



**AllUtahHealthPlans.com**

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**Universal Health Insurance Application**  
**Utah – Use for all Health Insurance Companies**

**GENERAL APPLICATION INSTRUCTIONS:**

- 1) Print out the application and fill it out in any color pen

Note: If you have not got your quote yet from your agent, please call us now!

- 2) The applicant is ALWAYS the oldest person applying. They must sign at the end of the application as the applicant, the younger as “spouse”.
- 3) Depending on which company you are applying for, you will need to fill out the Company Specific Additional forms (ie 3-5 extra pages with plan selection, etc.) Fill out the additional forms and send those with this “Universal” application using one of following methods:

a) **Mail**

IBP – Insurance Benefit Plans of Utah  
Attn: New Health Insurance  
PO Box 95210  
South Jordan, UT 84095

b) **Fax**

all pages to: (801) 386-5499

c) **Scan & Email**

to this email address: AllUtahHealthPlans@gmail.com



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**AllUtahHealthPlans.com • (801) 406-9502**

## › 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

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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.

### Optional Benefits

Please select an optional benefit if available with chosen health 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.

### 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

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

### • Existing Life Coverage

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#### 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 #
<hr/>		

#### 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 #
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## Eligibility & Health Status

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

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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?	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.

<b>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.</b>							
<b>Respond to the following questions:</b>		<b>YES</b>	<b>NO</b>	<b>Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following (cont.):</b>		<b>YES</b>	<b>NO</b>
1	<b>Pregnancy/Adoption:</b> 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	<b>Female Reproductive Conditions/Disorders:</b> Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, pelvic inflammatory disease, or any other disorder of the reproductive system?		
2	<b>Pregnancy/Fertility Related Treatment:</b> 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	<b>Digestive Conditions/Disorders:</b> 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	<b>Last Menstrual Period:</b> 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	<b>Nervous, Mental and Behavioral:</b> Mental health counseling, psychotherapy, depression, stress, anxiety, attention deficit hyperactivity disorder (ADHD), mental health disorder, or chemical imbalance that required consultation or medication?		
<b>Within the past 12 MONTHS has any applicant:</b>		<b>YES</b>	<b>NO</b>	<b>Within the past 10 YEARS has any applicant been diagnosed with or treated for any of the following:</b>		<b>YES</b>	<b>NO</b>
4	<b>Prescriptions/Medications/Immunizations:</b> Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?			24	<b>Gout, arthritis, Rheumatoid arthritis, fibromyalgia, or scleroderma?</b>		
5	<b>Conditions Requiring Follow Up Medical Consult/Treatment:</b> 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	<b>Musculoskeletal Conditions/Disorders:</b> Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, spondylolysis, or other musculoskeletal disorder?		
6	<b>Medical Consult/Treatment:</b> Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine & wellness care?			26	<b>Digestive Conditions/Disorders:</b> Crohn's disease. Colitis, colostomy, ileostomy, or other digestive disorder?		
7	<b>Conditions Requiring Initial Medical Consult/Treatment:</b> 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	<b>Alcohol or Drug Use/Abuse:</b> 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?		
<b>Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:</b>		<b>YES</b>	<b>NO</b>	28	<b>Eating Disorders/Obesity Treatment:</b> including bulimia, anorexia, or obesity and any surgical services for obesity.		
8	<b>Urinary, bladder, incontinence, kidney or liver conditions or disorders:</b> Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?			29	<b>Respiratory Conditions/Disorders:</b> RSV, reactive airway disease, tuberculosis, asthma, sleep apnea, pleurisy, COPD, sarcoidosis, or emphysema?		
9	<b>Neurological Disorders:</b> Recurring headaches, migraines, head injury, epilepsy, seizures, convulsions, or other neurological disorder?			30	<b>Tobacco use (chewing or smoking)?</b> Quit Date: _____		
10	<b>Metabolic and Endocrine Conditions/Disorders:</b> Lupus, thyroid disorder, goiter, or any other lymph system disorder?			<b>Has any applicant EVER been diagnosed with or treated for any of the following:</b>		<b>YES</b>	<b>NO</b>
11	<b>Eyes, ears, nose, sinus, or throat conditions/disorders</b> or any other respiratory system disorder, including allergies or hay fever?			31	<b>Birth Defects/Congenital Abnormalities:</b> premature birth, development or learning disability, mental impairment, Down syndrome, or autism spectrum disorder?		
12	<b>Skin Conditions/Disorders:</b> Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?			32	<b>Nervous, Mental and Behavioral:</b> Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, or psychotic disorder?		
13	<b>Breast Conditions/Disorders:</b> Breast lumps, breast augmentation, or breast reduction?			33	<b>Transplant or Implanted Device:</b> Any organ or tissue transplant, pacemaker, or other implanted device?		
14	<b>Heart Conditions/Disorders:</b> Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition?			34	<b>Heart and Circulatory Conditions/Disorders:</b> Heart murmur, heart attack, bypass surgery, angioplasty/stent, blood clot, stroke, heart surgery, coronary artery disease, or congestive heart failure?		
15	<b>Back, neck, bone, joint or spinal disorder:</b> bone or joint disorders (including foot, knee, jaw, fracture, dislocation, or joint replacement)?			35	<b>Brain/Nervous System Conditions/Disorders:</b> Multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia?		
16	<b>Blood Conditions/Disorders:</b> Hemophilia, anemia, blood, or bleeding disorder?			36	<b>Diabetes (type I or II), insulin resistance?</b>		
17	<b>Male Reproductive Conditions/Disorders:</b> Impotence, prostate or testicular disorder, abnormal PSA, or other reproductive disorder?			37	<b>Immune System Conditions/Disorders:</b> Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?		
18	<b>Circulatory System Conditions/Disorders:</b> Varicose veins, or any other circulatory disorder?			38	<b>Cancer/Tumors:</b> (including skin cancer or melanoma) or tumors?		
19	<b>Hospitalization/Surgery:</b> Have you, your spouse, or any dependent family member been hospitalized or had surgery?			39	<b>Urinary/Liver Conditions/Disorders:</b> Cirrhosis, hepatitis, or renal failure?		
20	<b>Sexually transmitted diseases?</b>			<b>OTHER MEDICAL INFORMATION</b>		<b>YES</b>	<b>NO</b>
				40	Any medical condition or treatment that you are unsure of where it fits in above?		





**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 Gregory W. Davies License # 100072 Agency Wasatch Benefits Inc Phone (801) 406-9502

Producer Signature *Gregory W. Davies* Agent # 1392992 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.)

Commissions paid to agent for the submission of this application does not directly affect the amount of premium the applicant pays for this policy. Applicant could go directly to Humana and get the same premium with or without an Agent. No other agent can give you a higher or a lower premium for this plan. Humana pays agents 22% first year, 6% second year and 3% third year and beyond as long as the policy is in force. As soon as the policy is dropped by applicant, commissions cease. If application is not approved, agent did lots of work for zero commission. Bonuses, prizes and incentive trips could also be awarded by Humana to agents depending on volume of applications they submit in a given time period. These commissions paid to the agent are meant to compensate the agent for paying 100% of their marketing, office, travel, supplies, utilities and advertising expenses each agent incurs without any fixed salary or retirement plan from the companies they write business with. That is until Obama Care kicks in after which I might be saying "would you like fries with that" or "welcome to Walmart" :) But as long as we have a free market health care system for the next couple of years we will continue offer these health plans that give you access to the best health care in the world. Thank you for allowing me to serve you!

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 X 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"/> <b>Dental Coverage</b>	<input type="checkbox"/> <b>Vision Coverage</b>
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.

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

<b>1. Agent / Agency of Record: (for commissions and correspondence)</b>	<b>2. Writing Agent / Producer:</b>
Name (print) <u>Gregory W. Davies</u>	Name (print) <u>N / A</u>
Humana Agent # <u>Agent #1392992</u>	Humana Agent # <u>N / A</u>

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 Gregory W. Davies 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 X Date \_\_\_/\_\_\_/\_\_\_

Relationship of Legal Guardian \_\_\_\_\_

Spouse Signature (if covered dependent) X 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**<sup>®</sup>  
*Guidance* when you need it most

**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.

<b>Primary Applicant</b> 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 **X** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_