2026
Enrollment Form

Follow these easy steps to become a Humana Medicare member

Have your Medicare card ready

Each individual applying must fill out a separate form.

Sign and date the enrollment form

If the enrollment form is not completed and returned within the allotted time period, the enrollment could be denied.

Submit your enrollment form

You may fax the Member Services pages of this enrollment form to: **1-877-889-9936**. Or mail this enrollment form to:

Humana Medicare Enrollment
P.O. Box 14309
Lexington, KY
40512-4309

Please don't send in the same enrollment form or apply to the same plan more than once.

Call us with questions

If you have questions, please call a licensed Humana sales agent at **1-800-833-2367 (TTY: 711)**. We're available seven days a week, 8 a.m. – 8 p.m.

However, please note that our automated phone system may answer your call on holidays and during weekends April 1 – September 30. Please leave your name and telephone number, and we'll call you back by the end of the next business day.

Electronic enrollment options

Have you considered enrolling online at **Humana.com/Medicare** instead? It's a fast, secure and easy way to apply.

Instructions

- Completely fill the ovals.
- Use black ink only.
- Print only one clear number or capital block letter 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:

Correct numbers and letters

Humana®

Additional Notes

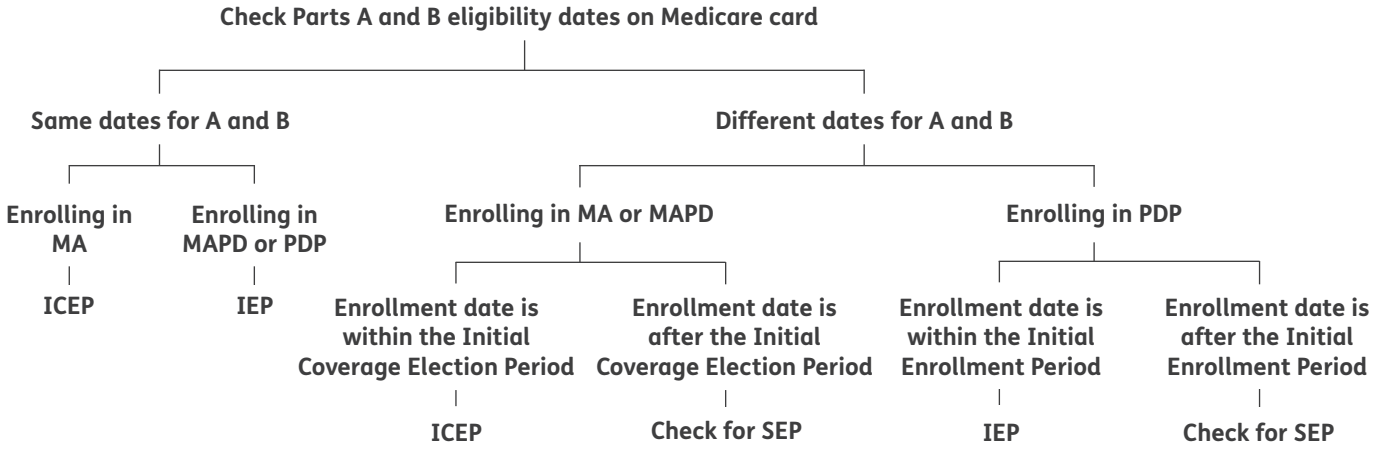
Asterisks (*) indicate required fields
Answering non-required fields is your choice. You can't be denied coverage if you don't complete them.

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.



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
OTH – Other
RET – Retail Partner
SEM – Seminar
TEL – Telephonic
WAL – Walmart

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019**, **800-537-7697 (TDD)**.

California members:

You can also file a civil rights complaint with the California Dept. of Health Care Services, Office of Civil rights by calling **916-440-7370 (TTY: 711)**, emailing **Civilrights@dhcs.ca.gov**, or by mail at: Deputy Director, Office of Civil Rights, Department of Health Care Services, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413. Complaint forms available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**.

This notice is available at **www.humana.com/legal/non-discrimination-disclosure**.

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Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **877-320-1235 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجانًا. اتصل على الرقم **877-320-1235 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք՝ **877-320-1235 (TTY: 711)**:

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **877-320-1235 (TTY: 711)** নম্বরে।

简体中文 [Simplified Chinese]：我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **877-320-1235（听障专线：711）**。

繁體中文 [Traditional Chinese]：我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **877-320-1235（聽障專線：711）**。

Kreyòl Ayisyen [Haitian Creole]: Lang gratis, èd oksilyè, ak lòt fòma sèvis disponib. Rele **877-320-1235 (TTY: 711)**.

Hrvatski [Croatian]: Dostupni su besplatni jezik, dodatna pomoć i usluge alternativnog formata. Nazovite **877-320-1235 (TTY: 711)**.

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **877-320-1235 (TTY: 711)** تماس بگیرید.

Français [French] : Des services gratuits linguistiques, d'aide auxiliaire et de mise au format sont disponibles. Appeler le **877-320-1235 (TTY: 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **877-320-1235 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **877-320-1235 (TTY: 711)**.

ગુજરાતી [Gujarati]: નિઃશુલ્ક ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **877-320-1235 (TTY: 711)** પર કૉલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **877-320-1235 (TTY: 711)**

हिन्दी [Hindi]: निःशुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। **877-320-1235 (TTY: 711)** पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **877-320-1235 (TTY: 711)**.

Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiama il numero **877-320-1235 (TTY: 711)**.

This notice is available at **https://www.humana.com/legal/multi-language-support**.

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日本語 [Japanese]:言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**877-320-1235 (TTY: 711)** までお電話ください。

ភាសាខ្មែរ [Khmer]៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅលេខ **877-320-1235 (TTY: 711)**។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다.
877-320-1235 (TTY: 711)번으로 문의하십시오.

ພາສາລາວ [Lao] ມີການບໍລິການດ້ານພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນໃຫ້ໃຊ້ຟຣີ. ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad t’áá jiik’eh, t’áadoole’é binahjį’ bee adahodooníłígíí diné bich’į’ anídahazt’i’í, dóó łahgo át’éego bee hada’dilyaaígíí bee bika’aanída’awo’í dahólǫ. Kohjį’ hodíilnih **877-320-1235 (TTY: 711)**.

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **877-320-1235 (TTY: 711)**.

Português [Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **877-320-1235 (TTY: 711)**.

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫ਼ਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **877-320-1235 (TTY: 711)** ‘ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **877-320-1235 (TTY: 711)**.

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **877-320-1235 (TTY: 711)**.

Tagalog [Tagalog]: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **877-320-1235 (TTY: 711)**.

தமிழ் [Tamil]: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. **877-320-1235 (TTY: 711)** ஐ அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **877-320-1235 (TTY: 711)** కి కాల్ చేయండి.

اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال **877-320-1235 (TTY: 711)**۔

Tiếng Việt [Vietnamese]: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **877-320-1235 (TTY: 711)**.

አማርኛ [Amharic]፦ ቋንቋ፣ አጋዥ ማዳመጫ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Bǎsɔ́ [Bassa]: Wuɖu-xwíníín-mú-zà-zà kǔà, Hwòɖǒ-fɔńɔ-ńnyɔ,́kè nyɔ-bɔǔn-po-kà ɓě ɓɛ́ nyuɛɛ se wíɖí pɛ́ɛ̀-pɛ́ɛ̀ ɖò kɔ.̃ **877-320-1235 (TTY: 711)** ɖá.

Bekee [Igbo]: Asụsụ n’efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

Òyìnbó [Yoruba]: Àwọn iṣẹ́ àtìlẹhìn ìrànlọ́wọ́ èdè, àti ọ̀nà kíkà míràn wà lárọwọ́tó. Pe **877-320-1235 (TTY: 711)**.

नेपाली [Nepali]: भाषासम्बन्धी नि:शुल्क, सहायक साधन र वैकल्पिक फार्मेट (ढाँचा/व्यवस्था) सेवाहरू उपलब्ध छन् । **877-320-1235 (TTY: 711)** मा कल गर्नुहोस् ।

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/or 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. Benefits and services must be obtained from Humana in order to be covered as Medicare benefits, with the exception of hospice and kidney acquisition costs for transplants, which are covered by Medicare. I will abide by the rules of my Evidence of Coverage.

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. Emergency coverage (both within and outside the plan's service area) and urgent care are always covered.

Sales agents/brokers may be compensated if they are helping the applicant enroll.

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 a Medicare Advantage health plan with 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 the U.S. Department of Health and Human Services (HHS), 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.

2026 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.

AGENT NUMBER (SAN)

DATE OF BIRTH* SEX*

M M – D D – Y Y Y Y ○ F ○ M

MEMBER ID NUMBER

H

(For current or past Humana members)

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

Please see your agent to complete these questions.

PROPOSED COVERAGE START DATE*

M M – 0 1 – 2 0 2 6

(Must be after the sign date on page 8)

○ ICEP MA or MAPD ○ IEP PDP or MAPD ○ AEP ○ OEP ○ OEP NEW ○ OEPI ○ SEP CODE†

(See Additional Notes page)

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

RESIDENTIAL ADDRESS* P.O. Box not allowed. ○ Experiencing homelessness

APT or STE

CITY* ST* ZIP*

COUNTY*

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
○	**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.
○	**DEP**	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.**
○	**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.
○	**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.
○	**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.
○	**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.
○	**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.**
○	**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
0 0

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 OSB premium, 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:*

- Humana Gold Plus® HMO
- Humana Gold Plus® Giveback HMO
- Humana USAA Honor Giveback HMO
- Humana Essentials Plus Giveback HMO
- Humana Gold Plus® HMO C-SNP (Additional Pre-Qualification Form Required)
- Humana Community HMO C-SNP (Additional Pre-Qualification Form Required)
- Humana Community HMO
- Humana Select Partner Plan HMO
- Humana Cleveland Clinic Preferred HMO
- Humana LCMC Advantage HMO
- Humana FMOL Network HMO
- Humana Total Complete HMO
- Humana Total Complete Giveback HMO
- HumanaChoice® PPO
- HumanaChoice® Giveback PPO
- Humana USAA Honor Giveback PPO
- Humana Essentials Plus Giveback PPO
- HumanaChoice® PPO C-SNP (Additional Pre-Qualification Form Required)
- Humana Together in Health PPO I-SNP (Additional Attestation Form Required)
- Humana Together in Health Select PPO I-SNP (Additional Attestation Form Required)
- Humana Senior Living Plan PPO I-SNP (Additional Attestation Form Required)
- Humana USAA Honor Giveback with Rx PPO
- Humana Full Access PPO
- Humana Full Access Giveback PPO
- Humana Value Plus PPO
- Humana Value Choice PPO
- Humana Direct Choice Giveback PPO
- Humana Basic Rx Plan (PDP)
- Humana Premier Rx Plan (PDP)
- Humana Value Rx Plan (PDP)
- 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

OPTIONAL SUPPLEMENTAL BENEFIT (OSB) YOU ARE ENROLLING IN:
OSB offerings are not available in all areas. **Please review your Summary of Benefits to see which Optional Supplemental Benefits are available for your plan.**

If you want to enroll in the OSB available for your plan, please fill in the oval.

◯ MyOption℠ DEN972

Applicants must continue to pay the Medicare Part B premium and the Humana plan premium plus the OSB premium.

Humana MyOption Optional Supplemental Benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans. Members of Humana plans that offer OSBs may enroll in OSBs at the time of initial enrollment in the MA plan or within 3 months after the plan's effective date. Benefits may change on January 1 each year.

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

ID NUMBER FOR THIS COVERAGE

GROUP NUMBER FOR THIS COVERAGE

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. If none are selected, you will receive standard font, printed materials.

◯ Audio ◯ Large print ◯ Accessible screen reader PDF

◯ Oral over the phone ◯ Braille ◯ Data CD

Please call **1-877-320-1235 (TTY:711)** if you need information in another format or language.

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

ROUTING NUMBER ACCOUNT NUMBER

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

M M – 2 0 Y Y

○ **Coupon book**

You can visit **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 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*
M M – D D – 2 0 Y Y

AFFINITY PARTNER | LOCATION | CAMPAIGN

REFERRING AGENT NAME

REFERRING AGENT NUMBER (SAN) | CONTRACT* | PBP* | SEGMENT
0 0

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

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

LEAD SOURCE*

○ Book of Business ○ Event ○ Marketing/Advertisement ○ Third-Party ○ Humana

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