

Humana TX Application Instructions

1) Fill the application out as best you can. On any dates for health history, you only need a month/year and do not need the exact date. If you don't know how to answer a particular question, just leave it blank.

2) Please fax it to us Toll Free at (877) 718-8056 and we'll call you immediately after we receive your fax. If you prefer, you can also scan/email it back to us at info@selectedbenefits.com

You only need to fax the application. We do not need the original.

**If you have any questions or need help in any way,
please call us Toll Free at (866) 270-6209.**

HumanaOne Individual Insurance Application

HUMANA.
one

TEXAS

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 \$ _____

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
- Dependent Child Therapy Coverage
- Carryover Deductible

Life Coverage

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 % _____

Dental Coverage

- Dental Traditional Plus
- Dental C550 DHMO Facility number _____

Your billing and effective date for the DHMO plan will be determined once your medical plan is issued. The effective date can be between 15 and 45 days after the medical plan is issued. The initial payment will be taken at the time the dental policy is issued; subsequent payments will be billed on the 15th of each month. All billing and payments will be separate from your medical plan.

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 Information

First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> 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	

Humana Insurance Company • HumanaDental Insurance Company • DentiCare, Inc. (d/b/a CompBenefits)

Primary Applicant/Insured Information continued

Primary Language: English Spanish Other _____

Please explain any disability affecting your ability to communicate or read. Please include an additional page if you need more space for your explanation. Each additional page must be signed and dated.

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 <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

Dependent 2 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

Dependent 3 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

Dependent 4 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> 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 future?

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 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 by a physician as having acquired immune deficiency syndrome (AIDS) or an AIDS-related complex or other immune system disorder?
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. <input type="checkbox"/> No <input type="checkbox"/> Yes Chest pain or Heart Attack	M. <input type="checkbox"/> No <input type="checkbox"/> Yes ADD/ADHD (Attention Deficit Disorder) or any other Behavioral, Emotional, Mental or Nervous Disorders
B. <input type="checkbox"/> No <input type="checkbox"/> Yes High Blood Pressure or Hypertension	N. <input type="checkbox"/> No <input type="checkbox"/> Yes Eating Disorder
C. <input type="checkbox"/> No <input type="checkbox"/> Yes High Cholesterol or Triglycerides	O. <input type="checkbox"/> No <input type="checkbox"/> Yes Developmental Disorder or Delay
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Cancer or Tumor of any kind	P. <input type="checkbox"/> No <input type="checkbox"/> Yes Human Papilloma Virus or Sexually Transmitted Disease
E. <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes or High Blood Sugar	Q. <input type="checkbox"/> No <input type="checkbox"/> Yes Infertility
F. <input type="checkbox"/> No <input type="checkbox"/> Yes Stroke	R. <input type="checkbox"/> No <input type="checkbox"/> Yes Uterine Fibroids
G. <input type="checkbox"/> No <input type="checkbox"/> Yes Paralysis	S. <input type="checkbox"/> No <input type="checkbox"/> Yes Cyst, Growth, Lump or Polyp
H. <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy or Seizure	T. <input type="checkbox"/> No <input type="checkbox"/> Yes Hernia
I. <input type="checkbox"/> No <input type="checkbox"/> Yes Migraines or frequent or severe headaches	U. <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis
J. <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis	V. <input type="checkbox"/> No <input type="checkbox"/> Yes Implants, Pins, Plates, Rods, Screws or Prosthesis
K. <input type="checkbox"/> No <input type="checkbox"/> Yes Sleep Apnea	W. <input type="checkbox"/> No <input type="checkbox"/> Yes Connective Tissue or Autoimmune Disorder
L. <input type="checkbox"/> No <input type="checkbox"/> Yes Anxiety or Depression	X. <input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> No <input type="checkbox"/> Yes Gallbladder, Liver or Pancreas	G. <input type="checkbox"/> No <input type="checkbox"/> Yes Eyes, Ears, Nose, Throat or Sinuses
B. <input type="checkbox"/> No <input type="checkbox"/> Yes Colon, Esophagus or Stomach	H. <input type="checkbox"/> No <input type="checkbox"/> Yes Breasts
C. <input type="checkbox"/> No <input type="checkbox"/> Yes Bladder or Kidneys	I. <input type="checkbox"/> No <input type="checkbox"/> Yes Menstrual Cycle
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Back, Disc, Neck or Spine	J. <input type="checkbox"/> No <input type="checkbox"/> Yes Cervix, Ovaries, Uterus or Vagina
E. <input type="checkbox"/> No <input type="checkbox"/> Yes Knee, Hip or Shoulder	K. <input type="checkbox"/> No <input type="checkbox"/> Yes Penis, Prostate or Testicles
F. <input type="checkbox"/> No <input type="checkbox"/> Yes Lungs	L. <input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood Vessels, Heart or Circulatory System	E. <input type="checkbox"/> No <input type="checkbox"/> Yes Urinary System
B. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood, Gland, Pituitary, Thyroid or Lymph System	F. <input type="checkbox"/> No <input type="checkbox"/> Yes Musculoskeletal System, including Bone/Joint Disorders
C. <input type="checkbox"/> No <input type="checkbox"/> Yes Brain or Nervous System	G. <input type="checkbox"/> No <input type="checkbox"/> Yes Respiratory System
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Digestive System	H. <input type="checkbox"/> No <input type="checkbox"/> 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 of material fact or omission 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. A minimum one year contract is required for Dental HMO plans offered by DentiCare, Inc. (d/b/a CompBenefits).

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

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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)

Name (print) Steven Wendlandt

Humana Agent # 1307480

Writing Agent / Producer:

Name (print) Steven Wendlandt

Humana Agent # 1307480

Agent replacement question:

Will this policy replace or change any existing life insurance policy(s) and/or annuity(s)? No Yes

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 _____ 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."

PPO plans insured by Humana Insurance Company
Life products insured by Humana Insurance Company
Dental HMO products offered by DentiCare, Inc. (d/b/a CompBenefits)
All other Dental products insured by HumanaDental Insurance Company

HUMANA
Guidance when you need it most

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 HMO products offered by DentiCare, Inc. (d/b/a CompBenefits)
All other Dental products insured by HumanaDental Insurance Company



HumanaOne Individual Insurance Payment Authorization & Billing Form



Quoted Monthly Payment Amount:

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

- Medical Plan Association Dues: \$3.95 Monthly (non-refundable) (Dues apply to specific plans in: AZ, FL, MI, WI)
- Dental Preventive Plus Association Dues: 75¢ Monthly (non-refundable) (Dues apply in: AZ, MI, 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 ____ / ____ / ____