Fax Cover Sheet

To: Health Plans of Georgia

Fax #: 770-271-4012

Please accept my completed application and contact me to confirm receipt.

Name: _____

Email: _____

Phone: _____

Humana*One* Dental & Vision Paper Application Checklist

TO ENSURE PROCESSING PLEASE USE THIS CHECKLIST

› Did you fill out the application completely?

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

  For Dental C550 and HI215 products: if an application is received prior to the 15th of the month, the effective date is the 1st of the following month. If the application is received after the 15th of the month, the effective date will be the 1st of the subsequent month.
  EXAMPLE: An application received on May 14th will have an effective date of June 1st. An application received on May 18th will have an effective date of July 1st.

  For all other products, applications received between the 1st and the last day of the month will be effective the first of the following month.
  EXAMPLE: An application received on May 21st will have an effective date of June 1st.
- ❑ **Coverage Options:** Please check the box of the coverage option(s) that you are interested in and include the product names.
- ❑ **Primary Insured Information:** The following fields are required for the primary applicant: Full Name, Date of Birth, Address, City, State, ZIP code, Social Security Number, and Dentist Facility ID number (for Dental C550 and HI215 applicants only. Please visit **HumanaOneNetwork.com** to find a dentist).
- ❑ **Family Information:** The following fields are required for a spouse and/or dependents: Full Name, Date of Birth and Social Security Number.
- ❑ **Agent/ Producer Information:** The following fields are required from the agent (if applicable): Name, Humana Agent #, License #, and Signature.
- ❑ **Agreement and Signature:** Please read the agreement and sign and date all applicable lines.

› Second page: Payment & Billing Authorization

- ❑ Please indicate whether you will be paying monthly or annually.
- ❑ Please check the plan that you are purchasing in the chart and write in the total first payment amount equal to the enrollment fee(s) and the monthly/ annual payment total indicated in the chart.
  - ❑ If you are enrolling in more than one plan, please add the payment totals from the chart together for each plan and include enrollment fees for both plans.
  - ❑ **PLEASE NOTE:** Your first payment will be taken immediately upon receipt of the application, so please ensure that the payment method provided has funds available/covers this transaction and is accurate and up-to-date.
- ❑ **Payor Information:** Only fill out this section of the billing name or address is different than the information provided on the first page for the primary insured. The payor will also need to sign the Payor Signature line at the bottom of the application.
- ❑ **Payment Options:** Please check whether you will be paying via credit card, automatic bank withdrawal, or check/ money order. Please include all requested information and check the payment authorization box under your payment method.
  - ❑ If you are paying through automatic bank withdrawal, make sure to include your account information and a blank voided check along with the application.
  - ❑ If paying with a credit card, please check your credit card's expiration date. This card will be charged for future payments, so please alert us with any changes.
- ❑ All signature areas are signed and dated. Please make sure you have read and agreed to the one year contract language.

› Have you reviewed our provider network?

- ❑ To see providers in our network for all plans, please visit **www.HumanaOneNetwork.com** and enter your zip code and plan name.

› Would you like to fax your application?

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

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

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

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Humana*One* Dental & Vision Application

HUMANA *one*

GEORGIA

Requested Effective Date: __ __/__ __/__ __ __ __

This form is for: ❑ New Business (First time applicant) ❑ Reinstatement (Reapplication)
❑ Change/Modification to Existing Policy or Plan

Reason for change _____ Change/Modification to Existing Policy or Plan # _____

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

❑ **Dental Coverage**	❑ **Vision Coverage**
Product Name	Product Name

2. Primary Applicant Information

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

3. Family Information

Please complete only if your spouse and/or dependent children are applying for coverage. Attach an additional family information sheet if necessary. Each additional page must be signed and dated.

Spouse First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Social Security #	E-mail			

Dependent First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Social Security #	E-mail			

Dependent First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Social Security #	E-mail			

Dependent First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Social Security #	E-mail			

4. Agent / Producer Information **This section to be completed by Agent or Producer.**

1. Agent/Agency of Record (for commissions and correspondence)	**2. Writing Agent / Producer:**
Name (print) Health Plans of Georgia	Name (print) Steven J. McClelland
Humana Agent # 1217829	Humana Agent # 1001727

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

Writing agent's signature _____ Date __ __/__ __/__ __ __ __

5. 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 any agent or producer 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 product applied for is not an employer-sponsored group insurance policy and it does not comply with state or federal small employer laws. I certify that I do not qualify for or have willingly waived a group insurance policy or receive favorable tax treatment under federal or state law that will be used to pay insurance premiums. If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the policy. Acceptance of premium and fees does not guarantee coverage. I agree to automatic withdrawal from my specified bank account or credit card for premium payment and administrative fees if selected on the Humana*One* Payment & Billing Authorization form. 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. As a parent or legal guardian of a dependent 18 years or older applying for coverage, I attest by my signature below, that I have gathered the necessary insurance information from my dependent in order to fully and truthfully complete this application. This document, together with any supplements, will form part of 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 in an insurance product or to give you insurance benefits.

Primary Insured or Legal Guardian Signature _____ Date __ __/__ __/__ __ __ __

Relationship of Legal Guardian _____

Spouse Signature (if covered dependent) _____ Date __ __/__ __/__ __ __ __

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

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

HumanaOne Payment & Billing Authorization and Association Enrollment

HUMANA one

❑ I would like to pay monthly.

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

MONTHLY PAYMENTS	1 member	2 members	3+ members
❑ Preventive Plus	$19.99	$38.98	$76.96
❑ Vision Care Plan	$15.99	$28.99	$49.99
CHOOSE YOUR PLAN(S) by placing a check in the box			

*Note that all quoted monthly payment amounts listed above include a $1 administration and $0.75 association fee (where applicable).

Monthly payment:

$ _____ Dental

$ _____ Vision

$ _____ **Total Monthly Payment**

+ $35 One-time non-refundable enrollment fee

$ _____ **Total First Payment**

❑ I would like to pay annually.

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

ANNUAL PAYMENTS	1 member	2 members	3+ members
❑ Preventive Plus	$227.88	$455.76	$911.52
❑ Vision Care Plan	$179.88	$335.88	$587.88
CHOOSE YOUR PLAN(S) by placing a check in the box			

*Note that all quoted annual payment amounts listed above include a $9 association fee (where applicable).

Annual payment:

$ _____ Dental

$ _____ Vision

$ _____ **Total Annual Payment**

+ $35 One-time non-refundable enrollment fee

$ _____ **Total First Payment**

Payer Information (Skip to Payment Options if Payer Information is the same as the Primary Insured's)

Please provide the following information about the payer and complete the Payment Options section below. The payer will be responsible for signing the authorization to withdraw funds from the selected account(s); not the primary insured.

First name	MI	Last name	Home phone #	Daytime phone #

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

Payment Options

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

❑ A. Credit Card

Choose one: ❑ Annual Payment ❑ Monthly Payment

❑ Visa ❑ Mastercard

Card # Expiration date /

Cardholder's name

❑ I authorize Humana to draw premium payment (checked above) and all applicable fees and charges from my credit card account until this authorization is revoked by me.

❑ C. Check or Money Order

Choose one: ❑ Annual Payment ❑ Monthly Payment

Please make check or money order payable to Humana Insurance Company. Mail completed enrollment form, payment form and check or money order for the full amount of premium, association and enrollment fees to:

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

❑ B. Automatic Bank Withdrawal

Choose one: ❑ Annual Payment ❑ Monthly Payment

Choose one: ❑ Savings Account ❑ Checking Account

Account holder's name

Bank name

Routing #

Account #

❑ I authorize Humana to draw premium payment (checked above) and all applicable fees and charges from my designated account until this authorization is revoked by me.

Please note: For automatic bank withdrawals, please send this application along with a blank voided check and payment information to:

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

I understand this is a minimum one-year contract that auto-renews and is non-refundable and non-cancellable for all insureds.

Payer Signature _____ Date _____

Association agreement is necessary to be eligible for HumanaOne Dental and Vision Products (excluding the Dental DHMO C550 and Dental Prepaid HI215) except in the states of CO, GA, MD, MN, NH, NY, SD and UT.

Association Enrollment

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

Primary Insured Member or Legal Guardian Signature _____ Date _____