

Thank you for your interest in applying for the Humana Medicare Supplement plan!

This application needs to be reviewed and signed by an Agent before it can be submitted to Humana. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: dann@lowinsure.com
- Mail: CDA Insurance LLC
2160 W 11th Ave
Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf)
Download Policy Outline (.pdf)

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

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 Medicare Supplement policy or Medicare Advantage plan with this policy, be sure to complete the enclosed form titled Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage.

③ Complete Guaranteed Acceptance

Please fill out this section if you are eligible for guaranteed acceptance.

④ Read and Complete Medical Questions

⑤ Determine Your Monthly Premium

⑥ 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.

⑦ Sign and Date the Enrollment Application

⑧ Keep Member Copy For Your Records

Return the original copy of your completed Enrollment Application, first month's premium and any additional required forms.

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.

T
S M I ~~R~~ 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)

The image shows a sample check form with the following fields and markings:

- Top right: 486
- Top right: 22-2189
- Top right: 31133
- Top right: 20
- Top right: \$
- Top right: DOLLARS
- Bottom left: FOR
- Bottom left: 08222350988 (circled)
- Bottom left: 08222350988 (circled)
- Bottom left: 08222350988

Routing
Number

Account
Number

STAMP DATE MU001

Humana Insurance Company
2432 Fortune Drive, Lexington, KY 40509

①

LAST NAME

[Grid for last name]

FIRST NAME

[Grid for first name]

MI

[Grid for MI]

ADDRESS

[Grid for address]

APT OR STE#

[Grid for apt or ste#]

ADDRESS (continued)

[Grid for address continued]

COUNTY

[Grid for county]

CITY

[Grid for city]

STATE

[Grid for state]

ZIP CODE

[Grid for zip code]

TELEPHONE

[Grid for telephone]

DATE OF BIRTH

[Grid for date of birth]

GENDER M F

HEIGHT [] FT

[] IN

WEIGHT [] LBS

MAILING ADDRESS (only if different from above street ADDRESS)

[Grid for mailing address]

APT OR STE#

[Grid for apt or ste#]

CITY

[Grid for city]

STATE

[Grid for state]

ZIP CODE

[Grid for zip code]

E-MAIL ADDRESS (optional)

[Grid for e-mail address]

(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 K
- Plan L
- Plan N

PROPOSED EFFECTIVE DATE

[Grid for proposed effective date]

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

MEDICARE CLAIM NUMBER

[Grid for Medicare claim number]

IS ENTITLED TO

EFFECTIVE DATE

HOSPITAL INSURANCE (PART A)

[Grid for hospital insurance effective date]

MEDICAL INSURANCE (PART B)

[Grid for medical insurance effective date]

PERSON TO NOTIFY IN AN EMERGENCY (optional):

LAST NAME

[Grid for last name]

FIRST NAME

[Grid for first name]

MI

[Grid for MI]

RELATIONSHIP TO APPLICANT

[Grid for relationship to applicant]

TELEPHONE

[Grid for telephone]

- -

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 coverage.
- 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).

Yes or No answers are required to the following questions. If you have lost, or you are losing or replacing, health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

- Did you turn age 65 in the last six months? Yes No
 - Did you enroll in Medicare Part B in the last six months? Yes No
If yes, what is the effective date? / /
- 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.)

 - If yes, will Medicaid pay your premiums for this Medicare Supplement policy? Yes No
 - Do you receive any benefits from Medicaid OTHER THAN payments toward Your Medicare Part B premium?
 Yes No
- If you had coverage from any Medicare 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 / /

 - If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? Yes No
 - Was this your first time in this type of Medicare plan? Yes No
 - Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes No
- Do you have another Medicare Supplement policy in force? Yes No

 - If so, with what company?
What plan do you have?
 - If so, do you intend to replace your current Medicare Supplement policy with this policy? Yes No
- Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) Yes No

 - If so, with what company?
What policy do you have?
 - What are your dates of coverage under this policy? (If you are still covered under this policy, leave "END" blank.)
START / / END / /
- Do you intend to replace your current healthcare coverage with this Medicare Supplement policy? Yes No

- -

③ GUARANTEED ACCEPTANCE

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. Are you applying for coverage during your Medicare Supplement Open Enrollment Period? Yes No
If yes, please go directly to Section 5.
2. Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed acceptance? Yes No
If yes, please go directly to Section 5.

④ MEDICAL QUESTIONS

Yes or No answers are required to the following questions, unless you indicated that you are applying for coverage during your Medicare Supplement Open Enrollment Period or qualify for guaranteed acceptance.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. In the last year, have you been hospitalized, confined to a nursing facility; or are you bedridden or confined to a wheelchair? Yes No
2. In the past 90 days have you received Home Health care? Yes No
3. Do you now have or within the last two years have you had or been advised by a physician that you need treatment or surgery for:
 - a. Heart, Coronary, or Carotid Artery Disease (not including high blood pressure), Peripheral Vascular Disease, Congestive Heart Failure or any other type of Heart Failure, Enlarged Heart, Stroke, Transient Ischemic Attacks (TIA), or Heart Rhythm disorders? Yes No
 - b. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other Chronic Pulmonary disorders? Have you used supplementary oxygen in the last year? Yes No
 - c. Parkinson's Disease, Multiple or Lateral Sclerosis, Huntington's Disease, Muscular Dystrophy, Lupus, Hepatitis, or Lou Gehrig's Disease? Yes No
 - d. Alzheimer's Disease, senile dementia, organic brain disorders, senility disorder, schizophrenia, other major depressive disorders, mental or nervous disorders, cirrhosis, alcoholism or drug abuse? Yes No
 - e. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection? Yes No
 - f. Kidney disease requiring dialysis or diabetes requiring more than 50 units of insulin daily? Yes No
 - g. Internal cancer, leukemia or melanoma? Yes No
 - h. Amputation caused by disease or trauma or neuralgic or poor circulation that has caused an ulcer on the skin? Do you have any paralytic conditions? Yes No
 - i. Rheumatoid arthritis, Paget's Disease, degenerative bone disease, crippling arthritis, vertebral or hip fractures/dislocations, spinal cord disorders/injuries? Yes No
 - j. Organ transplantation? Yes No
4. Please list any prescription drugs (full medication name) you are currently taking or have taken within the past 12 months:

Grid for Applicant Medicare Claim Number

5 MONTHLY PREMIUM DETERMINATION

If applying during your Medicare Supplement Open Enrollment Period or if you qualify for guaranteed acceptance, please skip the first question as it does not apply to your premium determination. If you did not answer "Yes" to either question in Section 3, please answer both questions. All applicants must answer the second question in this section.

- 1. Did you have Medicare coverage prior to age 65? Yes No
2. Have you used tobacco products within the last 12 months? Yes No

If your application is accepted, and you answered No to both questions, you qualify for the Preferred rates. You also qualify for the Preferred rates if you are a non-tobacco user applying during open enrollment or you qualify for guaranteed issue. To determine your monthly premium, refer to your Outline of Coverage.

6 PAYMENT OPTIONS

MONTHLY PREMIUM

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

INITIAL PAYMENT

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

CHECK NUMBER

MONEY ORDER

Grids for Check Number and Money Order

CREDIT CARD NAME MasterCard Visa Discover

CREDIT CARD NUMBER

EXPIRATION DATE

Grids for Credit Card Number and 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

Grid for Depository Bank Name

ROUTING NUMBER

ACCOUNT NUMBER Checking Savings

Grids for Routing Number and Account Number

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

CREDIT CARD NUMBER

EXPIRATION DATE

Grids for Credit Card Number and Expiration Date

I understand that if my application is not submitted during an open enrollment or guaranteed issue period, Humana has the right to reject my application and any premiums paid will be refunded. I also 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. Coverage is not limited if you enroll during an open enrollment or guaranteed issue period or satisfy the creditable coverage requirements.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement may be subject to prosecution for fraud.

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 false statement or 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.

Grid for Applicant Medicare Claim Number

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.

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.

7 SIGNATURE & DATE

APPLICANT'S SIGNATURE:

Signature line for Applicant

SIGNATURE DATE:

Signature date grid

AGENT'S SIGNATURE:

Signature line for Agent

SIGNATURE DATE:

Signature date grid

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

Company name grid

TYPE

Type grid

COMPANY

Company name grid

TYPE

Type grid

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 name: DANN LOEWENTHAL

WRITING AGENT ID

Writing agent ID: 1378448

MKTS

MKTS: 54

AGENCY (optional)

Agency: CD A Insurance LLC

AGENCY ID

Agency ID grid

ATTACHMENTS

Attachment selection: AM001, AM002, AM003, AM006, AM007, AM008

GR

GR grid

BN

BN grid

MAN selection

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage
Humana Insurance Company • 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 Medicare Supplement or Medicare Advantage insurance and replace it with a policy/certificate to be issued by Humana Insurance Company. 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 accident and sickness coverage you now have. If after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

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

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan.

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

- | | |
|---|--|
| <input type="checkbox"/> additional benefits | <input type="checkbox"/> no change in benefits, but lower premiums |
| <input type="checkbox"/> fewer benefits and lower premiums | <input type="checkbox"/> other (please specify) |
| <input type="checkbox"/> my plan has outpatient prescription drug coverage and I am enrolling in Part D | _____ |
| <input type="checkbox"/> disenrollment from a Medicare Advantage plan (please explain reason for disenrollment) | _____ |

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 law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy/certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy/certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy/certificate 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

