

Enrollment Application



Follow these easy steps to apply for a Humana Achieve Medicare Supplement insurance policy.

1 Have Your Medicare Card Ready

Please print legibly and complete the entire form. You will need to fill in the information exactly as it appears on your Medicare card. Each person must complete a separate application.

2 Read and Complete Other Coverage Information

Be sure you read and understand the information before completing this section. **If you intend to replace your current Medicare Supplement policy or Medicare Advantage plan with this policy, be sure to complete the enclosed form titled Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage.**

3 Complete Guaranteed Acceptance

Please fill out this section if you are eligible for guaranteed acceptance.

4 Read and Complete Medical Questions

5 Determine Your Premium

6 Determine Your Discount

7 Premium Payment Options

Indicate the option you choose for future premium payments. Your initial premium is not required at time of application and will be billed once your application is accepted and your policy has been issued.

8 Sign and Date the Enrollment Application

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Marking Instructions

- Please print clearly and press hard.
- **Use blue or black ink only.**
- Completely fill the ovals.

Correct Mark



Incorrect Marks



- Print legible numbers and capital block letters in the boxes.

Correct Numbers and Letters

1 2 3 A B C

- Print only one character per box.
- If you make a mistake, correct it by crossing out the box and writing the letter/number above or below the box as shown. Be sure to initial any and all corrections made.

T
S M I X H

- When filling out dates, such as effective dates or birth dates, be sure dates appear in the MMDDYYYY format. No dashes or spaces are necessary.

0 3 2 4 2 0 1 0

Required Fields Must Be Completed

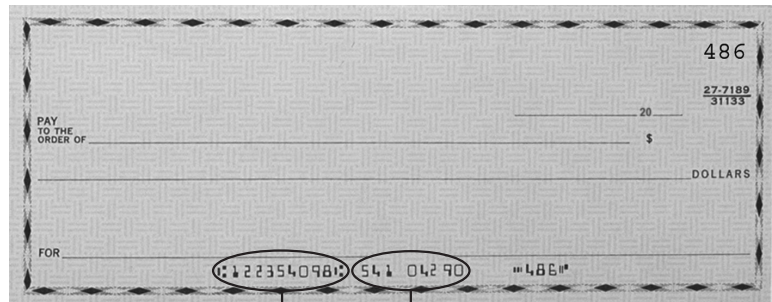


Optional Fields



Sample Void Check

(If you are choosing the auto bank withdrawal.)



Routing Number Account Number

1

LAST NAME

[Grid of 15 boxes for last name]

FIRST NAME

[Grid of 15 boxes for first name]

MI

[Box for MI]

ADDRESS

[Grid of 25 boxes for address]

APT OR STE#

[Grid of 5 boxes for apt or ste#]

ADDRESS (continued)

[Grid of 25 boxes for address continued]

COUNTY

[Grid of 15 boxes for county]

CITY

[Grid of 25 boxes for city]

STATE

[Grid of 2 boxes for state]

ZIP CODE

[Grid of 5 boxes for zip code]

TELEPHONE

[Grid of 10 boxes for telephone]

DATE OF BIRTH

[Grid of 8 boxes for date of birth]

GENDER M F

HEIGHT [] FT [] IN

WEIGHT [] [] [] LBS

MAILING ADDRESS (only if different from above street ADDRESS)

[Grid of 25 boxes for mailing address]

APT OR STE#

[Grid of 5 boxes for apt or ste#]

CITY

[Grid of 25 boxes for city]

STATE

[Grid of 2 boxes for state]

ZIP CODE

[Grid of 5 boxes for zip code]

E-MAIL ADDRESS (optional)

[Grid of 30 boxes for email address]

(E-mail address, if available, will be used as a means to communicate only coverage information.)

Select the policy you are applying for:

- Plan A
- Plan F*
- Plan G
- High Deductible Plan G
- Plan N

* Only applicants eligible for Medicare prior to 1/1/2020 may purchase Plan F.

PROPOSED EFFECTIVE DATE

[Grid of 8 boxes for proposed effective date: MM / 01 / 20 YY]

Please complete the information below as it appears on your Medicare card.

MEDICARE NUMBER

[Grid of 9 boxes for Medicare number]

IS ENTITLED TO

HOSPITAL INSURANCE (PART A)

EFFECTIVE DATE

[Grid of 8 boxes for effective date: MM / DD / YYYY]

MEDICAL INSURANCE (PART B)

[Grid of 8 boxes for effective date: MM / DD / YYYY]

PERSON TO NOTIFY IN AN EMERGENCY (optional):

LAST NAME

[Grid of 15 boxes for last name]

FIRST NAME

[Grid of 15 boxes for first name]

MI

[Box for MI]

RELATIONSHIP TO APPLICANT

[Grid of 25 boxes for relationship to applicant]

TELEPHONE

[Grid of 10 boxes for telephone]

Agent Number (SAN)

[Grid of 5 boxes for agent number]

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3 Guaranteed Acceptance

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. Are you applying for coverage during your Medicare Supplement Open Enrollment Period? Yes No
If yes, please go directly to Section 6.
2. Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed acceptance? Yes No
If yes, please go directly to Section 6. Additionally, if you are submitting a Notice of Replacement, please provide the criteria qualifying you for guaranteed acceptance on the form. For example, if you qualify for guaranteed acceptance due to a Medicare Advantage plan exit, please check "Disenrollment from a Medicare Advantage plan" and indicate that your plan is exiting the market and no longer available.

If you answered yes to either question in this section, you qualify for the Preferred rates.

4 Medical Questions

IF YOU ARE APPLYING FOR COVERAGE DURING YOUR MEDICARE SUPPLEMENT OPEN ENROLLMENT PERIOD OR QUALIFY FOR GUARANTEED ACCEPTANCE, YOU ARE NOT REQUIRED TO ANSWER THE FOLLOWING QUESTIONS. A MEDICAL RECORDS RELEASE AUTHORIZATION FORM IS REQUIRED.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. In the last year, have you been hospitalized, confined to a nursing facility; or are you bedridden or confined to a wheelchair? Yes No
2. In the past 90 days have you received Home Health care? Yes No
3. Have you ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions or tested positive for the presence of HIV antibodies, antigens, or the virus? Yes No
4. Do you now have or within the last two years have you had or been advised by a physician that you need treatment or surgery for:
 - a. Heart, Coronary, or Carotid Artery Disease (not including high blood pressure), Peripheral Vascular Disease, Congestive Heart Failure or any other type of Heart Failure, Enlarged Heart, Stroke, Transient Ischemic Attacks (TIA), or Heart Rhythm disorders? Yes No
 - b. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other Chronic Pulmonary disorders? Have you used supplementary oxygen in the last year? Yes No
 - c. Parkinson's Disease, Multiple or Lateral Sclerosis, Huntington's Disease, Muscular Dystrophy, Lupus, Hepatitis, or Lou Gehrig's Disease? Yes No
 - d. Alzheimer's Disease, senile dementia, organic brain disorders, senility disorder, schizophrenia, other major depressive disorders, mental or nervous disorders, cirrhosis, alcoholism or drug abuse? Yes No
 - e. Kidney disease requiring dialysis or diabetes requiring more than 50 units of insulin daily? Yes No
 - f. Internal cancer, leukemia or melanoma? Yes No
 - g. Amputation caused by disease or trauma or neuralgic or poor circulation that has caused an ulcer on the skin? Do you have any paralytic conditions? Yes No
 - h. Rheumatoid arthritis, Paget's Disease, degenerative bone disease, crippling arthritis, vertebral or hip fractures/dislocations, spinal cord disorders/injuries? Yes No
 - i. Organ transplantation? Yes No
5. Please list any prescription drugs (full medication name) you are currently taking or have taken within the past 12 months:

Grid of 12 empty boxes for Medicare number

Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

The undersigned applicant certifies that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy. The applicant further acknowledges receipt of the currently available Outline of Coverage and the "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" publication.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility.*

If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan.*

*If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

8 Signature & Date

APPLICANT'S SIGNATURE:

Large empty box for Applicant's signature

SIGNATURE DATE:

Grid for signature date: MM / DD / YYYY

AGENT'S SIGNATURE:

Large empty box for Agent's signature

SIGNATURE DATE:

Grid for signature date: MM / DD / YYYY

TO BE COMPLETED BY SALES AGENT- PLEASE LIST All health insurance policies sold to the applicant which are still in force and all health insurance policies sold to the applicant within the past five years which are no longer in force.

A response is required. NONE or Not Applicable ○

COMPANY

Grid of 15 empty boxes for Company name

TYPE

Grid of 15 empty boxes for Company type

COMPANY

Grid of 15 empty boxes for Company name

TYPE

Grid of 15 empty boxes for Company type

If you are the authorized legal representative, you must sign above on behalf of Applicant and provide the following information:

LAST NAME

Grid of 20 empty boxes for Last Name

FIRST NAME

Grid of 15 empty boxes for First Name

MI

STREET ADDRESS

Grid of 30 empty boxes for Street Address

CITY

Grid of 25 empty boxes for City

ST

ZIP

Grid of 5 empty boxes for ZIP

TELEPHONE

Grid for telephone number: () () () / () () () - () () () ()

RELATIONSHIP TO APPLICANT

Grid of 10 empty boxes for Relationship to Applicant

Insured by CompBenefits Insurance Company

Humana[®]

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

CompBenefits Insurance Company • P.O. Box 14309, Lexington, KY 40512-4309

 Save this notice! It may be important to you in the future.

According to information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy/certificate to be issued by CompBenefits Insurance Company. Your new policy/certificate will provide 30 days within which you may decide - without cost - whether you desire to keep the policy/certificate.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to the Applicant by Issuer, Agent (Broker or other Representative)

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan.

The replacement policy/certificate is being purchased for the following reason (check one):

- | | |
|---|--|
| <input type="checkbox"/> additional benefits | <input type="checkbox"/> no change in benefits, but lower premiums |
| <input type="checkbox"/> fewer benefits and lower premiums | <input type="checkbox"/> other (please specify) _____ |
| <input type="checkbox"/> my plan has outpatient prescription drug coverage and I am enrolling in Part D | _____ |
| <input type="checkbox"/> disenrollment from a Medicare Advantage plan (please explain reason for disenrollment) | _____ |

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy/certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy/certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy/certificate until you have received your new policy/certificate and are sure that you want to keep it.

Applicant's signature	Signature of agent/broker/representative	
Print name	Print name and address of agent or broker below	
Social Security number		Date



Medical Records Release Authorization

Purpose of the Authorization

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

Information we will use and/or disclose

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, employer or the Consumer Reporting Agency having information regarding myself 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 CompBenefits Insurance Company, its reinsurer or its legal representatives, and its affiliates.

- The information obtained by use of this authorization may be used by CompBenefits Insurance Company to determine eligibility for coverage.
- Any information obtained will not be released by CompBenefits Insurance Company to any person or organization except to reinsuring companies, 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 may request to be interviewed in connection with the preparation of the report and I may request a copy of the report.
- Once personal and health (including medical 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 2 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 (Humana Privacy Office, P.O. Box 1438 Louisville, KY 40202).
- 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 were required to answer medical questions on your Medicare Supplement Enrollment Application, you must complete this authorization to be eligible for enrollment.

LAST NAME

FIRST NAME

MI

MEDICARE NUMBER

SOCIAL SECURITY NUMBER

DATE

Applicant Signature _____ Date _____

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