage, including Medicare or Medicaid, in effect within 24 months prior to the proposed effective date of this policy. Each person applying for coverage must be listed below. If no health care coverage was in effect within the past 24 months, please indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care coverage so that the insurer can determine whose coverage is primary.

Enrolling Individual's Name (Non-Medicare)	Insurer (Including policyholder name, insurer name and phone number)	Date of Coverage Month/Day/Year		Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage (Check all that apply)
		From	To		
Self				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical

If you were previously insured on a group plan, have you exhausted your COBRA rights? Yes No NA If "Yes" Date Started _____ Date Ended _____

If COBRA was not an option for you, have you exhausted your Utah mini-COBRA rights? Yes No NA If "Yes" Date Started _____ Date Ended _____

Have you ever been or are you currently insured through HIPUtah? Yes No If "Yes" Date Started _____ Date Ended _____

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous insurer. Submission of prior coverage information does not automatically waive any PEC limitation. However, you will be subject to an automatic PEC Waiting Period of up to 12 months until we receive evidence of prior coverage.

D. EMPLOYMENT INFORMATION

Employer _____ Group Insurer _____ Job Title _____ Hrs/Week _____

Spouse's Employer _____ Spouse's Group Insurer _____ Spouse's Job Title _____ Hrs/Week _____

1. Is any employer reimbursing or paying for any portion of this policy? Yes No

2. Are you self-employed? Yes No If self employed, do you have any full or part-time employees? Yes No

E. HEALTH STATEMENT

IF ANY OF THE BELOW CONDITIONS OR QUESTIONS ARE CHECKED "YES" PROVIDE DETAILS IN SECTIONS G. & H. ON THE FOLLOWING PAGE.

The federal Genetic Information Nondiscrimination Act prohibits health insurers from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. "Genetic information" includes your genetic tests, the genetic tests of your family members, and the manifestation of a disease or disorder in family members not covered by the policy. Genetic information can also include requests for, or receipt of, genetic services, or participation in clinical research which includes genetic services. Do not report genetic information on this form. However, information about manifested diseases or conditions of anyone applying for coverage is not considered genetic information and is to be reported on this form, even if the disease or condition is caused by or associated with genetics.

EACH QUESTION MUST BE CHECKED "YES" OR "NO." This health statement must be complete or the application will be returned. Inaccurate health information may result in the policy being cancelled retroactively. It is your responsibility to notify the insurer of any change in health status while application is pending.							
Respond to the following questions:		YES	NO	Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following (cont.):		YES	NO
1	Pregnancy/Adoption: Are you, your spouse, or any dependent family member pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months?			21	Female Reproductive Conditions/Disorders: Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, pelvic inflammatory disease, or any other disorder of the reproductive system?		
2	Pregnancy/Fertility Related Treatment: Are you, your spouse, or any dependent family member being treated for infertility, fertility evaluation or treatment (including medication), or miscarriage, complications related to pregnancy (including premature births)?			22	Digestive Conditions/Disorders: Ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, GERD, any other gallbladder or digestive disorder, hemorrhoids, polyps, or any other rectal disorder?		
3	Last Menstrual Period: Have you, your spouse or any dependent (whether or not proposed for insurance) missed her last menstrual period? If yes, provide date of last menstrual cycle on the following page.			23	Nervous, Mental and Behavioral: Mental health counseling, psychotherapy, depression, stress, anxiety, attention deficit hyperactivity disorder (ADHD), mental health disorder, or chemical imbalance that required consultation or medication?		
Within the past 12 MONTHS has any applicant:		YES	NO	Within the past 10 YEARS has any applicant been diagnosed with or treated for any of the following:		YES	NO
4	Prescriptions/Medications/Immunizations: Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?			24	Gout, arthritis, Rheumatoid arthritis, fibromyalgia, or scleroderma?		
5	Conditions Requiring Follow Up Medical Consult/Treatment: Do you, your spouse or any dependent family member have a condition for which hospitalization, tests, consultation, evaluation, surgery, or medication have been advised, but not completed?			25	Musculoskeletal Conditions/Disorders: Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, spondylolysis, or other musculoskeletal disorder?		
6	Medical Consult/Treatment: Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine & wellness care?			26	Digestive Conditions/Disorders: Crohn's disease. Colitis, colostomy, ileostomy, or other digestive disorder?		
7	Conditions Requiring Initial Medical Consult/Treatment: Had a health condition, problem, disorder, or any other medical or mental health conditions not listed for which medical or mental health advice or treatment has not been sought?			27	Alcohol or Drug Use/Abuse: been advised to reduce/limit alcohol use, or attended Alcoholics Anonymous (or similar program) for his/her own alcohol consumption, drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens?		
Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:		YES	NO	28	Eating Disorders/Obesity Treatment: including bulimia, anorexia, or obesity and any surgical services for obesity.		
8	Urinary, bladder, incontinence, kidney or liver conditions or disorders: Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?			29	Respiratory Conditions/Disorders: RSV, reactive airway disease, tuberculosis, asthma, sleep apnea, pleurisy, COPD, sarcoidosis, or emphysema?		
9	Neurological Disorders: Recurring headaches, migraines, head injury, epilepsy, seizures, convulsions, or other neurological disorder?			30	Tobacco use (chewing or smoking)? Quit Date: _____		
10	Metabolic and Endocrine Conditions/Disorders: Lupus, thyroid disorder, goiter, or any other lymph system disorder?			Has any applicant EVER been diagnosed with or treated for any of the following:		YES	NO
11	Eyes, ears, nose, sinus, or throat conditions/disorders or any other respiratory system disorder, including allergies or hay fever?			31	Birth Defects/Congenital Abnormalities: premature birth, development or learning disability, mental impairment, Down syndrome, or autism spectrum disorder?		
12	Skin Conditions/Disorders: Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?			32	Nervous, Mental and Behavioral: Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, or psychotic disorder?		
13	Breast Conditions/Disorders: Breast lumps, breast augmentation, or breast reduction?			33	Transplant or Implanted Device: Any organ or tissue transplant, pacemaker, or other implanted device?		
14	Heart Conditions/Disorders: Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition?			34	Heart and Circulatory Conditions/Disorders: Heart murmur, heart attack, bypass surgery, angioplasty/stent, blood clot, stroke, heart surgery, coronary artery disease, or congestive heart failure?		
15	Back, neck, bone, joint or spinal disorder: bone or joint disorders (including foot, knee, jaw, fracture, dislocation, or joint replacement)?			35	Brain/Nervous System Conditions/Disorders: Multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia?		
16	Blood Conditions/Disorders: Hemophilia, anemia, blood, or bleeding disorder?			36	Diabetes (type I or II), insulin resistance?		
17	Male Reproductive Conditions/Disorders: Impotence, prostate or testicular disorder, abnormal PSA, or other reproductive disorder?			37	Immune System Conditions/Disorders: Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?		
18	Circulatory System Conditions/Disorders: Varicose veins, or any other circulatory disorder?			38	Cancer/Tumors: (including skin cancer or melanoma) or tumors?		
19	Hospitalization/Surgery: Have you, your spouse, or any dependent family member been hospitalized or had surgery?			39	Urinary/Liver Conditions/Disorders: Cirrhosis, hepatitis, or renal failure?		
20	Sexually transmitted diseases?			OTHER MEDICAL INFORMATION		YES	NO
				40	Any medical condition or treatment that you are unsure of where it fits in above?		

I. ACKNOWLEDGMENT & SIGNATURE

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage. When incorporated with the policy, this application will become part of the policy. Once fully signed and executed, insurer and I agree to terms set forth in the policy. In connection with both this application and any coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. I agree to act on behalf of myself and my dependents. I understand that coverage is dependent upon my satisfaction of applicable underwriting criteria. I also understand that no coverage will be in force until each person listed above is approved; that no benefits will be provided for any services which begin before the policy is effective; and that except as expressly provided in the policy, benefits will not extend beyond the termination of either my coverage or the policy.

CONSENT AT ENROLLMENT. I understand that no producer or insurer representative is allowed to permit me to answer any question inaccurately, untruthfully, or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to the insurer changes in the eligibility of any applicants who become enrolled.

I understand that the data obtained by the use of this authorization will only be used to determine eligibility for coverage and for future benefit administration. I understand that my choice of health care providers whose services will be covered may be restricted by the policy, and I agree that coverage for any services that are obtained without or contrary to required preauthorization/precertification requirements in the policy may be denied. I understand the policy for which I am applying may limit or exclude certain conditions, regardless of whether or not they are pre-existing. I also understand that the policy may limit or exclude conditions for which a family member or I have received, or have been recommended to receive, any medical advice, diagnosis, care, or treatment during the six months immediately preceding the date I apply for coverage, according to the pre-existing conditions limitation provisions of the policy.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE. According to information furnished, you may intend to lapse or otherwise terminate existing accident and health insurance and replace it with a new policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new plan. This could result in a denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present coverage.
2. You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present coverage and replace it with a new policy, be certain to truthfully and completely answer all questions on the application concerning your medical/health history.
4. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though the policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

I hereby declare that to the best of my knowledge and belief, the information given on this application, including the health information on pages two and three of this application, is correctly recorded, true, and complete. I understand that material omissions or intentional misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or could void any coverage issued. **If I subsequently become aware of information different from that provided in this application, I agree to provide that additional information promptly to the insurer. A change of information prior to the effective date of the policy may void an offer to provide coverage.**

I understand there may not be participating providers in all specialty fields.

I understand that credit for prior coverage will be based upon the information contained in this application and/or proof of prior coverage, such as a Certificate of Creditable Coverage that I have obtained from my prior health care insurer(s) and provided to the insurer.

If any information provided is false or incomplete, the insurer may without advance notice pursue any remedies available under state or federal law, including but not limited to: declaring the policy null and void and canceling the policy retroactive to its original effective date; or imposing the pre-existing condition waiting period and denying claims that are pre-existing, subject to credit for prior coverage.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. THE INSURER SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I further certify that all information completed on this form is true, correct and complete and acknowledge the policy is subject to cancellation or other action permissible at law, if any completed information is found to be false or incorrect.

I attest that all information on this form is accurate. I have read the Acknowledgment of this document and agree to its terms. I have also completed an authorization to disclose protected health information, if such form accompanies this application.

Applicant Signature _____ Date _____

(A faxed signature shall be valid as an original signature.)

Spouse Signature _____ Date _____

(Required if applying for coverage. A faxed signature shall be valid as an original signature.)

Requested Effective Date _____ (Coverage is not in force until the insurer approves your application and determines the effective date.)

J. PRODUCER AGREEMENT AND COMPENSATION DISCLOSURE (If applicable)

I understand and agree that in acting as the producer for this applicant:

1. The application was completed by the applicant.
2. I am in possession of a valid license issued by the State of Utah that authorizes me to sell and service health insurance;
3. I have no authority to: a) make, alter, interpret, or discharge an application or policy in the name of a insurer; or b) waive any of the terms or conditions of the policy.
4. I have no authority to assign effective dates or to effect member changes.

Producer Name _____ License # _____ Agency _____ Phone (____) _____

Producer Signature _____ Date Signed _____

(A faxed signature shall be valid as an original signature.)

Producer Compensation Disclosure:

(Compensation includes commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration.)

I have received written disclosure that the producer will receive compensation from the insurer or a third party administrator for the placement of insurance, including the amount or type of compensation.

Applicant Signature _____ Date _____

HumanaOne Dental & Vision Application



Requested Effective Date: ___/___/___

This form is for: New Business (First time applicant) Reinstatement (Reapplication) Change/Modification to Existing Policy or Plan

UTAH

Reason for change _____ Change/Modification to Existing Policy or Plan # _____

Dental and vision products offered do not have pre-existing waiting periods.

1. Coverage Options Please complete this section when selecting a dental or vision product.

<input type="checkbox"/> Dental Coverage	<input type="checkbox"/> Vision Coverage
Product Name _____	Product Name _____

2. Primary Applicant Information

First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / / _____
Home address (not P.O. Box) _____		City _____	State _____	ZIP code _____
E-mail _____	Home phone # () _____		Daytime phone # () _____	
Social Security # _____				

3. Family Information

Please complete only if your spouse and/or dependent children are applying for coverage. Attach an additional family information sheet if necessary. Each additional page must be signed and dated.

Spouse First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / / _____
Social Security # _____		E-mail _____		
Dependent First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / / _____
Social Security # _____		E-mail _____		
Dependent First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / / _____
Social Security # _____		E-mail _____		

4. Replacement Questions Please answer the following.

No Yes Will the insurance coverage applied for be used to replace existing dental coverage?
 No Yes Will the insurance coverage applied for be used to replace existing vision coverage?

5. 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) _____	Name (print) _____
Humana Agent # _____	Humana Agent # _____

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting this application 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 applicant in the benefit summary document or other product literature.

Writing agent's signature _____ Date ___/___/___

6. 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 applied for is not an employer-sponsored group insurance policy 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 policy or receive favorable tax treatment under federal or state law that will be used to pay insurance premiums. If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the policy. 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 application may be used by Humana during the first two policy 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 applying 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 application. The policy provides dental and vision benefits only. Review your policy carefully. This document, together with any supplements, will form part of and be the basis for any policy issued. **A person that knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.**

Primary Insured or Legal Guardian Signature _____ Date ___/___/___

Relationship of Legal Guardian _____

Spouse Signature (if covered dependent) _____ Date ___/___/___

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana".

Dental products insured by HumanaDental Insurance Company
Vision products insured or administered by Humana Insurance Company
1100 Employers Boulevard • De Pere, WI 54155

Medical Records Release Authorization

Purpose of the Authorization

By signing the form, you will authorize the disclosure and use of the protected health information described below for pre-enrollment underwriting or risk-rating of health insurance coverage for you, or to determine your eligibility for enrollment or benefits under a health plan.

Information we will use and/or disclose

My dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., employer or the Consumer Reporting Agency having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness and copies of all hospital or medical records, non-public personal health information, and any other non-medical information to share any and all such information with the Company, its reinsurer or its legal representatives, and its affiliates.

- The information obtained by use of this authorization may be used by the Company to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
- Any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing health care operations or business or legal services in connection with any application, claim or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report and I (we) may request a copy of the report.
- Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.

Expiration and revocation

- A copy of this authorization is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below. I have the right to revoke this authorization at any time.
To revoke this authorization:
 - I must do so in writing and send my written revocation to Humana’s Privacy Office.
 - The revocation will not apply to information that has already been released in response to this authorization.
 - The revocation may adversely affect my application, a claim or a pending insurance action.
 - The revocation will become effective after it is received by Humana’s Privacy Office.

If you decide not to sign this authorization, we will decline to enroll you in a medical plan or to give you medical benefits.

Primary Applicant or Legal Guardian Signature _____ Date __/__/____

Relationship of Legal Guardian _____

Spouse Signature _____ Date __/__/____
(if covered dependent)

Child Signature _____ Date __/__/____
(if covered dependent over the legal age)

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as “Humana”.

**Medical and Life products insured by Humana Insurance Company
Dental products insured by HumanaDental Insurance Company**



**Humana Insurance Company • N19 W24133 Riverwood Drive • Waukesha, WI 53188
HumanaDental Insurance Company • 1100 Employers Boulevard • Green Bay, WI 54344**

HumanaOne Individual Insurance Payment Authorization & Billing Form



Quoted Monthly Payment Amount:

\$ _____ (total payment for all products selected; not including administrative or enrollment fees)

- PPO Annual Max Plan Association Dues: \$3.95 Monthly (non-refundable)
- Dental Preventive Plus Association Dues: 75¢ Monthly (non-refundable) (no dues apply if enrolled in PPO Annual Max Plan Association)
- Administration Fee (DHMO, Dental Preventive Plus & Vision Direct): \$1 Fee applies to each payment
- Enrollment Fee (Vision Direct & Dental Preventive Plus): \$35 One-Time Fee per plan (non-refundable)
- Dental DHMO Enrollment Fee: \$19 One-Time Fee (non-refundable)

Payor Information

If you are paying for the plan(s), please provide the following information. Then tell us how you would like to pay for the plan(s) by completing 1 and 2 below. If you will be paying for someone else's plan(s), please also complete the Alternate Payor section below.

First name	MI	Last name	Home phone # ()	Daytime phone # ()
Home address (not P.O. Box)		City	State	ZIP code

Alternate Payor: If you are paying for an insurance plan(s) for someone else, please provide the following information about the primary applicant whose plan(s) you will be paying for. Please note, if you are paying for someone else's plan(s), you will be responsible for signing this authorization to withdraw funds from your selected accounts; not the primary applicant.

Primary Applicant First name	MI	Last name
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1. Initial Payment Options

Please choose either credit card or one-time bank withdrawal payment of the first month's payment. Initial payment for each product applied for will be drafted separately against your account.

A. Credit Card Payment

- Visa Mastercard

Card # _____

Expiration date /

Cardholder's name _____

- I authorize Humana to draw initial payment of \$ _____ and fees from my Visa / Mastercard account.

B. One-time Automatic Bank Withdrawal

Account holder's name _____

Bank name _____

Routing # _____

Account # _____

- I authorize Humana to draw initial payment of \$ _____ and fees from my designated checking account.

2. Subsequent Payment Options

Please indicate billing preference. If choosing automatic bank withdrawal, please complete the section to the right.

A. Credit Card Payment (monthly billing)

If selected a fee of \$ _____ will apply.

- Mastercard

Card # _____

Expiration date /

Cardholder's name _____

- I authorize Humana to draw subsequent payment of \$ _____ and fees from my Mastercard account until this authorization is revoked by me.

B. Automatic Bank Withdrawal (monthly billing)

Account holder's name _____

Bank name _____

Routing # _____

Account # _____

- I authorize Humana to draw subsequent payment of \$ _____ and fees from my designated checking account until this authorization is revoked by me.

C. Direct Bill

If selected a fee of \$ _____ will apply.

- Monthly billing _____

- Quarterly billing _____

- Semi-Annual billing _____

Payor Signature _____ Date ____/____/____