

Additional Notes

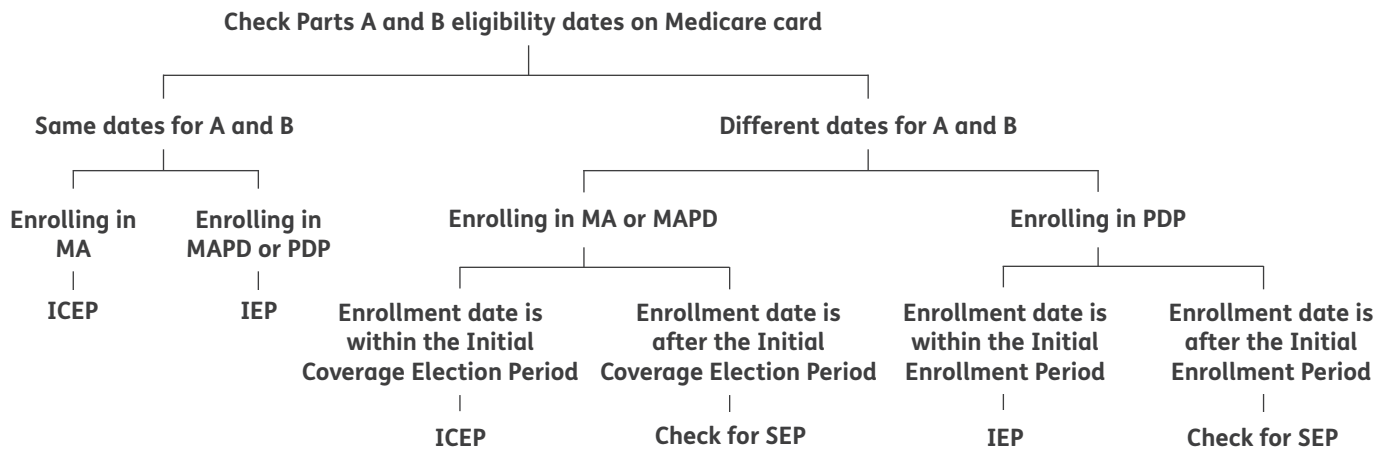
Asterisks (*) indicate required fields
 Answering non-required fields is your choice. You can't be denied coverage if you don't complete them.

Initial Enrollment Period (IEP) and Initial Coverage Election Period (ICEP)

- If Part A and Part B dates are the same, the election period spans 7 months: 3 months prior to the month you become eligible, the month you become eligible, and 3 months after the month you became eligible.
- If Part A and Part B dates are different, the election period spans 5 months: 3 months prior to the month of the later effective date (often Part B), the month you become eligible, and 1 month after the month you become eligible. Only for enrollment into a Medicare Advantage (MA)-only plan or a Medicare Advantage prescription drug (MAPD) plan. If enrollment is for a prescription drug plan (PDP), check to see if the 7-month IEP may still be available.
- The coverage start date is based on factors such as Medicare entitlement and the submission of the completed enrollment form.

When inputting your Medicare Number on the enrollment form, print it exactly as it is on your Medicare card. N indicates a number, A indicates an alphabetic character, and E indicates either a number or alphabetic character. Medicare numbers will not start with a zero or contain the letters B, I, L, O, S or Z.

Enrollment periods may overlap. Ensure you mark any Special Election Period (SEP) oval that applies to you from the list of SEP statements on page 4 of the enrollment form. When enrolling specifically during an SEP, one of the SEP statements must be true to be eligible for an SEP. Agents, please refer to the Enrollment Options Job Aid (DMS-024) found in Humana MarketPoint University in Vantage if you do not see the SEP listed on page 4, or contact the Agent Support Unit for assistance.



Scope Of Appointment (SOA) (Page 8)

Agents, please use one of the three-letter codes below for the appointment type field.

- | | | |
|-----------------------------------|---------------------------|------------------|
| F2F – Face to Face | INH – In Home Appointment | SEM – Seminar |
| GCS – Neighborhood Center Seminar | OTH – Other | WAL – Walmart |
| GCW – Neighborhood Center Walk-in | RET – Retail Partner | TEL – Telephonic |

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**.

Auxiliary aids and services, free of charge, are available to you.

877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

This information is available for free in other languages. Please call our customer service number at **877-320-1235 (TTY: 711)**. Hours of operation: **8 a.m. – 8 p.m. Eastern time.**

Español (Spanish): Llame al número indicado para recibir servicios gratuitos de asistencia lingüística. **877-320-1235 (TTY: 711)**. Horas de operación: 8 a.m. a 8 p.m. hora del este.

繁體中文 (Chinese): 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235 (聽障專線：711)**。辦公時間：東部時間上午 8 時至晚上 8 時。

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235 (听障专线：711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235 (聽障專線：711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Form CMS-10802 (Expires 12/31/25)

Form Approved OMB# 0938-1421

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخططنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711) 1-877-320-1235. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY:711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。



PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining Humana could affect your employer or union healthcare benefits. You could lose your employer or union health coverage if you join Humana.

By completing this enrollment form, 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 and B to stay in the plan. I must continue to pay my Medicare Part B premium. If I am enrolling in a Medicare prescription drug plan, I will need to keep my Medicare Parts A or B 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.** With few exceptions, I can only be in one Medicare Advantage health plan or Medicare prescription drug plan at a time. I understand that my enrollment in my selected plan may end my enrollment in another Medicare Advantage health plan or prescription drug plan. Enrollment in my selected plan is generally for the entire year.

I understand that when my Humana coverage begins, I must get all of my medical and prescription drug benefits from Humana. Benefits and services provided by Humana and contained in my "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Humana will pay for benefits or services that are not covered. I will abide by the rules of my Evidence of Coverage. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree.

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 Humana has received my enrollment form, I may get a verification letter to make sure that I understand how my plan works and to confirm my intent to enroll. This is not a secondary plan to Medicare Parts A and B. Humana pays instead of Medicare, and I will be responsible for the amounts that Humana doesn't cover, such as copayments and coinsurances. Medicare Parts A and B won't pay for my healthcare while I am enrolled in Humana.

- If you are requesting membership in a **Private Fee For Service (PFFS)** plan, the following statement applies: I understand that this plan is a Medicare Advantage PFFS plan which may have prescription drug coverage built in. Before seeing a provider, I should verify that the provider will accept this plan before each visit. My doctor or hospital isn't required to agree to accept the plan's terms and conditions, and thus may choose not to treat me, except for emergencies. I understand that my healthcare providers have the right to choose whether to accept a PFFS 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, I may obtain coverage from another Medicare prescription drug plan.
- If you are requesting membership in a **Chronic Condition Special Needs Plan (C-SNP)**, the following statement applies: I understand this plan is a chronic condition special needs plan. My ability to enroll is based on physician verification that I have the qualifying medical condition(s).
- If you are requesting membership in an **Institutional Special Needs Plan (I-SNP)**, the following statement applies: I understand this plan is an institutional special needs plan. My ability to enroll is based on verification that my condition makes it likely that either the length of stay or the need for an institutional level of care would be at least 90 days; or, I reside in the community and meet state requirements for institutional level of care.
- I understand that I am enrolling into a Humana Medicare Advantage plan or a Humana Medicare prescription drug plan and not a Medicare Supplement, Medigap, Medicare Select or Medicaid plan.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Release of Information:

By joining this Medicare plan, I acknowledge that Humana will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below).

Privacy Act Statement:

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. **Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.**


Individuals experiencing homelessness:

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security benefit checks) may be considered and used in the residential address field as your permanent residence address.

2025 Humana Medicare Enrollment Form

Please print this information exactly as it is on your Medicare card.

Print clearly. Use black ink.
Asterisks (*) indicate required fields.

 **MEDICARE HEALTH INSURANCE**

LAST NAME*

FIRST NAME* MI

MEDICARE NUMBER*
N A E N - A E N - A A N N

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A) M M - 0 1 - Y Y Y Y

MEDICAL (PART B) M M - 0 1 - Y Y Y Y

AGENT NUMBER (SAN)

DATE OF BIRTH* M M - D D - Y Y Y Y SEX* F M

MEMBER ID NUMBER
H

(For current or past Humana members)

Please see your agent to complete these questions.

PROPOSED COVERAGE START DATE*

M M - 0 1 - 2 0 2 5

(Must be after the sign date on page 8)

ICEP IEP AEP OEP OEP OEPI SEP
MA or PDP or NEW CODE[†]

(See Additional Notes page)

[†]Required if SEP selected. See page 4 for code.

RESIDENTIAL ADDRESS* P.O. Box not allowed.

APT or STE

CITY* ST* ZIP*

COUNTY*

Experiencing homelessness

MAILING ADDRESS Your residential address confirms your service area. Print your mailing address/P.O. Box here, if applicable. If your mailing address is your residential address, please fill this oval.

APT or STE

CITY ST ZIP

It is important that we can reach you to help you stay informed and take care of your health. Please provide your telephone number and email address.

TELEPHONE TELEPHONE TYPE Cellphone Home (landline)

There may be times when Humana will use an automated system to call or text you. When that happens we will be sure to use the telephone number you provided.

EMAIL By providing your email address, you authorize Humana to send you health information to this address.

Go paperless. Many plan documents are now available in a digital format. See the enrollment book for a list of available communications and guidance on how to view your documents. To choose this option, please fill this oval.

We strongly recommend that all medical plan applicants include their primary care physician's (PCP) information below. If you are applying for an HMO plan, then you must complete this section. Please see your Summary of Benefits to determine if your plan requires a PCP.

PCP ID NUMBER

PRIMARY CARE PHYSICIAN (PCP)

Are you already a patient of the physician you chose? Yes No

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N - A E N - A A N N

Typically, you may enroll in a Medicare Advantage or prescription drug plan during the Annual Election Period (AEP) between October 15 and December 7 of each year. In addition, you can choose to change your Medicare Advantage plan once during the annual Open Enrollment Period (OEP) between January 1 and March 31 of each year, or immediately after enrolling in a plan during your IEP/ICEP (OEP NEW). Limitations on allowed plan changes during OEP apply. There are exceptions that may allow you to enroll outside of these periods. Please read the following statements carefully and mark the oval to the left of any statement that applies to you. By marking any of the following ovals you are certifying that, to the best of your knowledge, the text is a true statement about you. **If we later determine that this information is incorrect, you may be disenrolled.**

SEP Code	Special Election Period (SEP) statements
<input type="radio"/> LEC	I am either losing/leaving coverage I had from an employer or union or lost this type of coverage within the last two months.
<input type="radio"/> MDE	I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I HAVEN'T had a change. Note: This SEP is valid once per month throughout each year, and only for enrollment into a PDP.
<input type="radio"/> NLS	I had a change in my Extra Help paying for Medicare prescription drug coverage (newly got assistance, had a change in level or lost eligibility) within the last three months.
<input type="radio"/> MCD	I had a change in my Medicaid status (newly got assistance, had a change in level or lost eligibility) within the last three months.
<input type="radio"/> MOV	I am moving or have moved within the last two months. The move is either outside the service area for my current plan or this plan is a new option for me.
<input type="radio"/> SNP	I have been notified that I no longer qualify for my Dual Eligible Special Needs Plan and am in a period of deemed continued eligibility or I was disenrolled from my Dual Eligible Special Needs Plan within the past three months due to a Medicaid change or loss.
<input type="radio"/> DST	I was affected by a Federal Emergency Management Agency (FEMA) declared emergency/ disaster or a disaster or other emergency declaration issued by a federal, state or local government entity, and was unable to use another election period available to me due to it. Election Period Missed: _____ Emergency/Disaster Experienced: _____
<input type="radio"/> EOC	My existing Medicare Advantage (MA) plan is ending its contract for the upcoming contract year. Note: This SEP is only valid from December 8 through the last day of February.
<input type="radio"/> OTH	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. Must include the reason below.

Notes (if OTH):

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N - A E N - A A N N

Plan selection

Please provide the plan information below for the medical or prescription drug plan you'd like. Plan information can be found in your Summary of Benefits.

CONTRACT*	PBP*	SEGMENT
<input type="text"/>	<input type="text"/>	0 0 <input type="text"/>

Please provide the base monthly premium for this plan from the Summary of Benefits. This amount helps us identify the plan you would like and should not include any late enrollment penalties or payments from other parties, like Medicaid.

BASE MONTHLY PREMIUM*

\$.

Select one option below corresponding with the plan details you provided above. Refer to your Summary of Benefits or your agent for assistance.

I would like **ONE** of the following options:*

- | | |
|---|---|
| <input type="radio"/> Humana Gold Plus® HMO | <input type="radio"/> HumanaChoice® PPO |
| <input type="radio"/> Humana Gold Plus® Giveback HMO | <input type="radio"/> HumanaChoice® Giveback PPO |
| <input type="radio"/> Humana Value Plus HMO | <input type="radio"/> Humana Value Plus PPO |
| <input type="radio"/> Humana USAA Honor Giveback HMO | <input type="radio"/> Humana USAA Honor Giveback PPO |
| <input type="radio"/> Humana Gold Plus® HMO C-SNP
(Additional Pre-Qualification Form Required) | <input type="radio"/> HumanaChoice® PPO C-SNP
(Additional Pre-Qualification Form Required) |
| <input type="radio"/> Humana Community HMO C-SNP
(Additional Pre-Qualification Form Required) | <input type="radio"/> Humana Together in Health PPO I-SNP
(Additional Attestation Form Required) |
| <input type="radio"/> Humana Community HMO | <input type="radio"/> Humana Senior Living Plan PPO I-SNP
(Additional Attestation Form Required) |
| <input type="radio"/> Humana Community Select HMO | <input type="radio"/> HumanaChoice® Value PPO |
| <input type="radio"/> Humana Select Partner Plan HMO | <input type="radio"/> HumanaChoice® Partnered PPO |
| <input type="radio"/> Humana Cleveland Clinic Preferred HMO | <input type="radio"/> Humana USAA Honor Giveback with Rx PPO |
| <input type="radio"/> Humana LCMC Advantage HMO | <input type="radio"/> Humana Full Access PPO |
| <input type="radio"/> UC San Diego Health Humana HMO | <input type="radio"/> Humana Full Access Giveback PPO |
| <input type="radio"/> Humana FMOL Network HMO | <input type="radio"/> Humana Basic Rx Plan (PDP) |
| <input type="radio"/> Humana BR Clinic-BR Gen HMO | <input type="radio"/> Humana Premier Rx Plan (PDP) |
| | <input type="radio"/> Humana Value Rx Plan (PDP) |
| | <input type="radio"/> Humana Gold Choice® PFFS |

If selecting a Medicare Advantage HMO or PPO plan that does not include prescription drug coverage, a stand-alone prescription drug plan (PDP) cannot be carried at the same time.

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N - A E N - A A N N

If you will have other prescription drug coverage (like VA, TRICARE) in addition to this plan for which you are applying, please fill this oval.* I will have other prescription drug coverage

Please provide your other prescription drug coverage details here, if applicable.

NAME OF OTHER COVERAGE

[Grid for Name of Other Coverage]

ID NUMBER FOR THIS COVERAGE

[Grid for ID Number]

GROUP NUMBER FOR THIS COVERAGE

[Grid for Group Number]

Once enrolled, will you or your spouse work? Yes No

Preferred Written Language (when available)

- English Spanish Chinese Korean Other

Preferred Verbal Language

- English Spanish Mandarin Cantonese Korean Other

If an accessible format is needed, please select one option

- Audio Large print Accessible screen reader PDF Oral over the phone Braille Data CD

Please call a licensed Humana sales agent at 1-800-833-2367 (TTY: 711) if you need information in another format or language.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- No, not of Hispanic, Latino/a, or Spanish origin Yes, Mexican, Mexican American, Chicano/a Yes, Puerto Rican Yes, Cuban Yes, another Hispanic, Latino/a, or Spanish origin I choose not to answer

What's your race? Select all that apply.

- American Indian or Alaska Native Asian Indian Black or African American Chinese Filipino Guamanian or Chamorro Japanese Korean Native Hawaiian Other Asian Other Pacific Islander Samoan Vietnamese White I choose not to answer

What was your sex assigned at birth? You can find this on an original birth certificate or similar document.

Select one.

- Female Not sure Male I choose not to answer A sex that's not listed:

What's your gender identity? Select one.

- Female A gender that's not listed: Male Not sure Transgender female I choose not to answer Transgender male

What's your sexual orientation? Select one.

- Lesbian or gay A sexual orientation that's not listed: Straight Not sure Bisexual I choose not to answer

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N - A E N - A A N N

PLEASE SELECT ONE PREMIUM PAYMENT OPTION. You may pay your monthly plan premium and/or late enrollment penalty via automatic deduction from your bank account, Social Security Administration (SSA) or Railroad Retirement Board (RRB) benefit check, or credit or debit card. You may also choose to pay by mail using a coupon book. **If you do not select a payment option below, you may be defaulted to a coupon book.**

Automatic bank account deduction

Bank account information (Only complete this section if you selected Automatic bank account deduction as your payment option).

Checking account Savings account

BANK NAME

Grid of 30 empty boxes for bank name input.

ROUTING NUMBER

ACCOUNT NUMBER

Grid of 18 empty boxes for routing and account numbers, with vertical bars on the left and right sides.



Routing number Account number

Social Security benefit check deduction (Please see note below)

Railroad Retirement Board benefit check deduction (Please see note below)

You must currently be receiving a Railroad Retirement Board benefit check in order to qualify for this payment option.

NOTE: Due to processing timelines mandated by CMS (Medicare), your SSA or RRB deduction may be denied for your first premium payment. Humana will issue you an invoice for the initial payment and resubmit your request to CMS (Medicare) for SSA or RRB deduction to begin with your second month's premium. The deduction may take two or more benefit checks to begin. In most cases, if SSA or RRB accepts your request for automatic deduction, the first deduction from your benefit check will start with the month that SSA accepts the withholding. If SSA or RRB does not approve your request for automatic deduction, we will send you a coupon book for your monthly premiums.

Automatic credit or debit card deduction

Credit or debit card information (Only complete this section if you selected Automatic credit or debit card deduction as your payment option).

Mastercard Visa Discover American Express

CREDIT OR DEBIT CARD NUMBER

EXPIRATION DATE

Grid of 16 empty boxes for card number and expiration date (MM - 20 YY).

Coupon book

You can visit [Humana.com/pay](https://www.humana.com/pay) to make your monthly premium payments online. If you have selected coupon book as your payment option, you can pay as far in advance as you like. You can also log in to your secure MyHumana account (click Register if you haven't signed up yet) or download the MyHumana mobile app to take advantage of other premium-related services.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. Do NOT pay Humana the Part D-IRMAA.

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N - A E N - A A N N

I have read and understand the important information on the preceding pages. I have reviewed and received a copy of the Summary of Benefits.

SIGNATURE OF APPLICANT* or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.)

[Signature line]

SIGNATURE DATE*

M M - D D - 2 0 Y Y

I understand that my signature (or the signature of the individual legally authorized to act on my behalf) on this enrollment form means that I have read and understand the contents of this enrollment form. If signed by an authorized representative (as described above), the signature certifies that: 1) this individual is authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request by Medicare.

If you are the authorized legal representative, you MUST sign above and provide the following information:*

LAST NAME FIRST NAME MI STREET ADDRESS CITY ST ZIP TELEPHONE RELATIONSHIP TO APPLICANT

FOR INDIVIDUALS HELPING AN APPLICANT WITH COMPLETING THIS FORM ONLY

Complete this section if you're an individual (e.g. agents, brokers, SHIP counselors, family members, or other third parties) helping an applicant fill out this form.

NAME SIGNATURE RELATIONSHIP TO APPLICANT NATIONAL PRODUCER NUMBER (AGENTS/BROKERS ONLY)

AGENT USE ONLY

APPOINTMENT TYPE SCOPE OF APPOINTMENT ID NUMBER WRITING AGENT NAME* AGENT NUMBER (SAN)* DATE* AFFINITY PARTNER LOCATION CAMPAIGN REFERRING AGENT NAME REFERRING AGENT NUMBER (SAN) CONTRACT* PBP* SEGMENT

ASK THE APPLICANT: Would you like to provide your Veteran status?*

Self Spouse Dependent I am not a Veteran Prefers not to answer

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