Application Submission Instructions

Please complete the attached application and send to HealthPlanOne either via fax or mail:
(must submit by mail if enclosing a check or money order)

HealthPlanOne
35 Nutmeg Drive, Suite 220
Trumbull, CT 06611

Fax (Toll Free): 888.812.6887

Please make check payable to the carrier to which you are applying.

Any questions? Please call HealthPlanOne at 1-877.567.5267. Thank you!

Individual Medical Insurance 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."
The Company will respond to this application within 60 days of receipt.

Medical products insured by Humana Insurance Company
Dental products insured by Humana Insurance Company
1100 Employers Boulevard • Green Bay, WI 54344 • 1-800-825-7858

Missouri

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

Date of application: _____
The effective date is assigned by Humana, based on the date of receipt of a completed application. An agent cannot assign an effective date.

Qualifying Life Event: _____
Only individuals experiencing a Qualifying Life Event are eligible for enrollment outside of the annual open enrollment period.

Existing Policy # (if applicable) 51354694785

Coverage Options

Health Coverage - Please complete this section to select a health plan.

Plan name	Deductible

Dental Coverage - Please complete this section if selecting a dental plan. Dental coverage is not available with all plans. If you are changing or modifying an existing/approved policy or plan, dental is only available at your anniversary. This application cannot be used as a dental only application, health coverage must be selected.

Proposed Primary Insured Information

If child-only coverage is requested, the youngest child is the Proposed Primary Insured. Questions must be filled out by parent or legal guardian.

First name	MI	Last name	Suffix

Social Security #	Primary phone #	Secondary phone #

E-mail	Gender ☐ M ☐ F	Date of birth

Home address (not P.O. Box)	City	State	ZIP code

Mailing address (if different from home address)	City	State	ZIP code

Occupation	Type of Business or Industry

Primary Language: ☐ English ☐ Spanish ☐ Other _____
When available, communications will be provided in the preferred language.

Policyholder (Parent or Legal Guardian) Information: To be completed if Proposed Primary Insured is a minor.

First name	MI	Last name	Suffix

Social Security #	E-mail	Date of birth

Home address (not P.O. Box)	City	State	ZIP code

Primary phone #	Secondary phone #	Relationship to Proposed Primary Insured

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.

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

Existing/Prior Coverage - Please provide the status of current coverage or prior coverage, including Humana, for each applicant. If additional space is needed, please attach additional pages. Each additional page must be signed and dated.

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

• Existing or Prior Health Coverage

1. ☐ Yes ☐ No Does any person applying for coverage currently have or had any group or individual medical health insurance coverage within the last 18 months?
   - ***If YES, please supply the following for all applicants applying for coverage on the policy:***

   Carrier _____

   Effective Date _____ Termination Date _____

   Name of the Insured _____

2. ☐ Yes ☐ No Will the policy applied for replace any coverage currently in force?

• Existing or Prior Dental Coverage

1. ☐ Yes ☐ No 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:***

   Carrier _____

   Effective Date _____ Termination Date _____

   Name of the Insured _____

2. ☐ Yes ☐ No Will the policy applied for replace any coverage currently in force?

Tobacco Use

Please answer the following question to the best of your knowledge.

Within the past six months, have you used any tobacco product regularly (four or more times per week on average excluding religious or ceremonial uses)?

Proposed Primary Insured ☐ Yes ☐ No If YES, when was the last time you used tobacco regularly? Date_____

Spouse ☐ Yes ☐ No If YES, when was the last time you used tobacco regularly? Date_____

Dependent ☐ Yes ☐ No If YES, when was the last time you used tobacco regularly?

Dependent Name(s): _____

Date(s): _____

Citizenship / Legal Residency

For this insurance to be issued, the following questions must be answered fully and truthfully. Failure to fully disclose any eligibility information may result in your policy being rescinded back to your original effective date.

1. ☐ Yes ☐ No Are all individuals applying for coverage U.S. citizens or nationals (or lawfully present) living in the U.S.?
   NOTE: If you answer No, the person(s) named below will not be covered under the policy.
   - ***If NO:*** Name(s): _____

2. ☐ Yes ☐ No Are any individuals applying for coverage currently incarcerated?
   NOTE: If you answer Yes, the person(s) named below will not be covered under the policy.
   - ***If YES:*** Name(s): _____

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. 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 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. Coverage will be effective on the date specified by Humana. Acceptance of premium and fees does not guarantee coverage. 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. I agree to terminate any existing coverage if this application is approved and coverage accepted.

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

Any person who submits an application containing a false, incomplete or deceptive statement may be guilty of insurance fraud.

If you decide not to sign this agreement, we will decline to enroll you or provide benefits.

Signed at: City_____ State _____

➲ Proposed Primary Insured or Policyholder/Legal Guardian Signature

_____ Date _____

➲ Spouse Signature (if covered dependent)

_____ Date _____

Agent / Producer Information

This section to be completed by Agent or Producer (if applicable).

Agent / Agency of Record:		**Writing Agent / Producer:**	
Name (print)	William C. Stapleton	Name (print)	William C. Stapleton
Humana Agent #		Humana Agent #	1392525

Agent replacement question:

Will this policy replace or change any existing insurance policy(ies)? ☐ Yes ☐ No

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 policies 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 policy literature.

➲ Writing Agent's Signature _____ Date _____

The original version of this application 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.