Enrollment Application

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

1 Have Your Medicare Card Ready

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

2 Read and Complete Other Coverage Information

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

3 Premium Determination

4 Be Sure to Include Your Initial Premium Payment

Your first month's premium payment must be included. This is necessary even if you choose our Automatic Bank Withdrawal or Auto Credit Card Charge options for future premium payments.

5 Third Party Designee

6 Sign and Date the Enrollment Application

Humana®

NY85026M10NG

Marking Instructions

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

Correct Mark ●

Incorrect Marks ✓ ✗ ◉ ⊙

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

Correct Numbers and Letters

1 2 3 A B C

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

T

S M I X H

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

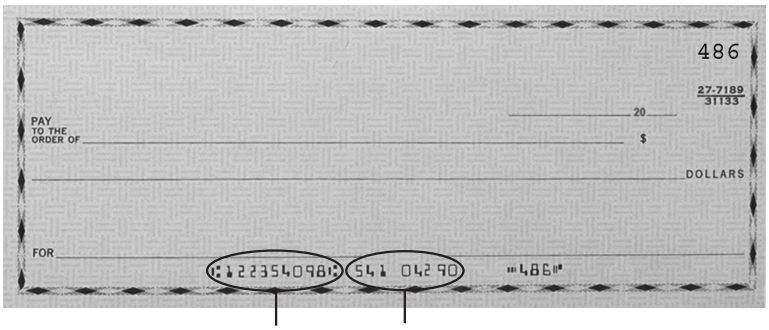
0 3 2 4 2 0 1 0

Required Fields Must Be Completed

Optional Fields

Sample Check

(If you are choosing the auto bank withdrawal.)



Routing Number **Account Number**

STAMP DATE MU001

Humana Insurance Company of New York
Administrative Office: 125 Wolf Road, Suite 501, Albany, NY 12205

1

LAST NAME | FIRST NAME | MI

ADDRESS | APT OR STE#

ADDRESS (continued) | COUNTY

CITY | STATE | ZIP CODE

TELEPHONE / – | DATE OF BIRTH | GENDER ◯ M ◯ F

MAILING ADDRESS (only if different from above street ADDRESS) | APT OR STE#

CITY | STATE | ZIP CODE

E-MAIL ADDRESS (optional)

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

Select the policy you are applying for:

- ◯ Plan A
- ◯ Plan B
- ◯ Plan C
- ◯ Plan F
- ◯ High Deductible Plan F
- ◯ Plan G
- ◯ Plan K
- ◯ Plan L
- ◯ Plan N

PROPOSED EFFECTIVE DATE

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

MEDICARE NUMBER

IS ENTITLED TO | EFFECTIVE DATE

HOSPITAL INSURANCE (PART A)

MEDICAL INSURANCE (PART B)

PERSON TO NOTIFY IN AN EMERGENCY (optional):

LAST NAME | FIRST NAME | MI

RELATIONSHIP TO APPLICANT | TELEPHONE / –

AGENT NUMBER (SAN)

➤ **You Must Read and Sign**

2 Other Coverage Information

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB).

HUMANA INSURANCE COMPANY OF NEW YORK IS PROHIBITED FROM SELLING MEDICARE SUPPLEMENT INSURANCE TO AN INDIVIDUAL COVERED UNDER A MEDICARE SUPPLEMENT POLICY OR CERTIFICATE WHO DOES NOT DESIRE TO REPLACE THE POLICY OR CERTIFICATE, OR WHERE THE MEDICARE SUPPLEMENT POLICY OR CERTIFICATE WOULD DUPLICATE BENEFITS TO WHICH THE INDIVIDUAL IS ENTITLED UNDER A MEDICARE ADVANTAGE PLAN.

YES OR NO ANSWERS ARE REQUIRED TO THE FOLLOWING QUESTIONS.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. a. Did you turn age 65 in the last six months: ◯ Yes ◯ No
   b. Did you enroll in Medicare Part B in the last six months? ◯ Yes ◯ No

   If yes, what is the effective date? / /

2. Are you covered for medical assistance through the State Medicaid program? ◯ Yes ◯ No

   (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)

   a. If yes, will Medicaid pay your premiums for this Medicare Supplement policy? ◯ Yes ◯ No
   b. Do you receive any benefits from Medicaid OTHER THAN payments toward Your Medicare Part B premium? ◯ Yes ◯ No

3. If you had coverage from any Medicare Advantage plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

   START / / END / /

   a. If you are still covered under the Medicare Advantage plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ◯ Yes ◯ No
   b. Was this your first time in this type of Medicare Advantage plan? ◯ Yes ◯ No
   c. Did you drop a Medicare Supplement policy to enroll in the Medicare Advantage plan? ◯ Yes ◯ No

4. Do you have another Medicare Supplement or Medicare Select policy or certificate in force? ◯ Yes ◯ No

   a. If so, with what company?

      What plan do you have?

   b. If so, do you intend to replace your current Medicare Supplement or Medicare Select policy or certificate with this policy or certificate? ◯ Yes ◯ No

5. Have you had coverage under any other health insurance policy or certificate within the past 63 days? (For example, an employer, union, or individual plan.) ◯ Yes ◯ No

   a. If so, with what company?

      What policy do you have?

   b. What are your dates of coverage under this policy? (If you are still covered under this policy, leave "END" blank.)

      START / / END / /

6. Do you intend to replace your current healthcare coverage with this Medicare Supplement policy? ◯ Yes ◯ No

3 Monthly Premium Determination

To determine your monthly premium, refer to your Outline of Coverage.

4 Payment Options

MONTHLY PREMIUM

In order for us to process your application, you must submit your first month's premium.

INITIAL PAYMENT

- **Initial Premium Payment, if you are submitting more than your first month's premium.**

CHECK NUMBER **MONEY ORDER**

CREDIT CARD NAME ◯ **MasterCard** ◯ **Visa** ◯ **Discover**

CREDIT CARD NUMBER **EXPIRATION DATE**

Future Payment options: ◯ **Automatic Withdrawal** ◯ **Coupon Book** ◯ **Auto Credit Card Charge**

I hereby authorize Humana to initiate debit/credit entries to my checking/savings account or my credit card account, as indicated below, in amounts appropriate to my coverage; and authorize the bank named below to debit/credit the same to such account. I authorize Humana to change the amount of the debit/credit, provided that I am given advance written notice. This authorization is to remain effective until I give Humana and the bank reasonable notice of termination.
I have included a voided check/savings withdrawal slip from the bank account I want debited.

DEPOSITORY BANK NAME

ROUTING NUMBER **ACCOUNT NUMBER** ◯ **Checking** ◯ **Savings**

If you choose the auto credit card charge option, complete the following: ◯ **MasterCard** ◯ **Visa** ◯ **Discover**

CREDIT CARD NUMBER **EXPIRATION DATE**

I understand that the policy will not pay benefits for stays beginning or medical expenses incurred during the first three months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within six months prior to the insurance effective date. Hospital stays that begin before the expiration of the pre-existing waiting period, but continue past the expiration of this period, will be covered. Time covered under any other health insurance or employer-provided health benefit arrangement before becoming covered under this policy will be counted toward the six-month waiting period as long as the break in coverage is not greater than 63 days between prior coverage and this policy.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

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

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

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

5 Third Party Designee (Optional)

Under New York State law, customers with Medicare Supplement insurance may designate another person (a third party) to receive a notice of nonpayment of insurance premiums. In the event premium is not received by the due date a THIRD PARTY BILLING STATEMENT will be sent to the designated person. This designation does not include the ability to make decisions concerning your health care.

If you wish to authorize a person to receive this notice of payment due, please call Humana's Customer Service department at 1-800-866-0581.

6 Signature & Date

APPLICANT'S SIGNATURE: **SIGNATURE DATE:** / /

I have reviewed the current health insurance coverage of the applicant and find that the additional coverage of the type and amount applied for is appropriate for the applicant's needs.

AGENT'S SIGNATURE: **SIGNATURE DATE:** / /

Sales Agent – Please list: All health insurance policies sold to the applicant which are still in force and all health insurance policies sold to the applicant within the past five years which are no longer in force (if none or not applicable, write NONE)

COMPANY **TYPE**

COMPANY **TYPE**

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

LAST NAME **FIRST NAME** **MI**

STREET ADDRESS

CITY **ST** **ZIP**

TELEPHONE / – **RELATIONSHIP TO APPLICANT**

OFFICE USE ONLY

WRITING AGENT

WRITING AGENT ID

MKTS 5 4

AGENCY (optional)

AGENCY ID

ATTACHMENTS

AM001 AM002 AM003 AM006 AM007 AM008

GR

BN

MAN

➤ **You Must Read and Sign**

Insured by Humana Insurance Company of New York

Humana®

Discrimination is against the law

Humana Inc. and its subsidiaries ("Humana") comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Humana does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Humana provides:

• Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

• Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call **1-800-866-0581 (TTY: 711)**.

If you believe that Humana has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call **1-800-866-0581 (TTY: 711)**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800–368–1019. If you use a TTY, call **1-800-537-7697**.
Complaint Forms are available at www.hhs.gov/ocr/office/file/index.html.

Humana®

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-866-0581 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-866-0581 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-866-0581 （TTY: 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-866-0581 (TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-800-866-0581 (TTY: 711)번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-866-0581 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-866-0581 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-866-0581 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-866-0581 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-866-0581 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-866-0581 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-866-0581 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-866-0581 (TTY: 711).

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-866-0581 (رقم هاتف الصم والبكم: 711).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-866-0581 （TTY：711）まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-866-0581 (TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-866-0581 (TTY: 711).

Notice to Applicant Regarding Replacement of Accident and Health Insurance, HMO Coverage or Employer-Provided Health Benefit Arrangement

Humana Insurance Company of New York • P.O. Box 14309, Lexington, KY 40512-4309

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

According to information you have furnished, you intend to terminate existing accident and health insurance, health maintenance organization coverage or employer-provided health benefit coverage and replace it with a policy/certificate to be issued by Humana Insurance Company of New York. Your new policy/certificate will provide 30 days within which you may decide - without cost - whether you desire to keep the policy/certificate.

You should review this new coverage carefully. Compare it with all health coverage you now have and evaluate the need for existing coverage that may duplicate this policy/certificate. Terminate your present coverage only if, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

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

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction (does) (does not) duplicate coverage, to the best of my knowledge.

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

- ☐ additional benefits
- ☐ fewer benefits and lower premiums
- ☐ my plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ disenrollment from a Medicare Advantage plan (please explain reason for disenrollment)
- ☐ no change in benefits, but lower premiums
- ☐ other (please specify)

_____

_____

_____

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State regulation provides that in applying a pre-existing condition limitation, a Medicare supplement insurer must credit the time the applicant was previously covered under creditable coverage (including Medicare supplement insurance, Medicare select coverage and Medicare Advantage plans) if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new policy or certificate.
3. If you still wish to terminate your present policy/certificate and replace it with new coverage, review the application carefully before you sign it to be certain that all information has been properly recorded.

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

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

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