## 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 Individual Insurance Application

HUMANA One

GEORGIA

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

**Date of application:** __ __/__ __/__ __ __ __ **Requested Effective Date:** __ __/__ __/__ __ __ __

This application is for:
- ❑ New Business (First time applicant)
- ❑ Reinstatement (Reapplication)
- ❑ Change/Modification to Existing Policy

Reason for change _____

Change/Modification to Existing Policy #_____

## Coverage Options

### Health Coverage

**Please complete this section when selecting a health plan.**

Plan name

Deductible $

### Dental Coverage

❑ Dental Traditional 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
- ❑ Mental Disorder Benefit
- ❑ Carryover Deductible

**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 or plan, dental is only available at your anniversary.

### Life Coverage

**Please complete this section if choosing 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.**

**Primary Applicant:**

❑ **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:**

❑ **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 Information

| First name | MI | Last name | Height | Weight | Gender ❑ M ❑ F | Date of birth / / |
|---|---|---|---|---|---|---|
| Home address (not P.O. Box) | | | City | | State | ZIP code |
| Social Security # | | Country or State of birth | | E-mail | | |
| Type of business or industry | | Occupation | Home phone # ( ) | | Daytime phone # ( ) | |
| Mailing address (if different from home address) | | | City | | State | ZIP code |

## 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 | Height | Weight | Gender ❑ M ❑ F | Date of birth / / |
|---|---|---|---|---|---|---|
| Country or State of birth | Spouse's type of business or industry | | | Spouse's occupation | | |
| Social Security # | | E-mail | | | | |

| **Dependent 1** First name | MI | Last name | Height | Weight | Gender ❑ M ❑ F | Date of birth / / |
|---|---|---|---|---|---|---|
| Full-time student (if 18 or older) ❑ No ❑ Yes | | | | | | |

| **Dependent 2** First name | MI | Last name | Height | Weight | Gender ❑ M ❑ F | Date of birth / / |
|---|---|---|---|---|---|---|
| Full-time student (if 18 or older) ❑ No ❑ Yes | | | | | | |

| **Dependent 3** First name | MI | Last name | Height | Weight | Gender ❑ M ❑ F | Date of birth / / |
|---|---|---|---|---|---|---|
| Full-time student (if 18 or older) ❑ No ❑ Yes | | | | | | |

| **Dependent 4** First name | MI | Last name | Height | Weight | Gender ❑ M ❑ F | Date of birth / / |
|---|---|---|---|---|---|---|
| Full-time student (if 18 or older) ❑ No ❑ Yes | | | | | | |

## Existing/Prior Coverage

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

### • Existing or Prior Health Coverage

**If you are applying for health coverage, please provide the status of current coverage or coverage within the past 24 months, including Humana, for each applicant. If additional space is needed, please attach additional pages. Each additional page must be signed and dated.**

❑ No ❑ Yes Do you or anyone applying for coverage have any major medical health insurance coverage currently in force?

- ***If YES, please supply the following for all applicants applying for coverage on the policy:***

  Name(s) of covered persons

  Major Medical Insurance Carrier Name Effective Date __ __ / __ __ / __ __ __ __

- ***If NO, please answer the following question:***

  ❑ No ❑ Yes Have you or anyone applying for coverage had major medical health insurance coverage within the past 24 months?

  - ***If YES, please supply the following for all applicants applying for coverage on the policy:***

  Name(s) of covered persons

  Major Medical Insurance Carrier Name

  Effective Date __ __ / __ __ / __ __ __ __

  Termination Date __ __ / __ __ / __ __ __ __

## • Existing Dental Coverage

1. ❑ No ❑ Yes Does anyone applying for coverage currently have or had any group or individual dental coverage within the last 18 months?

- ***If YES, please supply the following for all applicants applying for coverage on the policy:***

Name(s) Effective Date __ __ / __ __ / __ __ __ __

Insurance Carrier Name Termination Date __ __ / __ __ / __ __ __ __

Name(s) Effective Date __ __ / __ __ / __ __ __ __

Insurance Carrier Name Termination Date __ __ / __ __ / __ __ __ __

2. ❑ No ❑ Yes Will the insurance coverage applied for be used to replace existing dental 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

**Please answer for all individuals applying for coverage.**

**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 applying 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 policy being rescinded or modified back to your original effective date.**

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

**Has anyone applying 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 applicant, or spouse or dependent applying for coverage used any tobacco product?

   **Primary Applicant:** ❑ No ❑ Yes
   **Spouse:** ❑ No ❑ Yes
   **Dependent:** ❑ No ❑ Yes

4. ❑ 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 next year?
5. ❑ No ❑ Yes Are you or is any immediate family member (whether applying for coverage or not) pregnant, an expectant parent, in the process of adopting a child, or undergoing infertility treatment?

**Within the past 1-5 years, has anyone applying 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 diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS), or tested positive for AIDS or Human Immunodeficiency Virus (HIV)?
8. ❑ No ❑ Yes Had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any alcohol abuse, dependency or problem, or had any alcohol related arrests?
9. ❑ No ❑ Yes Used any illegal or taken prescription drugs not prescribed by their health care provider or had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any drug abuse, dependency or problem; or had any drug related arrests?
10. ❑ No ❑ Yes Had any testing or procedure performed that has been abnormal or the results of which are pending or unknown?
11. ❑ No ❑ Yes Had surgery or been advised to have surgery that has not been completed?
12. ❑ No ❑ Yes Consulted, advised or recommended to have follow-up testing or treatment by a health care provider or specialist that has not been completed?

## Eligibility & Health Status continued

13. **Within the past 5 years,** has anyone applying for coverage had signs of, been prescribed medication or received injections for, or been diagnosed with or treated for:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| A. | ❑ No | ❑ Yes | Chest pain or Heart Attack | M. | ❑ No | ❑ Yes | ADD/ADHD (Attention Deficit Disorder) or any other Behavioral, Emotional, Mental or Nervous Disorders |
| B. | ❑ No | ❑ Yes | High Blood Pressure or Hypertension | N. | ❑ No | ❑ Yes | Eating Disorder |
| C. | ❑ No | ❑ Yes | High Cholesterol or Triglycerides | O. | ❑ No | ❑ Yes | Developmental Disorder or Delay |
| D. | ❑ No | ❑ Yes | Cancer or Tumor of any kind | P. | ❑ No | ❑ Yes | Human Papilloma Virus or Sexually Transmitted Disease |
| E. | ❑ No | ❑ Yes | Diabetes or High Blood Sugar | Q. | ❑ No | ❑ Yes | Infertility |
| F. | ❑ No | ❑ Yes | Stroke | R. | ❑ No | ❑ Yes | Uterine Fibroids |
| G. | ❑ No | ❑ Yes | Paralysis | S. | ❑ No | ❑ Yes | Cyst, Growth, Lump or Polyp |
| H. | ❑ No | ❑ Yes | Epilepsy or Seizure | T. | ❑ No | ❑ Yes | Hernia |
| I. | ❑ No | ❑ Yes | Migraines or frequent or severe headaches | U. | ❑ No | ❑ Yes | Arthritis |
| J. | ❑ No | ❑ Yes | Hepatitis | V. | ❑ No | ❑ Yes | Implants, Pins, Plates, Rods, Screws or Prosthesis |
| K. | ❑ No | ❑ Yes | Sleep Apnea | W. | ❑ No | ❑ Yes | Connective Tissue or Autoimmune Disorder |
| L. | ❑ No | ❑ Yes | Anxiety or Depression | X. | ❑ No | ❑ Yes | Birth Defect |

14. **Within the past 5 years,** has anyone applying for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| A. | ❑ No | ❑ Yes | Gallbladder, Liver or Pancreas | G. | ❑ No | ❑ Yes | Eyes, Ears, Nose, Throat or Sinuses |
| B. | ❑ No | ❑ Yes | Colon, Esophagus or Stomach | H. | ❑ No | ❑ Yes | Breasts |
| C. | ❑ No | ❑ Yes | Bladder or Kidneys | I. | ❑ No | ❑ Yes | Menstrual Cycle |
| D. | ❑ No | ❑ Yes | Back, Disc, Neck or Spine | J. | ❑ No | ❑ Yes | Cervix, Ovaries, Uterus or Vagina |
| E. | ❑ No | ❑ Yes | Knee, Hip or Shoulder | K. | ❑ No | ❑ Yes | Penis, Prostate or Testicles |
| F. | ❑ No | ❑ Yes | Lungs | L. | ❑ No | ❑ Yes | Skin |

15. **Within the past 5 years,** has anyone applying for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder (not previously disclosed) involving or affecting:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| A. | ❑ No | ❑ Yes | Blood Vessels, Heart or Circulatory System | E. | ❑ No | ❑ Yes | Urinary System |
| B. | ❑ No | ❑ Yes | Blood, Gland, Pituitary, Thyroid or Lymph System | F. | ❑ No | ❑ Yes | Musculoskeletal System, including Bone/Joint Disorders |
| C. | ❑ No | ❑ Yes | Brain or Nervous System | G. | ❑ No | ❑ Yes | Respiratory System |
| D. | ❑ No | ❑ Yes | Digestive System | H. | ❑ No | ❑ Yes | Reproductive System |

16. ❑ No ❑ Yes Within the past 24 months, has anyone applying for coverage seen a health care provider or specialist for a routine physical/wellness exam, or been seen for *any* reason not previously disclosed?

17. ❑ No ❑ Yes Within the past 24 months, has anyone applying for coverage been advised to take or taken any prescription medications or injections not previously disclosed?

## Additional Eligibility or Health Status Question Information

**To be completed if anyone applying for coverage answered "Yes" to any question(s) in the Eligibility & Health Status section. Please provide details such as; specific condition, dates of treatment, results or advice given, medication (dosage and frequency), treatment plan, recovery date, physician name and address. Attach an additional health information sheet if necessary. Additional information sheets must be signed and dated by the primary applicant or legal representative and/or spouse (if applying).**

| Question # | Letter | Person treated | Condition |
|---|---|---|---|
| Details: | | | |

| Question # | Letter | Person treated | Condition |
|---|---|---|---|
| Details: | | | |

| Question # | Letter | Person treated | Condition |
|---|---|---|---|
| Details: | | | |

## 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 agree to immediately notify Humana of any changes to the information contained in this form that occur prior to the policy 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 policy applied 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 policy or otherwise 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. Unless Humana agrees to an earlier date, the effective date for sickness begins on the 15th day after the approved effective date of the policy. Acceptance of premium and fees does not guarantee coverage. 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. I agree to terminate any existing coverage if this application is approved and coverage accepted. 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 health information regarding my dependent in order to fully and truthfully complete this application.

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

**Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and, upon conviction, may be subject to fines or confinement in prison, or both.**

**If you decide not to sign this agreement, 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 (if covered dependent) _____ Date __ __/__ __/__ __ __ __

## Agent / Producer Information

**This section to be completed by Agent or Producer.**

| **Agent / Agency of Record: (for commissions and correspondence)** | **Writing Agent / Producer:** |
|---|---|
| Name (print) Insurance Now | Name (print) Holly G. Conley |
| Humana Agent # 1299674 | Humana Agent # 1299674 |

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 plans 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 plan literature.

Writing Agent's Signature Holly G Conley 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."

**POS plans offered by Humana Employers Health Plan of Georgia, Inc. and insured by Humana Insurance Company**
**Life products insured by Humana Insurance Company**
**Dental products insured by HumanaDental Insurance Company**

HUMANA®
*Guidance* when you need it most

## Pre-Notice

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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.

# Humana*One* **Dental Application**

HUMANA One

**Requested Effective Date:** __ __/__ __/__ __ __ __

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

GEORGIA

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

## 1. Coverage **Please complete this section when selecting a dental product.**

| **Dental Coverage** |
|---|
| Product Name |

## 2. Primary Applicant Information

| First name | MI | Last name | Gender ❑ M ❑ 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 ❑ M ❑ F | Date of birth / / |
|---|---|---|---|---|
| Social Security # | | E-mail | | |

| **Dependent** First name | MI | Last name | Gender ❑ M ❑ F | Date of birth / / |
|---|---|---|---|---|
| Social Security # | | E-mail | | |

| **Dependent** First name | MI | Last name | Gender ❑ M ❑ F | Date of birth / / |
|---|---|---|---|---|
| Social Security # | | E-mail | | |

| **Dependent** First name | MI | Last name | Gender ❑ M ❑ F | Date of birth / / |
|---|---|---|---|---|
| Social Security # | | E-mail | | |

## 4. 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 __ __/__ __/__ __ __ __

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

**Any person who submits an application containing a false, incomplete or deceptive statement may be guilty of insurance fraud. 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 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**

# 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**
**POS plans offered by Humana Employers Health Plan of Georgia, Inc. , and/or insured by Humana Insurance Company**
**PPO plans insured by Humana Insurance Company**
**Dental products insured by HumanaDental Insurance Company**

HUMANA®
*Guidance* when you need it most

# HumanaOne Individual Insurance
# Payment Authorization & Billing Form

HUMANA One

## Quoted Monthly Payment Amount:

**$ _____ (total payment for all products selected; not including, association dues, administrative or enrollment fees)**

**Please note: Rates quoted are not guaranteed. The final rate will be based on underwriting completion and approval of the application or enrollment form.**

- **Medical Plan Association Dues: $3.95 Monthly (non-refundable) (Dues apply to specific plans in: AL, AZ, FL, IL, MI, WI)**
- **Dental Preventive Plus Association Dues: 75¢ Monthly (non-refundable) (Dues apply in: AL, AR, AZ, FL, IL, IN, KS, KY, LA, MI, MO, MS, NC, NE, NM, NV, OH, OK, SC, TN, TX, VA, WI, unless enrolled in a Medical 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 # ( ) |
|---|---|---|---|---|
| | | | | |

| Mailing address | 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 |
|---|---|---|
| | | |

## 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

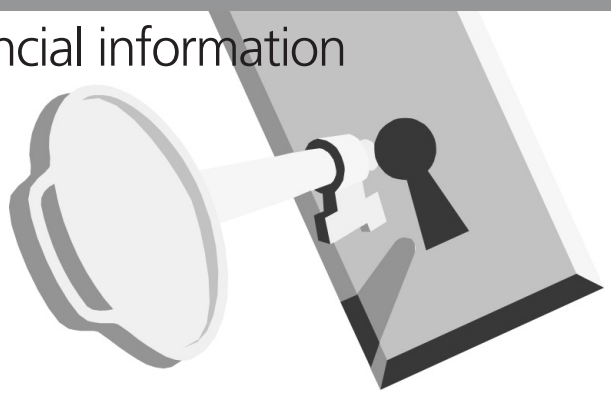
❑ Quarterly billing

❑ Semi-Annual billing

Payor Signature _____ Date __ __/__ __/__ __ __ __

# Notice of Privacy Practices

## for your *personal* health and financial information



**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.**

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. We at Humana value our relationship with you, and we take your personal privacy seriously.

This notice explains Humana's privacy practices, our legal responsibilities, and your rights concerning your personal and health information. We follow the privacy practices described in this notice and will notify you of any changes.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

### What is personal and health information?

Personal and health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information created or received by a healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare. We protect this information in all formats including electronic, written and oral information.

### How does Humana protect my information?

In keeping with federal and state laws and our own policy, Humana has a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy policies and procedures

### How does Humana use and disclose my information?

We must use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law.

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments
- For healthcare operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, and determining premiums
- For performing underwriting activities. However, we will not use any results of genetic testing.
- To your plan sponsor to permit them to perform plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations such as to allow your plan sponsor to obtain bids from other health plans. We will not share detailed health information to your plan sponsor unless you provide us your permission or your plan sponsor has certified they agree to maintain the privacy of your information.

# Notice of Privacy Practices *(continued)*

- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you
- To your family and friends if you are unavailable to communicate, such as in an emergency
- To your family and friends or any other person you identify, provided the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law
- To assist in disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill Humana's obligations under any workers' compensation law or contract
- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director.

### Will Humana use my information for purposes not described in this notice?

In all situations other than described in this notice, Humana will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission.

### What does Humana do with my information when I am no longer a Humana member or I do not obtain coverage through Humana?

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through Humana. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

### What are my rights concerning my information?

The following are your rights with respect to your information:

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- Adverse Underwriting Decision – You have the right to be provided a reason for denial or adverse underwriting decision if Humana declines your application for insurance.*
- Alternate Communications – You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life threatening situation. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. Effective April 1, 2003 or whenever you became a Humana member, Humana began maintaining these types of disclosures and will maintain this information for a period of six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- Notice – You have the right to receive a written copy of this notice any time you request.
- Restriction – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the

* This right applies only to our Massachusetts residents in accordance with state regulations.

# Notice of Privacy Practices *(continued)*

right to agree to or terminate a previously submitted restriction.

### How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- E-mailing us at privacyoffice@humana.com

Send completed request form to:
Humana Inc.
Privacy Office 003/10911
101 E. Main Street
Louisville, KY 40202

### What should I do if I believe my privacy has been violated?

If you believe your privacy has been violated in any way, you may file a complaint with Humana by calling us at: 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to OCRComplaint@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

### PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION

Humana and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

### How does Humana collect information about me?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

### What information does Humana receive about me?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our Website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

### Where will Humana disclose my information?

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

### What can I prevent with an opt-out disclosure?

You can prevent the disclosures to non-affiliated third parties that provide products and services not offered by Humana or where the non-affiliated company provides services related to your plan by requesting to opt-out of such disclosures. Your opt-out request will apply to all members or individuals covered under your Humana identification number or member account.

Your opt-out request will continue to apply until you revoke your request or terminate your membership.

### How do I request an opt-out?

At any time you can tell Humana not to share any of your personal information with affiliated companies that provide offers of non-Humana products or services. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth, and your Humana member identification

# Notice of Privacy Practices *(continued)*

number. You can use any of the methods below to request or revoke your opt-out:

- Call us at 1-866-861-2762
- E-mail us at privacyoffice@humana.com.
- Send your opt-out request to us in writing:
  Humana Inc.
  Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

Humana follows all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, Humana follows the law, rule, or regulation which provides greater protection.

The following affiliates and subsidiaries also adhere to Humana's privacy policies and procedures:

American Dental Plan of North Carolina, Inc.
American Dental Providers of Arkansas, Inc.
CarePlus Health Plans, Inc.
Cariten Health Plan, Inc.
Cariten Insurance Company
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
CompBenefits of Alabama, Inc.
CompBenefits of Georgia, Inc.
CorpHealth, Inc. dba LifeSynch
CorpHealth Provider Link, Inc.
DentiCare, Inc.
Emphesys, Inc.
Emphesys Insurance Company
HumanaDental Insurance Company
Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of California, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana MarketPOINT, Inc.*
Humana MarketPOINT of Puerto Rico, Inc.*
Humana Medical Plan, Inc.
Humana Medical Plan of Utah, Inc.
Humana Pharmacy, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Kanawha Insurance Company*
Managed Care Indemnity, Inc.
Preferred Health Partnership, Inc.*
Preferred Health Partnership of Tennessee, Inc.
The Dental Concern, Inc.
The Dental Concern, Ltd.

* These affiliates and subsidiaries are only covered by the Privacy Notice Concerning Financial Information section.

HUMANA®
*Guidance* when you need it most

## HEALTH INSURANCE DISCLOSURES

### FAIR CREDIT REPORTING ACT AND PRIVACY ACT PRE-NOTIFICATION:

Public Law 91-508 and state privacy acts require that Humana Insurance Company advise person(s) applying for coverage that an investigative report may be made in connection with this application which will provide applicable information concerning character and general reputation. I (we) understand that this information may be obtained through a phone interview or personal interview with the person (s) applying for coverage or other third parties. 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.

### NOTICE OF INFORMATION PRACTICES:

I (we) understand that in order to properly underwrite insurance coverage, Humana Insurance Company must collect personal information concerning the insurability of person(s) applying for coverage. Humana Insurance Company may also contact other sources, including medical professionals and institutions, employer, and other insurance companies. I (we) understand that I (we) have the right to be told about, and to see (and receive a copy of) items of personal information about me (us) which may appear in my (our) files. I (we) understand that I (we) have the right to seek correction, amendment, or deletion of information I (we) believe to be inaccurate. If I (we) have questions or desire additional information about the items disclosed above, I (we) understand that I (we) may write to:

Humana Insurance Company
P. O. Box 1633
Waukesha, WI 53187-1633

HUMANA one

Insured by Humana Insurance Company

Dental Insurance provided by HumanaDental Insurance Company

# GEORGIA REPLACEMENT NOTICE

**Replacing your life insurance?**

Are you thinking about buying a new policy and discontinuing or changing an existing policy? If you are, your decision could he a good one — or a mistake. You will not know for sure unless you make a careful comparison of your existing policy and the proposed policy.

Make sure you understand the facts. Georgia law gives you the right to obtain a policy summary statement from your existing insurer at any time. Ask the company or agent that sold you your existing policy to give you information about it.

Do not let one agent or insurer prevent you from obtaining information from another agent or insurer which may be to your advantage.

Hear both sides before you decide. This way you can he sure you are making a decision that is in your best interest.

☐ If you wish a policy summary statement from your existing insurer, or insurers, check this box.

We are required to notify your existing company that you may be replacing their policy.

Existing life insurance to be replaced:

| | Name of Existing Insurer | Contract or ID Number | Date of Policy | Name of Insured |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

Applicant's Name

Applicant's Signature

Date

HUMANA one

Insured by Humana Insurance Company

**Please retain this disclosure form for your records**

# Georgia Participating Provider Disclosure

Managed care plans in the state of Georgia are required to disclose certain specific information as shown below.

- **Benefits and services as well as obligations including premiums, deductibles, copayments, maximum limits on out of pocket expenses** of the Individual Major Medical Preferred Provider Policy are available in the Georgia Benefit Summary grid which can be obtained from your sales representative or you can view the Benefit Summary on-line at www.humana.com.

- **Insured Rights and Responsibilities**. You have the right to:
  - Be provided with information about your plan, its services and benefits.
  - Be informed of your diagnosis, treatment choices, including non-treatment, and prognosis in terms you can reasonably expect to understand, and to participate in decision-making about your health care and treatment.
  - File a formal complaint, as outlined in the policy, and to expect a response to that complaint within a reasonable period of time.
  - Be provided with information about the Consumer Choice Option which allows you to nominate a non-participating provider. You may contact us to obtain a nomination form for completion by both the provider and you. The provider must be located and licensed in the state of Georgia and must also agree to the same payment rates, terms and conditions as participating providers. The provider must meet our credentialing standards.

  You have the responsibility to:
  - Give your Humana plan and your health care provider complete and accurate information needed to care for you.
  - Read and be aware of all material distributed by the plan explaining policies and procedures regarding services and benefits.
  - Follow the treatment plan agreed on with your health care provider and to weigh the consequences of any refusal to observe those instructions or recommendations.
  - Follow health care facility rules and regulations for patient care and conduct.

- **Prior authorization and review requirements.** We require notification and obtain our approval before and during certain services as noted in the policy. If preauthorization is not received from us, benefits will be reduced by 25% for these services. You are also required to notify us prior to receiving inpatient services, non-emergency care, outpatient services in a hospital or health care treatment facility, or diagnostic services as outlined in the policy.

  - Prescription Drugs. Prescription drugs covered in Humana's pharmacy benefit, Rx4, are assigned to one of four different levels with corresponding copayment amounts. Refer to your plan contract for specific copayment amounts.

  Some prescription drug benefits require that you receive prior approval from us for coverage of certain medications from the prescribing physician for the drug to be covered. In many cases, prior authorization for medications in the first 3 levels of Rx4 are eliminated. For a complete list of drugs that require prior authorization, log on to www.humana.com or call customer service.

  **The number, mix and distribution of participating providers.** You are entitled to a list of individual participating providers. Provider changes occur daily. Some of the providers may no longer participate, while other new providers may have joined. Currently there are 1,726 obstetricians, 220 hospitals, 10,266 specialists and 5,614 primary care physicians in the network. Please see the provider directory available on-line at www.humana.com. You may also call customer service for a provider directory to be mailed to you.

HUMANA one

Insured by Humana Insurance Company

**Please retain this disclosure form for your records**

# Georgia Participating Provider Disclosure

- **Limitations on choices of health care providers.** The PPO plan was built to offer you choices – including the option to see any physician and go to any hospital you choose. By using in-network hospitals and doctors you receive a higher level of benefits. You can choose any doctor or hospital but you will receive payment at a reduced benefit level.

- **A summary of any agreements or contracts between the managed care plan and any health care provider or hospital as they pertain to financial incentive programs which is as follows:**

  Provider financial arrangements
  Humana has an extensive provider network and several types of contractual provider agreements that are common to managed care plans.

  Many physicians are paid on a fee-for-service basis or for each service you receive from them. Some physicians have capitation agreements. This means the physician is prepaid a set dollar amount each month to care for each member regardless of how few or how many services a particular member may receive, or in some cases, whether services are provided by the primary care physician or a specialist. Stop-loss insurance protects some physicians from financial loss in case the actual costs incurred in caring for their patients exceed certain sums.
  Some providers may also be eligible to receive additional reimbursement from us that is based on established utilization and quality criteria.

  Participating primary care and specialist physicians and other provider in Humana's networks are not the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgment or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

- **Explanation of what constitutes an emergency situation and emergency services**.
  Emergency care means any service provided for a bodily injury or sickness manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
  - Placing the health of that individual (or with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy;
  - Serious impairment of bodily functions; or
  - Serious dysfunction of any bodily organ or part.

If you receive emergency care and cannot reasonably access care from your PPO provider, benefits for that emergency which are rendered during the course of the emergency will be payable at the PPO levels. However, if you could have reasonably reached a PPO provider, benefits will be payable at the non-preferred provider level.

- **Explanation of the Grievance process**
  If you disagree with our decision on payment of a particular claim, you can request a second review. To request the review, you must send us a letter requesting a second claim review within 60 days from the time you received notice of our claims payment decision. We will make a second review and provide notice of our decision within 60 days of receiving the request.
  If you wish to receive a summary of the number, nature and outcome results of grievances filed, this information is available upon request at a reasonable cost.

HUMANA one

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