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): 888.342.1612

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

HumanaOne Individual Insurance Application

SOUTH CAROLINA

Please print clearly in ink and complete all questions and fill in all fields or indicate "not applicable."

Date of Application: ____________________ Requested effective date: ________________

(If no continuous prior coverage, effective date may be later than requested.)

Is this application for: ❑ New Business (First time applicant) ❑ Reinstatement (reapplication)

❑ Change/modification to existing policy

Current policy number________________________________

Reason for change _________________________________

Health Coverage Plans

Please choose one of the following health coverage plans.

❑ **Monogram Plan**
$_________deductible

❑ **Portrait Plan**
$_________deductible

$0 prescription drug deductible
❑ No ❑ Yes

❑ **Autograph Plan Share 80**
$_________deductible

$500 prescription drug deductible
❑ No ❑ Yes

❑ **Autograph Plan Share 70**
$_________deductible

❑ **Autograph Plan HSA-Eligible**
$_________ deductible

❑ Total
❑ Total Plus Rx
❑ Share 80

I understand by choosing the Balanced Benefit HSA-Eligible plan I have the option to request:

❑ Health savings account application **-or-**
❑ Health savings account educational materials **-or-**
❑ Not interested at this time

Options Available with Health Coverage Plans

The following options are available with all health plans.

❑ Lifetime Maximum Buy-Up

❑ Supplemental Accident Benefit :

❑ $500 ❑ $1000

Additional Coverage Options

You may purchase additional coverage if health coverage is chosen and approved.

❑ Dental

❑ $20,000 Term Life Rider

Primary Applicant:
❑ Primary beneficiary name____________________
❑ Secondary beneficiary name____________________

Spouse:
❑ Primary beneficiary name____________________
❑ Secondary beneficiary name____________________

Term Life Plan for Primary Applicant

The amount of term life insurance I want is__________. (Minimum selection is $25,000 and $1,000 increments)

Term length:
❑ 10 years
❑ 15 years
❑ 20 years

Primary beneficiary name ______________________________
Relationship ______________ Benefit % ________________
Secondary beneficiary name ____________________________
Relationship ______________ Benefit % ________________

Term Life Plan for Spouse

The amount of term life insurance I want is__________. (Minimum selection is $25,000 and $1,000 increments)

Term length:
❑ 10 years
❑ 15 years
❑ 20 years

Primary beneficiary name ______________________________
Relationship ______________ Benefit % ________________
Secondary beneficiary name ____________________________
Relationship ______________ Benefit % ________________

Primary Applicant Information

If child-only coverage is requested, the youngest child is the Primary Applicant; questions must be filled out by custodial parent.

Last name	First name	Middle initial	Gender ❑ M ❑ F	Height	Weight
Home address (not PO Box)		City			
State	Zip code	Birth date		Country / State of birth	
Mailing address (If different from home address)					

continued

Primary Applicant Information (continued)

If child-only coverage is requested, the youngest child is the Primary Applicant; questions must be filled out by custodial parent.

City		State	Zip code
Home phone number ( )	Daytime phone number ( )	Social Security number - -	Driver's license number
Type of business or industry	Occupation	If translation service is needed, please indicate language preference:	
Email address (If you are 18 years of age or older)		Policy owner name if different than Primary Applicant	

Parent or Guardian Information

Please complete this section if Primary Applicant is under 18 years of age.

Parent or guardian full legal name		Parent or guardian's Social Security number
Address		
Birth date	Relationship to child(ren)	Email address

Family Information

Please complete only if your spouse and/or dependent children are applying for coverage. Attach an additional family information sheet if necessary.

Spouse name (include last name if different from Primary Applicant)			Middle initial	Gender ❑ M ❑ F
Birth date	Social Security number	Country / State of birth	Height	Weight
Spouse's type of business or industry		Spouse's occupation	Full-time student ❑ No ❑ Yes	

Name (include last name if different from Primary Applicant)				Middle initial	Gender ❑ M ❑ F
Social Security number	Birth date	Height	Weight	Full-time student ❑ No ❑ Yes	

Name (include last name if different from Primary Applicant)				Middle initial	Gender ❑ M ❑ F
Social Security number	Birth date	Height	Weight	Full-time student ❑ No ❑ Yes	

Name (include last name if different from Primary Applicant)				Middle initial	Gender ❑ M ❑ F
Social Security number	Birth date	Height	Weight	Full-time student ❑ No ❑ Yes	

Name (include last name if different from Primary Applicant)				Middle initial	Gender ❑ M ❑ F
Social Security number	Birth date	Height	Weight	Full-time student ❑ No ❑ Yes	

Name (include last name if different from Primary Applicant)				Middle initial	Gender ❑ M ❑ F
Social Security number	Birth date	Height	Weight	Full-time student ❑ No ❑ Yes	

General Eligibility

Please answer for all individuals applying for coverage.

1. Has anyone applying for coverage used any type of tobacco product in the past 12 months? ❑ No ❑ Yes
If yes, check all that apply:

❑ Primary Applicant - How frequently do you use tobacco?
- ❑ More than once per week
- ❑ One time or less per week

❑ Spouse - How frequently do you use tobacco?
- ❑ More than once per week
- ❑ One time or less per week

2. Within the past 10 years has anyone applying for coverage been previously denied, rated or had health conditions excluded or ridered from life, disability, annuity or health insurance coverage? ❑ No ❑ Yes
If yes, please supply the following:

Name of person: ____
❑ Denied ❑ Rated ❑ Ridered

Name of person: ____
❑ Denied ❑ Rated ❑ Ridered

3. Are you or anyone applying for coverage a U.S. citizen(s) or are you permanent legal residents that have resided in the U.S. for the past 2 years? ❑ Yes ❑ No
If no, list names
Name(s): ____
____
____
____
____

4. Has anyone applying for coverage spent more than 3 months outside of the U.S. in the last year or intend to spend more than 3 months outside of the U.S. in the next year? ❑ No ❑ Yes
If yes, please provide details including location: ______________
____
____
____
____
____

Recreational Activity

During the next two years does anyone applying for coverage participate or plan to participate in any of the following activities: Bungee jumping, private aviation, motorized vehicle racing, rock climbing, rodeo events, scuba diving or sky diving? ❑ No ❑ Yes
If yes:
Name of person ____
What activities ____
When (month/year) ____

Lifestyle

Has anyone applying for coverage:
1. In the past 5 years been convicted for driving under the influence? ❑ No ❑ Yes
2. In the past 5 years used marijuana? ❑ No ❑ Yes
3. In the past 10 years used any other illegal, controlled drugs or substances or been diagnosed as alcohol or chemically dependent? ❑ No ❑ Yes

If yes to any question listed above:
Question Number ____________
Name of person ____
When (month/year) ____

Existing Coverage

If additional space is needed please attach additional pages, each page must be signed and dated.
IMPORTANT: It is important that you do not cancel any existing coverage until you receive notification from Humana of your acceptance for coverage.

Humana Coverage

1. Has anyone applying for coverage ever had Humana group or individual coverage? ❑ No ❑ Yes
   - If yes, please supply the following for all applicants on the policy:

Name(s)	
Effective Date	Termination Date

Name(s)	
Effective Date	Termination Date

Fill out the following for each line of coverage which you have chosen.

Existing Health Coverage

1. Has anyone applying for coverage had any group or individual health plan coverage within the last 18 months? ❑ No ❑ Yes
   - If yes, please supply the following information for each applicant for the last 18 months:

Name(s)	
Insurance carrier name	
Effective date	Termination date

Name(s)	
Insurance carrier name	
Effective date	Termination date

2. If anyone applying for coverage has any existing group or individual health plan coverage, do you agree to terminate this existing coverage if approved for the coverage being applied for? ❑ No ❑ Yes

Existing Dental Coverage

1. Does anyone applying for coverage currently have any group or individual dental coverage? ❑ No ❑ Yes
   - If yes, please supply the following for all applicants on the policy:

Name(s)	
Insurance carrier name	
Effective date	Termination date

Name(s)	
Insurance carrier name	
Effective date	Termination date

2. Has anyone applying for coverage had this existing dental coverage within the last 18 months? ❑ No ❑ Yes
   - If yes, will the insurance coverage applied for be used to replace existing dental coverage? ❑ No ❑ Yes

Existing Life Coverage

Primary Applicant:

1. Do you have any life insurance and/or annuity coverage currently in force? ❑ No ❑ Yes
2. Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage? ❑ No ❑ Yes
   - If yes:

Company name	
Amount	Policy number

Spouse:

1. Do you have any life insurance and/or annuity coverage currently in force? ❑ No ❑ Yes
2. Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage? ❑ No ❑ Yes
   - If yes:

Company name	
Amount	Policy number

Evidence of Health Status

For this insurance to be issued, the following health questions must be answered fully and truthfully. All of the health information, including routine physical exams, must be provided. If any of the answers are "Yes," please provide complete details. Failure to disclose any health information may result in your policy being modified or terminated, back to your original effective date.

Please answer for all individuals applying for coverage.		
1.	Within the past 2 years been advised to have or have had a check-up (annual or otherwise), electrocardiogram, x-ray, lab tests, or other medical tests (such as: blood tests, urine analysis, MRI, CT scan, blood pressure check, etc)?	❑ No ❑ Yes
2.	a. Within the past 2 years been treated in the ER, an Urgent Care Center, or been hospitalized? b. Within the past 2 years have you had, or been advised to have, any inpatient /outpatient surgery that is complete or yet to be completed?	❑ No ❑ Yes ❑ No ❑ Yes
3.	Within the past 10 years had cosmetic or reconstructive surgery, implant(s), internal fixation (i.e. pins, plates, rods, screws, etc.), prosthesis or prosthetic device, joint replacement, monitoring device, pacemaker, or valve replacement?	❑ No ❑ Yes
4.	Had a positive pregnancy test in the last 90 days, or are currently an expectant parent, male or female, regardless of whether or not the mother is listed on the application?	❑ No ❑ Yes
5.	Within the past 10 years had any signs or chronic symptoms of fatigue, fever, loss of appetite, oral thrush, recurrent infections or weight loss with no known cause?	❑ No ❑ Yes
6.	Within the past 10 years has anyone applying for coverage been diagnosed or received treatment for AIDS or an AIDS-related complex or other immune system disorder?	❑ No ❑ Yes

In the past 10 years, has anyone applying for coverage been treated for, taken medication for, had symptoms of, been advised or counseled that they have or may have had any of the following: (Check all conditions which apply)

7. Cardiovascular, Circulatory or Heart Disorder	
❑ a. Angina, Chest Pain or Heart Attack ❑ b. High Blood Pressure or Hypertension ❑ c. Coronary Artery Disease ❑ d. Heart Murmur, Mitral Valve Prolapse or Irregular Heartbeat ❑ e. Edema, Phlebitis, Varicose Veins, Deep Vein Thrombosis, Blood Clot, or Aneurysm	❑ f. Congenital Heart Disorder (existing at or dating from birth) ❑ g. Congestive Heart Failure ❑ h. Valve Disorder ❑ **No to all Cardiovascular, Circulatory, or Heart Disorders**
8. Blood, Gland, Endocrine, Pituitary or Lymph Node Disorder	
❑ a. Elevated Cholesterol or Triglycerides ❑ b. Diabetes, High or Low Blood Sugar ❑ c. Anemia ❑ d. Obesity ❑ e. Thyroid or Glandular Disorder	❑ f. Enlarged or Swollen Lymph Nodes ❑ g. Blood, Endocrine, Pituitary or Lymph Node Disorder ❑ **No to all Blood, Gland, Endocrine, Pituitary or Lymph Node Disorders**
9. Digestive Disorder	
❑ a. Gastroesophageal Reflux Disease (GERD) or Heartburn ❑ b. Ulcer, Gastritis or Hernia ❑ c. Irritable Bowel Syndrome (IBS), Colitis or Crohn's Disease ❑ d. Diverticulitis, Diverticulosis, Hemorrhoids, or Colon Polyps	❑ e. Cirrhosis or Hepatitis ❑ f. Stomach, Liver, Pancreas, Spleen, Colon or Gallbladder Disorder ❑ **No to all Digestive Disorders**
10. Genitourinary Disorder	
❑ a. Bladder Infection, Cystitis or Bladder Disorder ❑ b. Kidney Disorder, Kidney Stones or Kidney Infection	❑ **No to all Genitourinary Disorders**
11. Muscular Skeletal Disorder	
❑ a. Back or Spine Disorder, ❑ b. Arthritis, Bursitis, Tendonitis or Gout ❑ c. Fibromyalgia ❑ d. Temporomandibular Joint Syndrome (TMJ) ❑ e. Connective Tissue Disorder or Systemic Lupus	❑ f. Bone, Joint, Muscular, Neuromuscular Disorder or Injury ❑ g. Muscular Dystrophy, Amyotrophic Lateral Sclerosis (ALS) or Polio ❑ **No to all Muscular Skeletal Disorders**
12. Brain or Nerve System Disorder	
❑ a. Headaches-recurrent or severe ❑ b. Epilepsy, Seizures, Tics or Tremors ❑ c. Stroke or Transient Ischemic Attack (TIA) ❑ d. Alzheimer's, Dementia or Memory Loss ❑ e. Migraines, or Dizziness / Fainting	❑ f. Multiple Sclerosis or Paralysis ❑ g. Cerebral Palsy or Parkinson's ❑ h. Concussion, Brain Injury or Head Trauma ❑ **No to all Brain or Nervous Disorders**
13. Congenital or Development Disorder	
❑ a. Cleft Palate or Cleft Lip ❑ b. Club Foot / Feet ❑ c. Autism, Down's Syndrome or Mental Retardation	❑ d. Huntington's Chorea ❑ e. Developmental Disorder or Delay ❑ **No to all Congenital or Development Disorders**

In the past 10 years, has anyone applying for coverage been treated for, taken medication for, had symptoms of, been advised or counseled that they have or may have had any of the following: (Check all conditions which apply)

14. Respiratory Disorder

❑ a. Allergies, Bronchitis or Asthma ❑ b. Chronic Obstructive Pulmonary Disease (COPD) ❑ c. Emphysema, Pneumonia or Shortness of Breath	❑ d. Tuberculosis or Cystic Fibrosis ❑ e. Sleep Apnea ❑ **No to all Respiratory Disorders**

15. Cyst or Tumor

❑ a. Cancer, Carcinoma or Melanoma ❑ b. Cyst, Growth, Lump, Mass or Tumor	❑ **No to all Cyst or Tumors**

16. Female Reproductive Disorder

❑ a. Disorder of the Breast or Abnormal Mammogram ❑ b. Abnormal Pap Smear ❑ c. Endometriosis, Infertility, Uterine Fibroids or Pelvic Inflammatory Disease ❑ d. Complication of Pregnancy / Cesarean Section	❑ e. Menopausal Disorder ❑ f. Menstrual Disorder ❑ g. Cervical, Ovarian, Uterine or Vaginal Disorder ❑ **Not Applicable or No to all Female Reproductive Disorders**

17. Male Reproductive Disorder

❑ a. Penile, Prostate or Testicular Disorder ❑ b. Infertility or Sexual Dysfunction	❑ **Not Applicable or No to all Male Reproductive Disorders**

18. Sexually Transmitted Disease

❑ a. Chancroid or Chlamydia ❑ b. Genital Warts or Condyloma Acuminatum ❑ c. Genital Herpes	❑ d. Human Papilloma Virus (HPV) ❑ e. Gonorrhea or Syphilis ❑ **No to all Sexually Transmitted Diseases**

19. Emotional or Mental Disorder

❑ a. Anxiety, Depression or Panic Disorder ❑ b. Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) ❑ c. Eating Disorder	❑ d. Counseling-Psychiatric or Psychological ❑ e. Bipolar Disorder, Obsessive Compulsive Disorder, Multiple Personality Disorder, or Schizophrenia ❑ **No to all Emotional or Mental Disorders**

20. Skin Conditions

❑ a. Acne or Rosacea ❑ b. Eczema, Discoid Lupus or Psoriasis	❑ **No to all Skin Conditions**

21. Eyes, Ears, Nose or Throat Condition

❑ a. Disorder of the Ear, Ear Infections or Tubes In Ears ❑ b. Hearing Loss or Cochlear Implants ❑ c. Disorder of the Nose, Deviated Septum or Sinus Infection ❑ d. Meniere's, Labyrinthitis or Vertigo	❑ e. Disorder of the Throat, Tonsils or Adenoids ❑ f. Disorder of the Eyes, Blindness, Cataracts or Glaucoma ❑ g. Speech Impairment ❑ **No to all Eye, Ear, Nose or Throat Conditions**

22. Has anyone applying for coverage been seen by or consulted by a doctor, or any other person providing health care services for any other condition not listed on this application? ❑ No ❑ Yes

23. Has anyone applying for coverage, within the past 2 years been prescribed or taken any prescription medications, other than for the common cold or flu? ❑ No ❑ Yes
If yes, please list all details and medications in Additional Health Question Information section below.

Additional Health Question Information

To be completed if anyone applying for coverage answered "Yes" to any question(s) or checked any above conditions in the Evidence of Health Status section. Attach an additional health information sheet if necessary.

Person treated Question number

Condition

Treatment dates (First diagnosed / treated, last seen by a physician, and planned future dates)

Type of treatment

Medications-prescribed or taken (include name of medication, dosage and frequency taken)

Medication-First prescribed / taken (month/year)

Medication-Last prescribed / taken or date discontinued (month/year)

Recovery complete? ❑ No ❑ Yes If yes, please provide date (month/year)

Physician name

Physician address and telephone

Payment Authorization & Billing Information

If another person will be paying for coverage they must sign the agreement and signature page.

Who will be paying for this plan(s)? ________________ Name Phone number (_____) ________________

Address ________________

Initial Payment Options

Initial payment must total one month's premium for each product selected. Agent / Producer payments are not accepted. Please choose your preference for payment of first month's premium. Please complete credit card or one time bank withdrawal below.

❑ Credit card ❑ One time bank withdrawal

Credit Card Payment

Initial payment for each product applied for will be drafted separately against your account.

❑ Visa ❑ Mastercard

Card number ______ ______ ______ ______

Expiration date (Month/Year) ________________

Cardholder's name ________________

❑ I authorize Humana to bill my VISA / Mastercard account for the initial premium payment.

One Time Automatic Bank Withdrawal

(Please print)

Account holder's name ________________

Phone number (______) ________________

Bank name ________________

Address ________________

Routing number ________________

Account number ________________

❑ I authorize Humana to draw premium payment from the account above until this authorization is revoked by me.

Subsequent Payment Options

Please indicate both billing preference and payment method. If direct bill is selected a fee may apply. If choosing automatic bank withdrawal, please complete section to the right.

❑ Monthly billing	❑ Automatic bank withdrawal
	❑ Direct bill
❑ Quarterly billing	Direct bill
❑ Semi-Annual billing	Direct bill

Subsequent Automatic Bank Withdrawal

(Please print)

Account holder's name ________________

Phone number (______) ________________

Bank name ________________

Address ________________

Routing number ________________

Account number ________________

❑ I authorize Humana to draw premium payment from the account above until this authorization is revoked by me.

Agent / Broker / Producer Information

This section to be completed by Agent, Broker or Producer.

1. Agent/Agency of Record (for commissions and correspondence)

Name (print) William C. Stapleton

Tax ID -or- Social Security # -or- Humana ID 1392525

Commission split: ❑ No ❑ Yes

If yes, percentage ________________ (Total should equal 100%)

2. Agent/Agency of Record (for split-commissions)

Name (print) ________________

Tax ID -or- Social Security # -or- Humana ID ________________

Percentage of sales: ❑ No ❑ Yes

If yes, percentage ________________ (Total should equal 100%)

1. Writing Agent / Broker / Producer:

Name (print) ________________

Tax ID -or- Social Security # -or- Humana ID ________________

Commission split: ❑ No ❑ Yes

If yes, percentage ________________ (Total should equal 100%)

2. Writing Agent / Broker / Producer (for split-commissions)

Name (print) ________________

Tax ID -or- Social Security # -or- Humana ID ________________

Percentage of sales: ❑ No ❑ Yes

If yes, percentage ________________ (Total should equal 100%)

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 / Broker / Producer, I acknowledge that I am responsible to meet with the 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 applicant in the benefit summary document or other plan literature.

Writing agent's signature ________________ Date ________________

Thank you for choosing Humana*One*.

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 have received and reviewed any state or federal required disclosures.
- Neither I nor my company representative has the authority to waive a complete answer to 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 do not qualify for a group health plan or receive favorable tax treatment under federal or state law.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the Policy. Acceptance of premium and fees does not guarantee coverage.
- To automatic withdrawal from my specified bank account for premium payment and administrative fees if selected under the product section.
- Premiums already paid will be refunded to me if a policy is not issued.
- **Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk.**

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

Authorization

My spouse, 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 Humana, or its reinsurer or its legal representatives, and its affiliates.

My spouse, dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
- If you decide not to sign this authorization, we will decline to enroll you in a medical plan or to give you medical benefits.
- Any information obtained will not be released by Humana 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 I (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.
- 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.

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

Primary Applicant or Legal Representative Signature ______________________ Date______________
(MM/DD/YYYY)

Name and Relationship of Legal Representative ______________________

Spouse Signature______________________ (if covered dependent) Date______________ (MM/DD/YYYY)

Payor Signature______________________ (if other than insured) Date______________ (MM/DD/YYYY)

Child Signature ______________________ (if over legal age and applying for dependent coverage) Date______________ (MM/DD/YYYY)

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 products insured by HumanaDental Insurance Company

Additional Forms and Documents

Humana Insurance Company
Individual Product Segment
Underwriting Department
P.O. Box 1633
Waukesha, WI 53187-1633

SOUTH CAROLINA NOTICETO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

Save a copy of this notice – it may be important to you in the future!

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy issued by Humana Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. In particular, study the comparison statement which your agent
is required to furnish you upon taking your application.

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. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims.

After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Applicant's name ______________________________

Applicant's Signature ___________________________ Date ___________________________

Insured by Humana Insurance Company

Humana
Individual Life Underwriting
P.O. Box 11506
Green Bay, WI 54307-9963

SOUTH CAROLINA NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITY

Are you thinking about buying a new life insurance policy or annuity, and discontinuing or changing an existing one?

If you are, your decision could be a good one_or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent who sold you your existing policy to give you information about it. You are urged not to take action to terminate, assign or alter your existing policy until your new policy has been issued and you have examined it and found it acceptable.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing its policy.

____

Applicant's Signature Date

____

Agent's Signature

HUMANA®
Guidance when you need it most

Insured by Humana Insurance Company

Notice of Privacy Practices

(privacy practices regarding your personal, health and financial information)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully. The privacy of your personal and health information is important. This requires no action on your part unless you have a request or complaint.

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. We at Humana value our relationship with you, and we take your personal privacy seriously.

This notice, effective April 1, 2003, explains Humana's privacy practices, our legal responsibilities, and your rights concerning your personal and health information.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information that we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is personal and health information?

Personal and health information (hereafter referred to as "information") includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. The term "information" in this notice includes any personal and health information that is created or received by a health care provider or health plan that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

How does Humana protect my information?

In accordance with federal and state laws and our own policy, Humana has a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways that include:

- Limiting the access to who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties regarding your information
- Following our policies
- Training of our associates
- Requesting approval from you for any potential situations where your information would be used for reasons other than payment and health plan operations

How does Humana use and disclose my information?

We must use and disclose your information:

- To you or someone who has the legal right to act on your behalf;
- To the Secretary of the Department of Health and Human Services; and
- Where required by law.

We have the right to use and disclose your information:

- To a doctor, a hospital or other health care provider which asks for it in order for you to receive medical care;
- To pay claims for covered services provided to you by doctors, hospitals or other health care provider;
- For health care operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of health care professionals, and determining premiums;
- For performing underwriting activities;
- To your plan sponsor to permit them to perform plan administration functions;
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you;

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We may use or disclose your information:

- To your family and friends if you are unavailable to communicate, such as in a medical or other emergency;
- **To provide payment information to the subscriber for Internal Revenue Service substantiation.**
- To public health agencies if we believe there is a serious health or safety threat;
- To appropriate authorities regarding abuse, neglect, or domestic violence;
- In response to a court or administrative order, subpoena, discovery request, or other lawful process;
- For law enforcement purposes;
- To military authorities;
- For research purposes in limited circumstances;
- For procurement, banking or transplantation of organs, eyes, or tissue; and
- To a coroner, medical examiner or funeral director.

Will Humana use my information for purposes not described in this notice?

In all situations other than described in this notice, Humana will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission.

What does Humana do with my information when I am no longer a Humana member?

Your information may continue to be used for purposes described in this notice when your membership is terminated. After the required legal retention period, information is destroyed following strict procedures to maintain the confidentiality of the information.

What are my rights concerning my information?

The following are your rights with respect to your information:

- **Access –** You have the right to review and obtain a copy of your information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, and per hour for staff time to locate and copy your information, and postage.
- **Alternate Communications –** You have the right to receive confidential communications of information in a different manner or at a different place to avoid a lifethreatening situation. We will accommodate your request if it is reasonable.
- **Amendment –** You have the right to request an amendment of information we maintain about you if you believe that it is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will provide you a written explanation of the denial.
- **Disclosure –** You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. Effective April 1, 2003, Humana began maintaining these types of disclosures and will maintain this information for a period of six (6) years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- **Notice –** All Humana members and prospective members have the right to receive a written copy of this notice upon request at any time.
- **Restriction –** You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time;
- Accessing our web site at **www.humana.com** and going to the Privacy link, or
- E-mailing us at privacyoffice@humana.com.

The completed request form should be sent to Humana's Privacy Office at:

Humana Inc
Privacy Office
P.O. Box 1438
Louisville, KY 40202

What should I do if I believe my privacy has been violated?

If you believe your privacy has been violated in any way, you may file a complaint with Humana by calling us at 1-866-861-2762 at any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office

of Civil Rights (OCR). We will provide you with the appropriate OCR regional address upon request. You also have the option to email your complaint to OCRComplaint@hhs. gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the US Department of Health and Human Services.

Humana follows all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, Humana follows the law, rule, or regulation which provides greater member protection.

The following affiliates and subsidiaries also adhere to Humana's privacy policies and procedures:
Humana Employers Health Plan of Georgia, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Emphesys Insurance Company
Humana Insurance of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana Wisconsin Health Organization
Insurance Corporation
HumanaDental Insurance Company
The Dental Concern, Inc.
The Dental Concern, Ltd.
Humana Health Plan Interests, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Health One, Inc.

PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION

Humana and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

How Does Humana Collect Information About You?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the health care system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What Information Does Humana Receive About You?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history and your activity on our Web site. This also includes information regarding your medical benefit plan, your health care benefits, and health risk assessments.

Where Will Humana Disclose My Information?

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

What Can I Prevent With An Opt-Out Disclosure?

You can prevent the disclosures to non-affiliated third parties that provide products and services not offered by Humana or where the non-affiliated company provides services related to your plan by requesting to opt-out of such disclosures . Your opt-out request will apply to all members or individuals covered under your identification number or member account. Your opt-out request will continue to apply until you revoke your request or terminate your membership.

How Do I Request An Opt-Out?

At any time you may instruct Humana not to share any of your personal information with affiliated companies that provide offers of non-Humana products or services. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth and your member identification number. Any of the methods below can be used to request or revoke your opt-out:

- Telephone us at 1-866-861-2762,
- E-mail your opt-out request to us at privacyoffice@humana.com,
- Send your opt-out request to us in writing:
  Humana Privacy Office
  P. O. Box 1483
  Louisville, KY 40202

Humana follows all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, Humana follows the law, rule, or regulation which provides greater member protection.

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Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Emphesys Insurance Company
Humana Insurance of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana Wisconsin Health Organization
Insurance Corporation
HumanaDental Insurance Company
The Dental Concern, Inc.
The Dental Concern, Ltd.
Humana Health Plan Interests, Inc.
Humana HealthBenefit Plan of Louisiana, Inc.
Health One, Inc.
Humana MarketPOINT, Inc.

HUMANA®
Guidance when you need it most

GN-14474-HH 1/06

Humana Insurance Company
Individual Products – Underwriting
2 Riverwood Place
N 19 W24133 Riverwood Drive Suite 250
Waukesha, WI 53188-9995

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Information

All carriers are obligated to advise customers of HIPAA and the right to a guaranteed issue policy.

In general HIPAA guarantees the availability of individual coverage for HIPAA eligible individuals. **In order to be considered HIPAA eligible, all of the following conditions must be met:**

- An individual must have at least 18 months of continuous creditable coverage without any significant breaks (greater than 63 days);
- The most recent coverage was under a group health plan, governmental plan or church plan;
- The most recent health coverage was not cancelled due to non-payment of premium or because of fraud;
- An individual must have been offered and accepted COBRA or State Continuation coverage and exhausted such coverage.

You are NOT HIPAA eligible if any of the following apply:
- You are eligible for coverage under another group plan;
- You are eligible for Medicare part A or Part B;
- You are eligible for a State plan under title 19 and do not have other health insurance coverage.

In order to better understand your rights and options, you may want to contact your state Department of Insurance.

DISCLOSURES

FAIR CREDIT REPORTING ACT AND PRIVACY ACT PRE-NOTIFICATION: Public Law 91-508 and state privacy acts require that Humana Insurance Company advise person(s) applying for coverage that an investigative report may be made in connection with this application which will provide applicable information concerning character and general reputation. I (we) understand that this information may be obtained through a phone interview or personal interview with the person (s) applying for coverage or other third parties. 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.

NOTICE OF INFORMATION PRACTICES: I (we) understand that in order to properly underwrite insurance coverage, Humana Insurance Company must collect personal information concerning the insurability of person(s) applying for coverage. Humana Insurance Company may also contact other sources, including medical professionals and institutions, employer, and other insurance companies. I (we) understand that I (we) have the right to be told about, and to see (and receive a copy of) items of personal information about me (us) which may appear in my (our) files. I (we) understand that I (we) have the right to seek correction, amendment, or deletion of information I (we) believe to be inaccurate. If I (we) have questions or desire additional information about the items disclosed above, I (we) understand that I (we) may write to Humana Insurance Company, N19 W24133 Riverwood Drive, Suite 250, Waukesha, WI 53188.

Insured by Humana Insurance Company