Individual Dental & Vision Paper Application Checklist

TO ENSURE PROCESSING PLEASE USE THIS CHECKLIST

Humana is the healthcare industry leader for being "green" and we wanted to be sure you know you can submit an application online on **Humana.com**, rather than the paper application. Humana tries to be conscious of all the ways we can be good stewards of our planet, and saving paper is a good way to do that. If you have any questions about online application submission you can contact **AgentSupport@humana.com** or call **1-800-309-3163**.

Did you fill out the application completely?

- ☐ Include your effective date. The effective date should be "mm/dd/yyyy". The requested effective date should be in the future. Please note the effective date rules below:

  For DHMO plans: if an application is received prior to the 15th of the month, the effective date is the 1st of the following month. If the application is received after the 15th of the month, the effective date will be the 1st of the subsequent month.

  EXAMPLE: An application received on May 14th will have an effective date of June 1st. An application received on May 18th will have an effective date of July 1st.

  For all other products, the effective can be as soon as 5 calendar days after the initial monthly payment and application have been received, or as far out as 90 calendar days from the date of application.
- ☐ **Coverage Options:** Please check the box of the coverage option(s) that you are interested in and include the product names.
- ☐ **Primary Insured Information:** The following fields are required for the primary applicant: Full Name, Date of Birth, Address, City, State, ZIP code, Social Security Number and any additional required questions or information as it pertains to the coverage being elected i.e. provider ID number, prior coverage information etc., and Dentist Facility ID number (for Dental C550 and HI215 applicants only. Please visit **Humana.com** to find a dentist).
- ☐ **Family Information:** The following fields are required for a spouse and/or dependents: Full Name, Date of Birth and Social Security Number.
- ☐ **Agent/ Producer Information:** The following fields are required from the agent (if applicable): Name, Humana Agent #, License #, and Signature.
- ☐ **Agreement and Signature:** Please read the agreement and sign and date all applicable lines.

Second page: Payment & Billing Authorization

- ☐ Please indicate whether you will be paying monthly or annually.
- ☐ Please check the plan that you are purchasing in the chart and write in the total first payment amount equal to the enrollment fee(s) and the monthly/ annual payment total indicated in the chart.
  - ☐ If you are enrolling in more than one plan on the same application, please add the payment totals from the chart together for each plan. If you are enrolling in dental and vision together, but if using 2 separate applications, make sure they are submitted together. If Dental and Vision plans are purchased together, only one enrollment fee (the larger of the 2) would apply. (not applicable for Select Dental, Smart Choice Dental or Dental Savings Plus).
  - ☐ **PLEASE NOTE:** Please ensure that the payment method provided has funds available/covers this transaction and is accurate and up-to-date.
- ☐ **Payor Information:** Only fill out this section of the billing name or address is different than the information provided on the first page for the primary insured. The payor will also need to sign the Payor Signature line at the bottom of the application.
- ☐ **Payment Options:** Please check whether you will be paying by credit card or automatic bank withdrawal for both initial and recurring payments. Please include all requested information and check the payment authorization box under your payment method.
  - ☐ If you are paying through automatic bank withdrawal, make sure to include your account information and a blank voided check along with the application.
  - ☐ If paying with a credit card, please check your credit card's expiration date. This card will be charged for future payments, so please alert us with any changes.
- ☐ All signature areas are signed and dated. Please make sure you have read and agreed to the one year contract language.

Have you reviewed our provider network?

- ☐ To see providers in our network for all plans, please visit **Humana.com** and enter your zip code and choose the network for the specific dental plan.

Would you like to fax your application?

- ☐ Only credit card and bank withdrawal applications may be faxed. Please keep the original application and submit a faxed copy to the Humana Dental & Vision Paper Application team at **502-508-6500**. If you are faxing an automatic bank withdrawal application, please fax a copy of a blank voided check.

Are you making changes to an existing plan or reinstating a previous plan?

- ☐ For changes to existing plans or for reinstatements, please call: **1-866-537-0232**.

Humana®

Complete Dental & Humana Vision Application

Humana.

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "We" or "Humana."

Dental products insured by Humana Insurance Company
Vision products insured by Humana Insurance Company

California

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

Requested Effective Date: _____

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

Reason for change_____ Change/Modification to Existing Coverage # _____

Coverage Options **Please complete this section when selecting a dental or vision product.**

Dental Coverage	Vision Coverage
Product Name	Product Name

Proposed Primary Insured Information

First name	MI	Last name		
Social Security #	Primary phone #		Secondary phone #	
E-mail		Gender M F	Date of birth	
Home address (not P.O. Box)	City		State	ZIP code

Dependent Information

Please complete only if your spouse and/or dependent children are applying for coverage. Attach an additional dependent information sheet if necessary. Each additional page must be signed and dated. All references of spouse in this application include domestic partner/civil union partner/reciprocal beneficiary.

Spouse First name	MI	Last name	
Social Security #	Gender M F		Date of birth
Dependent First name	MI	Last name	
Social Security #	Gender M F		Date of birth
Dependent First name	MI	Last name	
Social Security #	Gender M F		Date of birth
Dependent First name	MI	Last name	
Social Security #	Gender M F		Date of birth

Existing/Prior Coverage

Please provide the status of current coverage or prior coverage.

1. Have you had Dental Coverage for the past 12 months?

   Yes No *Answer "No" if you had any gaps in coverage greater than 63 days.*

2. What type of Dental Coverage did you have?

   Insurance for Cleanings, Exams, and X-Rays **only**

   Insurance for Cleanings, Exams, X-Rays, **and** Fillings, Crowns, Dentures or Root Canals

   Discount Dental Plan - **only** provided discounts

3. What is the name of the insurance company or discount plan that provided your Dental Coverage?

   _____

4. What was the policy number for your Dental Coverage? _____

5. When did your Dental Coverage end?

   Format (mm/dd/yyyy)_____

   or

   My Dental Coverage is still active

Agreement and Signature

True and Complete Acknowledgment: To the best of my knowledge or belief, 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 any required disclosures. 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 plan applied for is not an employer-sponsored group plan and it does not comply with state or federal small employer laws. I do not qualify for or have willingly waived an employer group insurance plan 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. Acceptance of premium and fees does not guarantee coverage. Any false statement(s) made with actual intent to deceive 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 claim denial. As a parent or legal guardian of a dependent applying for coverage, I attest by my signature below, that I have gathered the information from my dependent in order to fully and truthfully complete this application.

This document, together with any supplemental forms, will make up part of any contract and be the basis for any policy issued.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud.

If you decide not to sign this agreement, we will decline to approve you in an insurance product or to give you insurance benefits.

Proposed Primary Insured 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:	**Writing Agent / Producer:**
Name (print)	Name (print) Jorge Jiron
Humana Agent #	Humana Agent #

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the proposed primary insured submitting this application in order to fully and accurately represent the terms and conditions of the product and services of the insuring entity, or one of its subsidiaries. These provisions are available to me and the proposed primary insured in the benefit summary document or other product 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.

Payment Authorization & Association Enrollment

Off Marketplace Dental and Vision

Humana®

Amount for each recurring payment (based on the payment option selected)

$_____ (includes Association and/or Billing fees if applicable)

See initial payment section for initial payment amount.

Proposed Primary Insured Information

First name	MI	Last name

Payer Information

First name	MI	Last name	Suffix

Billing address	City	State	ZIP code

Primary phone #	Secondary phone #

FILL IN THIS SECTION WHEN APPLYING BY PAPER METHOD

Please fax or mail this along with your application to:

502-508-6500 or Humana Insurance Company, P.O. Box 769649 Roswell, GA 30076-8225

Please place a check in the box next to the product(s) you are purchasing. Then take the appropriate premium amount from the product rate sheet and if purchasing both a dental and vision plan please add the monthly or annual payments together and add the one-time non-refundable enrollment fee to calculate your total first payment. Please refer to rate sheets for state availability.

☐ I would like to pay monthly.

☐ **Complete Dental**

q **Preventive Value**
q **Preventive Plus**
q **Loyalty Plus**
q **Simple Choice**
q **Dental Value Plan (C550/HI215)**
q **Preventive Plus Package for Veterans**
q **Humana Vision**
q **Vision Care Plan (VCP)**
q **Vision Focus (Eyemed)**
q **Dental Select Basic**
q **Dental Select Plus**

*Note that all quoted monthly payment amounts listed on the rate sheets include (where applicable) a $1 administration fee and an association due of 50¢ for Preventive Plus Package for Veterans and 75¢ for all other plans

Monthly payment:

$ _____ Dental

$ _____ Vision

$ _____ **Total Monthly Payment**

+ $35 One-time non-refundable enrollment fee (excludes Preventive Value)
*$10 enrollment fee for the Dental Select products

$ _____ **Total First Payment**

☐ I would like to pay annually.

☐ **Complete Dental**

q **Preventive Value**
q **Preventive Plus**
q **Loyalty Plus**
q **Simple Choice**
q **Dental Value Plan (C550/HI215)**
q **Preventive Plus Package for Veterans**
q **Humana Vision**
q **Vision Care Plan (VCP)**
q **Vision Focus (Eyemed)**

*Note that all quoted annual payment amounts listed on the rate sheets include (where applicable) an association due of $6 for Preventive Plus Package for Veterans and $9 for all other plans

Annual payment:

$ _____ Dental

$ _____ Vision

$ _____ **Total Annual Payment**

+ $35 One-time non-refundable enrollment fee (excludes Preventive Value)

$ _____ **Total First Payment**

IN ADDITION: Fill out the Initial Payment Options section A., B. or C. and choose the date of initial payment AND the Recurring Payment Options section A., B. or C. and choose monthly or annually and the recurring payment.

PDN: _____
(FOR INTERNAL USE ONLY)

1. INITIAL Payment Options

Please choose either credit/debit card or one-time bank withdrawal of the initial payment. Initial payment for each product applied for or enrolled in will be drafted/charged separately against your account.

Choose date of initial payment_____ **(needs to be 5 days before the effective date)**

A. ONE-TIME AUTOMATIC BANK WITHDRAWAL

Bank name	Account holder's name
Routing #	Account #
q I authorize Humana to withdraw the initial payment of $_____ from the designated account. (includes enrollment, dues, and fees, if applicable)	

B. ONE-TIME CREDIT/DEBIT CARD PAYMENT

Choose one: q Visa q Mastercard

Card #	Expiration Date /
Cardholder's name	
q I authorize Humana to charge the initial payment of $_____ from the designated account. (includes enrollment, dues, and fees, if applicable)	

C. ONE-TIME CHECK OR MONEY ORDER **Only available when applying by paper method**

q Initial Payment

2. RECURRING Payment Options

Please select payment option for your billing cycle and payment preference for your premium payment. Payment of premiums for each product applied for or enrolled in will be drafted/charged separately against your account.

Choose one: q Monthly Payment q Annual Payment (not available for Dental Select plans)

Choose one recurring payment date (valid when using sections A or B below)**:** q 5th q 15th q 25th

A. RECURRING AUTOMATIC BANK WITHDRAWAL

Choose one: q Checking q Savings

Bank name	Account holder's name
Routing #	Account #

B. RECURRING CREDIT/DEBIT CARD

Choose one: q Visa q Mastercard

Card #	Expiration Date /
Cardholder's name	

C. RECURRING PAPER/EMAIL BILL **Only available when applying by paper method, no recurring payment date selection needed.**

Pay on the web or you can submit a check.

q Mail me a paper bill.

q Email me the bill. Email address (required): _____

PDN: _____
(FOR INTERNAL USE ONLY)

Agreement & Signature

All Products and Plans - Rates quoted are not guaranteed. Additional charges may apply based on frequency of payment chosen. The plan will automatically renew each year. **I understand an initial one-year contract which is non-refundable and non-cancellable may apply.**

By my signature, I acknowledge that I am an authorized user of the account information provided.

Proposed Primary Insured or Legal Guardian/Representative Signature

_____ Date _____

Association Enrollment

ASSOCIATION DUES - Veteran's Dental: 50¢/mo. - All other plans 75¢/mo. each product (non-refundable)
When purchasing product(s), only one association dues will be charged, per policyholder, when enrolled in more than one product. The dues of the least value will not be charged when enrolled in two or more products. Association enrollment is necessary to be eligible for HumanaOne Dental and Vision Products in the states of AR, DE, DC, ID, MA, ND, NV, NJ, SC, VA and WY. Dental Select products (Basic and Plus) sold with paper applications only, The Dental Value Plan (C550/HI215), Simple Choice, Complete Dental and Preventive Value products do not require Association enrollment.

The Association, Peoples' Benefit Alliance, is a membership organization that provides educational information and discounts on goods and services to its members. Membership in the Association is required, at additional cost, in order to be eligible for insurance coverage. The Association benefits information will be sent under separate cover. By signing below, you are requesting enrollment in the Association.

Proposed Primary Association Member or Legal Guardian/Representative Signature

_____ Date _____

Billing Fees

Monthly: All quoted monthly payment amounts listed on the rate sheets include a $1 administration fee and (where applicable) an association due of 50¢ for Preventive Plus Package for Veterans and 75¢ for all other plans

Annually: All quoted annual payment amounts listed on the rate sheets include (where applicable) an association due of $6 for Preventive Plus Package for Veterans and $9 for all other plans

Enrollment Fee: $35.00 one-time fee (non-refundable)

The companies listed below, severally or collectively, as the context may require, are referred to in this Authorization as Humana.
Humana Individual dental and vision plans are insured or offered by Humana Insurance Company, HumanaDental Insurance Company, Humana Insurance Company of New York, The Dental Concern, Inc., CompBenefits Insurance Company, CompBenefits Company, CompBenefits Dental, Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Benefit Plan of Louisiana, Inc., DentiCare, Inc. (d/b/a CompBenefits), Discount plans offered by HumanaDental Insurance Company, Humana Insurance Company or Texas Dental Plan, Inc. For Arizona residents: Insured by Humana Insurance Company. For Texas residents: Insured or offered by Humana Insurance Company, HumanaDental Insurance Company, or DentiCare, Inc. (d/b/a CompBenefits).

TO ENROLL:

Please Fax 502.508.6500 OR

Mail completed application/enrollment form, this payment authorization and check or money order (if applicable) for the total amount of premium, association dues if applicable and the enrollment fee to:

Humana Insurance Company
P.O. Box 769649
Roswell, GA 30076-8225

PDN: _____
(FOR INTERNAL USE ONLY)

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call the number on your ID card or if you use a **TTY**, call **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 **https://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, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you.
Call the number on your ID card (TTY: 711)

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.

Language assistance services, free of charge, are available to you.
Call the number on your ID card (TTY: 711)

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card **(TTY: 711)**

用 援 **(TTY: 711)**...

ID **(TTY: 711)** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card **(TTY: 711)**...

(телетайп: 711)... ATANSYON:

Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib pou ou. manm ou **(TTY: 711)**

(ATS: 711)

(TTY: 711)... ATTENZIONE: In caso la

(TTY: 711)...

ID **(TTY: 711)**...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره تلفن روی کارت شناسایی خود تماس بگیرید **(TTY: 711)**...

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, námboo ninaaltsoos yézhí, bee nééh ho'dólzin bikáá'ígíí bee hólne' **(TTY: 711)**...

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية المتوفرة لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاص بك **(TTY: 711)**.