Application Submission Instructions

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

Health Plan One
1000 Bridgeport Ave. 4th FL
Shelton, CT 06484

Fax (Toll Free): 888.812.6887

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

Any questions? Please call Health Plan One at 1-877.567.5267. Thank you!

Individual Medical Insurance Application

Humana®

Oklahoma

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

Medical products insured by Humana Insurance Company

Dental products insured by HumanaDental Insurance Company or Humana Insurance Company

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) _____

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.

❑ Traditional Plus

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?
3. ❑ Yes ❑ No Will any portion of the premium be paid by a small employer, either directly or indirectly?
4. ❑ Yes ❑ No Will the plan be part of a plan or program as defined by the following Internal Revenue Codes? Cafeteria Plans (Section 125) deduction of health insurance for a trade or business expense (Section 162), or contributions by employers to accident and health plans (Section 106)?

• 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.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

Payment Authorization & Association Enrollment

Humana®

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

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

See initial payment section for initial payment amount.

Primary Insured/Applicant Information

First name	MI	Last name

Payer Information

First name	MI	Last name		Suffix
Billing address		City	State	ZIP code
Primary phone #		Secondary phone #		

1. INITIAL Payment Options (not all payment options are available for all products or plans, see page 3 for details)

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.

A. ONE-TIME AUTOMATIC BANK WITHDRAWAL

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

B. ONE-TIME CREDIT/DEBIT CARD PAYMENT

Choose one: ❑ Visa ❑ Mastercard

Card #	Expiration Date /
Cardholder's name	
❑ 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 (Marketplace plans only)

Choose one: ❑ Initial Payment If selected, an Administration/Billing fee of $_____ will apply. (for Medical plans only)

Print this page and mail your initial payment to:

For Medical:
Humana Marketplace MEDICAL Exchange
P.O. BOX 14642
Lexington, KY 40512-4642

For Dental:
Humana Marketplace DENTAL Exchange
P.O. BOX 14692
Lexington, KY 40512-4692

PDN: _____
(FOR INTERNAL USE ONLY)

2. SUBSEQUENT Payment Options (not all payment options are available for all products or plans, see page 3 for details)

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.

A. RECURRING AUTOMATIC BANK WITHDRAWAL

Choose one: ❑ Monthly Payment ❑ Semi-annual Payment ❑ Annual Payment
Choose one: ❑ Savings ❑ Checking

Bank name	Account holder's name
Routing #	Account #
❑ I authorize Humana to draw subsequent payment of $_____ from the designated account until this authorization is revoked. (includes dues and fees, if applicable)	

B. CREDIT/DEBIT CARD - Reminder, see page 3 for credit/debit card options for selected plan.

Choose one: ❑ Visa ❑ Mastercard **If selected, a Billing fee of $_____ will apply.**
Choose one: ❑ Monthly Payment ❑ Semi-annual Payment ❑ Annual Payment

Card #	Expiration Date /
Cardholder's name	
❑ I authorize Humana to charge the subsequent payment of $_____ from the designated account until this authorization is revoked. (includes dues and fees, if applicable)	

C. PAPER BILL See page 3 for details.

❑ Monthly Payment **If selected, a Billing fee of $_____will apply.**

Agreement & Signature

All Products and Plans - Rates quoted are not guaranteed. Additional charges may apply based on method of payment chosen.

Medical - Debit information, refer to the Payment Option Information section below. The final rate will be based on underwriting completion (if applicable) and approval of the application or enrollment form (for plans effective prior to 1/1/2014).

Dental and Vision - Debit information, refer to the Payment Option Information section below. I understand this is an initial one-year contract which is non-refundable and non-cancellable for all insureds (excluding Maryland) and automatically renews each year. This does not apply to plans purchased on the Marketplace.

Life and Supplemental - The final rate will be based on underwriting completion (if applicable) and approval of the application or enrollment form. Debit on the _____ day of the month (1-28 only; 29, 30, 31 not available). If no election is made, debits will be made on the day of Policy. Each debit shall constitute proper notice of premium due and will be made on the day selected above or, if no day is selected, the day of Policy. This Authorization shall not become effective unless and until the coverage is issued. This Authorization shall not be construed as modifying any provisions of the coverage. Humana shall not incur any liability if a draft is returned unpaid by the bank. Drafts which do not clear within the time stipulated in the Policy for payment of premium shall constitute nonpayment of premiums and coverage shall lapse subject to nonforfeiture provisions. This Authorization may be discontinued by Humana or by the Authorized Account Holder at any time within FIVE (5) business days prior to the debit date. Upon termination of this Authorization, the premiums on the Policy covered will be payable annually. Humana will notify me TEN (10) days prior to any changes in payment amounts.

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

Primary Insured/Applicant or Legal Guardian/Representative Signature

➲ _____ Date _____

Association Enrollment - see state/product exclusions on page 3

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.

Primary Association Member or Legal Guardian/Representative Signature

➲ _____ Date _____

Payment Option Information

MEDICAL AND TRADITIONAL DENTAL
- Initial payment for Existing Underwritten plans prior to 1/1/2014 are processed on the issue date or the effective date, whichever is later.
- Initial payment for Marketplace plans are processed immediately after enrollment.
- Initial payment for Non-Marketplace plans are processed up to 2 days before the effective date or if applicable the date you selected.
- Initial payment: Automatic Bank Withdrawal, Mastercard or Visa for all plans, Check or Money Order also allowed for Marketplace plans
- Subsequent payment: Automatic Bank Withdrawal or Mastercard for all products, VISA and Paper Bill available based on product selected
- Subsequent payment debited between the 1st and 7th business day of each month
- Subsequent payment: Monthly only
- Traditional Dental: debited the 1st business day of each month

DENTAL AND VISION *(excluding Traditional Dental)*
- No Semi-Annual payment option
- Debited the 15th of each month (one month in advance)

LIFE AND SUPPLEMENTAL
- No Paper Bill on Initial payment
- Junior Estate Builder options: Initial and Annual payments (automatic bank withdrawal and recurring automatic bank withdrawal only)

Billing Fees & Association Dues Information

MEDICAL AND TRADITIONAL DENTAL
Billing Fee - $10.00/mo. ($6.00/mo. in MS, $5.00/mo. in UT and CO (except Connect for Health Colorado plans), not applicable in KS, MI, MO, NC) Waived for Recurring Automatic Bank Withdrawal.
Paper Bill Fee - $10.00/mo. ($5.00/mo. in UT and CO (except Connect for Health Colorado plans), $6.00/mo. in MS, not applicable in KS, MI)
Your total premium includes the cost of certain fees and taxes. Some of these fees and taxes support and fund components of the Affordable Care Act (ACA, commonly known as "healthcare reform"). Humana will pay any such applicable fees directly in compliance with federal and state regulation. More information on healthcare reform can be found at www.humana.com/healthreform.

***MEDICAL ASSOCIATION DUES -** $3.95/mo. (non-refundable)
Association enrollment is necessary to be eligible for medical products in AL, AZ, FL (only FL PPO products), IL, MI, WI
*does not apply to all plans. This applies only to existing underwritten products (for plans effective prior to 1/1/2014)

DENTAL OR VISION *(excluding Traditional Dental)*
Marketplace Consumers - No Fees (vision is not sold on the Marketplace)
Non-Marketplace: Billing Fee $1.00 per month for Monthly payments (waived for Annual payments) **Enrollment Fee** $35.00 one-time fee (non-refundable)

DENTAL OR VISION ASSOCIATION DUES - Veteran's Dental: 50¢/mo. - All other plans 75¢/mo. each product (non-refundable)
Association enrollment is necessary to be eligible for HumanaOne Dental and Vision Products except in the states of CO, GA, HI, MD, ME, MN, NH, NY, SD and UT. The Dental Value Plan (C550/HI215), Simple Choice and Traditional Dental products do not require Association enrollment.

LIFE OR SUPPLEMENTAL - Billing Fee $1.00 Monthly, $6.00 Semi-Annually, $12.00 Annually (not applicable in CA, GA, IN, KS, MA, MD, MI, NC, NJ, WA) Waived for Recurring Automatic Bank Withdrawal and/or check payments.

The companies listed below, severally or collectively, as the context may require, are referred to in this Authorization as Humana.
Humana Insurance Company, Humana Health Plan, Inc., Humana Health Insurance Company of Florida, Inc., Humana Health Plan of Texas, Inc., Humana Health Benefit Plan of Louisiana, Inc., HumanaDental Insurance Company, The Dental Concern, Inc., Humana Insurance Company of Kentucky, Humana Employers Health Plan of Georgia, Inc., Humana Medical Plan, Inc., Kanawha Insurance Company, Humana Insurance Company of New York, CompBenefits Insurance Company, CompBenefits Company CompBenefits Dental, Inc., CompBenefits of Alabama, Inc., CompBenefits of Georgia, Inc., and DentiCare, Inc. (d/b/a CompBenefits)

Consent for Electronic Delivery

Thank you for choosing Humana. If you'd like to view, print, and save your policy and other documents online, please complete this form and return it with your signed application. You must have Adobe Acrobat Reader to open and save your documents. **Note: To opt for this service, you must include your signature and e-mail address.**

- **Agreement with Humana**

This agreement is between you and Humana Inc., on behalf of its affiliates.

- **Consent to Electronic Transactions**

I, the User, and Humana acknowledge and agree to the following provisions:

1. To conduct this enrollment and any changes made to this enrollment information through the use of an electronic transaction, which will be verified by the user of an electronic signature.

2. This consent to conduct electronic transactions only applies to enrollment services and policy and/or certificate delivery and changes.

3. That I may request that this Agreement be terminated. If terminated, paper access to enrollment services and forms will be distributed at no cost to me if an address, phone number and a contact name are provided to a Humana representative.

4. That I may request a paper copy of this transaction.

5. To be bound by this agreement as stated by law throughout the term of this Agreement.

6. This Agreement may be modified at any time if Humana provides notice.

Email address _____

Signature _____ ____ Date _____