

## ENROLLMENT FORM

### Humana Medicare Plans

Humana Gold Plus® HMO (Health Maintenance Organization)  
HumanaChoicePPO® (Preferred Provider Organization)  
Humana Gold Choice® PFFS (Private Fee-For-Service)  
Humana Reader's Digest Healthy Living Plan (HMO)  
Humana Reader's Digest Healthy Living Plan (PPO)  
Humana Walmart-Preferred Rx Plan (PDP)  
Humana Prescription Drug Plan (PDP)

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Follow these easy steps to become a **Humana Medicare Member**

① **Have Your Medicare Card Ready**

Please print clearly and fill out the whole form. You will need to write the information exactly as it is on your Medicare card. **Each person applying must fill out a separate form.**

② **Please Read This Important Information**

Be sure you read each section. Make sure you understand the information.

③ **Please Sign And Date The Enrollment Form**

**This form isn't complete without your signature.** If you don't sign this form, your enrollment will be delayed. If someone helped you fill out the form (other than your plan representative), he/she will also need to sign. If this form is filled out by an authorized legal representative, legal documentation must be provided upon request.

**Keep Member Copy For Your Records**

To avoid any enrollment delays, **please don't send in the same application or apply to the same plan more than once.**

If you have questions, you can contact us seven days a week, from 8 a.m. to 8 p.m., by calling:

- 1-800-833-2367 (TTY 711)

You may mail this application to:

Humana Medicare Enrollment

PO Box 14309

Lexington, KY 40512-4309

or fax this application to 1-877-889-9936.

This information is available for free in other languages. Please contact our customer care number at 1-800-833-2367 for additional information.

Esta información está disponible gratis en otros idiomas. Para más información, comuníquese con el Departamento de Atención al Cliente llamando al 1-800-833-2367.

# 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 letter or number in each box.
- If you make a mistake, fix it by crossing out the box with an X. Put in the correct letter or number above or below the box as shown.

S M I ~~X~~ H  
                  T

- When filling out dates, be sure dates appear in the MMDDYYYY format. Don't use dashes or spaces.

0 3 2 4 2 0 1 0

**Required Fields Are Indicated With An Asterisk\***

## SAMPLE CHECK (If you are choosing the auto bank withdrawal.)

PAY TO THE ORDER OF \_\_\_\_\_ \$ \_\_\_\_\_ 20\_\_\_\_

FOR \_\_\_\_\_

486  
27-7189  
31133  
DOLLARS

⑆ 2223540988 ⑆ 541 042 90 ⑆ 486 ⑆

Routing  
Number

Account  
Number

Stamp Date

# 1 Humana Medicare Enrollment Form


Please fill in the information below exactly as it is on your Medicare card.

Are you currently on Medicaid?

Yes  No

IF YES, MEDICAID NUMBER

\_\_\_\_\_

<b>MEDICARE</b>			<b>HEALTH INSURANCE</b>	
<b>LAST NAME*</b>				
_____				
<b>FIRST NAME*</b>				<b>MI*</b>
_____				_____
<b>MEDICARE CLAIM NUMBER*</b>				
_____				
<b>IS ENTITLED TO</b>		<b>EFFECTIVE DATE*</b>		
<b>HOSPITAL (PART A)</b>		M M D D Y Y Y Y		
<b>MEDICAL (PART B)</b>		M M D D Y Y Y Y		

## NAME OF PLAN YOU ARE ENROLLING IN\*:

- Humana Gold Plus® HMO
- HumanaChoicePPO®
- Humana Gold Choice® PFFS
- Humana Reader's Digest Healthy Living Plan (HMO)
- Humana Reader's Digest Healthy Living Plan (PPO)

- Humana Walmart-Preferred Rx Plan (PDP)
  - Humana Prescription Drug Plan (PDP)
- (For Humana PDP selection, choose one below)
- Enhanced  Complete  Basic

## PLAN OPTION\*:

\_\_\_\_\_ - \_\_\_\_\_

## OPTIONAL SUPPLEMENTAL BENEFIT (OSB) YOU ARE ENROLLING IN:

- MyOption Platinum Dental
- MyOption Dental – High PPO
- MyOption Dental – Low PPO
- MyOption Enhanced Dental
- MyOption Enhanced Dental HMO
- MyOption Healthy Back
- MyOption Vision
- MyOption Plus
- MyOption Complete
- MyOption Fitness Well-being

If you're currently enrolled in an OSB, you must choose it on this form to continue receiving this benefit. Not all OSB offerings are available in all areas.

Language preference for Customer Service  English  Spanish  Other \_\_\_\_\_  
Please contact Humana at 1-800-833-2367 if you need information in another format or language. Our office hours are Monday through Friday, 8 a.m. to 8 p.m. (TTY 711)

**DATE OF BIRTH\*** M M D D Y Y Y Y      **SEX\***  Male  Female      **TELEPHONE\*** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**RESIDENTIAL ADDRESS\*** (No PO Box)  
\_\_\_\_\_

\_\_\_\_\_ **APT OR STE\***

**CITY\*** \_\_\_\_\_ **ST\*** \_\_\_\_\_ **ZIP\*** \_\_\_\_\_

**COUNTY\*** \_\_\_\_\_

## PLEASE COMPLETE IF THE MAILING ADDRESS IS DIFFERENT

**MAILING ADDRESS** (Check here if the Mailing Address is the same as the Residential Address )  
\_\_\_\_\_

\_\_\_\_\_ **APT OR STE**

**CITY** \_\_\_\_\_ **ST** \_\_\_\_\_ **ZIP** \_\_\_\_\_





Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between October 15 and December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. Please read the following statements carefully and mark the bubble to the left of the statement(s) that apply to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

	SEP Code	Special Election Period (SEP) Statements	Applicable Plan Type <sup>♦</sup>
<input type="radio"/>	<b>MOV</b>	Either: 1. In the past two months, one of the following moves occurred: I moved outside the service area for my current plan or I moved and this plan is a new option for me. 2. I returned to the United States after living permanently outside the U.S.	PDP, MAPD or MA
<input type="radio"/>	<b>MDE</b>	I have both Medicare and Medicaid or my state helps pay for my Medicare premiums or I lost this eligibility or was notified of the loss within the last two months.	PDP, MAPD or MA
<input type="radio"/>	<b>LIS</b>	I get extra help paying for Medicare prescription drug coverage.	PDP or MAPD
<input type="radio"/>	<b>LTC</b>	I am moving into, live in or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility). Or I moved out of a Long Term Care Facility within the last two months.	PDP
<input type="radio"/>	<b>PAC</b>	I left a PACE program within the last two months.	PDP, MAPD or MA
<input type="radio"/>	<b>LOC</b>	I involuntarily lost my creditable prescription drug coverage (as good as Medicare's) within the last two months.	PDP or MAPD
<input type="radio"/>	<b>LEC</b>	I am either losing/leaving coverage I had from an employer or union or lost this type of coverage within the last two months.	PDP, MAPD or MA
<input type="radio"/>	<b>SPA</b>	I belong to a pharmacy assistance program provided by my state (also known as a Qualified State Pharmaceutical Assistance Program or SPAP) or have lost eligibility or was notified of the loss within the last two months.	PDP, MAPD or MA
<input type="radio"/>	<b>LLS</b>	In the past three months, I no longer qualify for extra help paying for my Medicare prescription drugs.	PDP or MAPD
<input type="radio"/>	<b>NON</b>	My existing Medicare Advantage (MA) plan is non-renewing for the upcoming contract year. <b>Note: This SEP is only valid from December 8th through the last day of February.</b>	PDP, MAPD or MA
<input type="radio"/>	<b>ADP</b>	I used/I am using the Medicare Annual Disenrollment Period to return to Original Medicare and enroll in a Stand-alone PDP. (Only valid from January 1st through February 14th). <b>Note: If you are enrolled in a MA-only Private Fee-For-Service plan, you must request disenrollment from this plan in order to be eligible for this SEP.</b>	PDP
<input type="radio"/>	<b>OTH</b>	None of the above statements apply to me. However I feel I have a special circumstance which allows me an exception to enroll. Humana will contact you to determine if an exception can be granted. <b>Please include the reason below.</b>	
Notes (if OTHER):			

<sup>♦</sup>PDP = Prescription Drug Plan, MAPD = Medicare Advantage with Prescription Drug, MA = Medicare Advantage.

**② STOP PLEASE READ THIS IMPORTANT INFORMATION**

If you currently have health coverage from an employer or union, joining Humana could affect your employer or union health care benefits. You could lose your employer or union health coverage if you join Humana. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

**By completing this enrollment application, I agree to the following:**

If I am enrolling in a Medicare Advantage health plan that has a contract with the Federal government, I will need to keep my Medicare Parts A & B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. If I am enrolling in a Medicare drug plan that has a contract with the Federal Government, and it is in addition to my coverage under Medicare, I will need to keep my Medicare coverage. It is my responsibility to inform Humana of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I can be in only one Medicare prescription drug plan at a time. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances, by sending a request to Humana.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify Humana so I can disenroll and find a new plan in my new area. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Humana when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage or Prescription Drug Plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

Medically necessary services authorized by Humana Medicare Advantage health plans and other services contained in my Evidence of Coverage will be covered. **NEITHER MEDICARE NOR HUMANA WILL PAY FOR MEDICARE ADVANTAGE HMO SERVICES WITHOUT AUTHORIZATION.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Humana, he/she may be paid based on my enrollment in Humana.

- If you are requesting membership in a **HMO** plan, the following statement applies: I understand that on the date HMO coverage begins, I must get all of my health care from network providers, except for emergency or urgently needed services or out-of-area dialysis.
- If you are requesting membership in a **PPO** plan, the following statement applies: I understand that on the date PPO coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Humana provides reimbursement for all covered benefits, even if received out of network.
- If you are requesting membership in a **PFFS** plan, the following statement applies: I understand that this plan is a Medicare Advantage Private-Fee-for-Service plan and not a Medicare Supplement, Medigap, Medicare Select or Stand-Alone Prescription Drug Plan. Humana pays instead of Medicare, and I will be responsible for the amounts that Humana doesn't cover, such as copayments and coinsurances. Original Medicare won't pay for my health care while I am enrolled in Humana. **It is a Medicare Advantage plan which may have prescription drug coverage built-in.** Before seeing a provider, I should verify that the provider will accept PFFS before each visit. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, except for emergencies. Providers can find the plan's terms and conditions on our website at <http://www.humana-medicare.com/humana-gold-choice-terms-conditions.asp>. I understand that my health care providers have the right to choose whether to accept a Private Fee-For-Service plan's payment terms and conditions every time I see them. I understand that if my provider decides not to accept PFFS, I will need to find another provider that will. I understand that if my PFFS plan doesn't offer Medicare prescription drug coverage,





# HUMANA®

A Health plan with a Medicare contract, available to anyone enrolled in both Part A and Part B of Medicare. A stand-alone prescription drug plan with a Medicare contract, available to anyone entitled to Part A and/or enrolled in Part B of Medicare.

**[Humana-Medicare.com](http://Humana-Medicare.com)**