

HumanaOne Individual Insurance Application



Please print clearly in ink. Complete all questions. Fill in all fields or indicate "not applicable."

Date of application: ___/___/___ Requested Effective Date: ___/___/___

GEORGIA

This application is for: New Business (First time applicant)
 Reinstatement (Reapplication)
 Change/Modification to Existing Policy

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

Coverage Options

<p>Health Coverage Please complete this section when selecting a health plan. Plan name _____ Deductible \$ _____</p> <p>Dental Coverage <input type="checkbox"/> Dental Traditional Plus</p>	<p>Optional Benefits Please select an optional benefit if available with chosen health plan.</p> <p><input type="checkbox"/> Office visit copay</p> <p><input type="checkbox"/> Prescription drug deductible: <input type="checkbox"/> \$150 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500</p> <p><input type="checkbox"/> Supplemental Accident Benefit: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500</p> <p><input type="checkbox"/> Mental Disorder Benefit</p> <p><input type="checkbox"/> Carryover Deductible</p>
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Please note: You may purchase dental coverage if health coverage is chosen. If dental is selected, it will be approved if the health coverage is approved. If you are changing or modifying an existing/approved policy or plan, dental is only available at your anniversary.

Life Coverage

Please complete this section if choosing the term life plan for primary applicant and/or spouse.
 Please include an additional page if you need to list multiple beneficiaries. Each additional page must be signed and dated.

<p>Primary Applicant:</p> <p><input type="checkbox"/> Term Life Plan (Minimum selection is \$25,000. Additional amounts must be purchased in \$25,000 increments.)</p> <p>Term life insurance amount: \$ _____</p> <p>Term length: <input type="checkbox"/> 10 years <input type="checkbox"/> 15 years <input type="checkbox"/> 20 years</p> <p>Primary beneficiary name _____</p> <table style="width:100%;"> <tr> <td style="width:70%;">Relationship _____</td> <td style="width:30%;">Benefit % _____</td> </tr> </table> <p>Contingent beneficiary name _____</p> <table style="width:100%;"> <tr> <td style="width:70%;">Relationship _____</td> <td style="width:30%;">Benefit % _____</td> </tr> </table>	Relationship _____	Benefit % _____	Relationship _____	Benefit % _____	<p>Spouse:</p> <p><input type="checkbox"/> Term Life Plan (Minimum selection is \$25,000. Additional amounts must be purchased in \$25,000 increments.)</p> <p>Term life insurance amount: \$ _____</p> <p>Term length: <input type="checkbox"/> 10 years <input type="checkbox"/> 15 years <input type="checkbox"/> 20 years</p> <p>Primary beneficiary name _____</p> <table style="width:100%;"> <tr> <td style="width:70%;">Relationship _____</td> <td style="width:30%;">Benefit % _____</td> </tr> </table> <p>Contingent beneficiary name _____</p> <table style="width:100%;"> <tr> <td style="width:70%;">Relationship _____</td> <td style="width:30%;">Benefit % _____</td> </tr> </table>	Relationship _____	Benefit % _____	Relationship _____	Benefit % _____
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Primary Applicant Information

First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Home address (not P.O. Box)			City		State	ZIP code
Social Security #		Country or State of birth		E-mail		
Type of business or industry	Occupation		Home phone # ()		Daytime phone # ()	
Mailing address (if different from home address)			City		State	ZIP code

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	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Country or State of birth	Spouse's type of business or industry			Spouse's occupation		
Social Security #			E-mail			
Dependent 1 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						
Dependent 2 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						
Dependent 3 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						
Dependent 4 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

Existing/Prior Coverage

IMPORTANT: DO NOT cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

• Existing or Prior Health Coverage

If you are applying for health coverage, please provide the status of current coverage or coverage within the past 24 months, including Humana, for each applicant. If additional space is needed, please attach additional pages. Each additional page must be signed and dated.

No Yes Do you or anyone applying for coverage have any major medical health insurance coverage currently in force?

• **If YES, please supply the following for all applicants applying for coverage on the policy:**

Name(s) of covered persons _____

Major Medical Insurance Carrier Name _____

Effective Date ____/____/____

• **If NO, please answer the following question:**

No Yes Have you or anyone applying for coverage had major medical health insurance coverage within the past 24 months?

• **If YES, please supply the following for all applicants applying for coverage on the policy:**

Name(s) of covered persons _____

Major Medical Insurance Carrier Name _____

Effective Date ____/____/____

Termination Date ____/____/____

• Existing Dental Coverage

1. No Yes Does anyone applying for coverage currently have or had any group or individual dental coverage within the last 18 months?

• If YES, please supply the following for all applicants applying for coverage on the policy:

Name(s) Effective Date ___/___/___
Insurance Carrier Name Termination Date ___/___/___
Name(s) Effective Date ___/___/___
Insurance Carrier Name Termination Date ___/___/___

2. No Yes Will the insurance coverage applied for be used to replace existing dental coverage?

• Existing Life Coverage

Primary Applicant:

1. No Yes Do you have any life insurance and/or annuity coverage currently in force?

2. No Yes Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage?

• If YES, please supply the following information:

Company name Amount \$ Policy #

Spouse:

1. No Yes Do you have any life insurance and/or annuity coverage currently in force?

2. No Yes Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage?

• If YES, please supply the following information:

Company name Amount \$ Policy #

Eligibility & Health Status

Please answer for all individuals applying for coverage.

For this insurance to be issued, the following eligibility and health questions must be answered fully and truthfully. All requested health information including routine physical exams and information related to spouse and dependents applying for coverage must be provided. If any of the answers are "yes", please provide complete details. Failure to fully disclose any eligibility or health information may cause your claim to be reduced or denied, including the applicability of a condition specific deductible; or may result in your policy being rescinded or modified back to your original effective date.

1. No Yes Is anyone applying for coverage a citizen of a country other than the United States?

• If YES: Name(s):

Has anyone applying for coverage:

2. No Yes Experienced weight gain or loss of more than 20 pounds in the past 12 months?

3. Within the past 12 months, has the primary applicant, or spouse or dependent applying for coverage used any tobacco product?

Primary Applicant: No Yes

Spouse: No Yes

Dependent: No Yes

4. No Yes Has anyone applying for coverage participated in any dangerous or extreme sport activity in the past 24 months or plan to participate in the next year?

5. No Yes Are you or is any immediate family member (whether applying for coverage or not) pregnant, an expectant parent, in the process of adopting a child, or undergoing infertility treatment?

Within the past 1-5 years, has anyone applying for coverage:

6. No Yes Been denied for health or life insurance or had their health coverage ridered, rated or rescinded?

7. No Yes Been diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS), or tested positive for AIDS or Human Immunodeficiency Virus (HIV)?

8. No Yes Had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any alcohol abuse, dependency or problem, or had any alcohol related arrests?

9. No Yes Used any illegal or taken prescription drugs not prescribed by their health care provider or had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any drug abuse, dependency or problem; or had any drug related arrests?

10. No Yes Had any testing or procedure performed that has been abnormal or the results of which are pending or unknown?

11. No Yes Had surgery or been advised to have surgery that has not been completed?

12. No Yes Consulted, advised or recommended to have follow-up testing or treatment by a health care provider or specialist that has not been completed?

Eligibility & Health Status continued

13. **Within the past 5 years**, has anyone applying for coverage had signs of, been prescribed medication or received injections for, or been diagnosed with or treated for:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Chest pain or Heart Attack	M. <input type="checkbox"/> No <input type="checkbox"/> Yes ADD/ADHD (Attention Deficit Disorder) or any other Behavioral, Emotional, Mental or Nervous Disorders
B. <input type="checkbox"/> No <input type="checkbox"/> Yes High Blood Pressure or Hypertension	N. <input type="checkbox"/> No <input type="checkbox"/> Yes Eating Disorder
C. <input type="checkbox"/> No <input type="checkbox"/> Yes High Cholesterol or Triglycerides	O. <input type="checkbox"/> No <input type="checkbox"/> Yes Developmental Disorder or Delay
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Cancer or Tumor of any kind	P. <input type="checkbox"/> No <input type="checkbox"/> Yes Human Papilloma Virus or Sexually Transmitted Disease
E. <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes or High Blood Sugar	Q. <input type="checkbox"/> No <input type="checkbox"/> Yes Infertility
F. <input type="checkbox"/> No <input type="checkbox"/> Yes Stroke	R. <input type="checkbox"/> No <input type="checkbox"/> Yes Uterine Fibroids
G. <input type="checkbox"/> No <input type="checkbox"/> Yes Paralysis	S. <input type="checkbox"/> No <input type="checkbox"/> Yes Cyst, Growth, Lump or Polyp
H. <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy or Seizure	T. <input type="checkbox"/> No <input type="checkbox"/> Yes Hernia
I. <input type="checkbox"/> No <input type="checkbox"/> Yes Migraines or frequent or severe headaches	U. <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis
J. <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis	V. <input type="checkbox"/> No <input type="checkbox"/> Yes Implants, Pins, Plates, Rods, Screws or Prosthesis
K. <input type="checkbox"/> No <input type="checkbox"/> Yes Sleep Apnea	W. <input type="checkbox"/> No <input type="checkbox"/> Yes Connective Tissue or Autoimmune Disorder
L. <input type="checkbox"/> No <input type="checkbox"/> Yes Anxiety or Depression	X. <input type="checkbox"/> No <input type="checkbox"/> Yes Birth Defect

14. **Within the past 5 years**, has anyone applying for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Gallbladder, Liver or Pancreas	G. <input type="checkbox"/> No <input type="checkbox"/> Yes Eyes, Ears, Nose, Throat or Sinuses
B. <input type="checkbox"/> No <input type="checkbox"/> Yes Colon, Esophagus or Stomach	H. <input type="checkbox"/> No <input type="checkbox"/> Yes Breasts
C. <input type="checkbox"/> No <input type="checkbox"/> Yes Bladder or Kidneys	I. <input type="checkbox"/> No <input type="checkbox"/> Yes Menstrual Cycle
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Back, Disc, Neck or Spine	J. <input type="checkbox"/> No <input type="checkbox"/> Yes Cervix, Ovaries, Uterus or Vagina
E. <input type="checkbox"/> No <input type="checkbox"/> Yes Knee, Hip or Shoulder	K. <input type="checkbox"/> No <input type="checkbox"/> Yes Penis, Prostate or Testicles
F. <input type="checkbox"/> No <input type="checkbox"/> Yes Lungs	L. <input type="checkbox"/> No <input type="checkbox"/> Yes Skin

15. **Within the past 5 years**, has anyone applying for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder (not previously disclosed) involving or affecting:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood Vessels, Heart or Circulatory System	E. <input type="checkbox"/> No <input type="checkbox"/> Yes Urinary System
B. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood, Gland, Pituitary, Thyroid or Lymph System	F. <input type="checkbox"/> No <input type="checkbox"/> Yes Musculoskeletal System, including Bone/Joint Disorders
C. <input type="checkbox"/> No <input type="checkbox"/> Yes Brain or Nervous System	G. <input type="checkbox"/> No <input type="checkbox"/> Yes Respiratory System
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Digestive System	H. <input type="checkbox"/> No <input type="checkbox"/> Yes Reproductive System

16. No Yes Within the past 24 months, has anyone applying for coverage seen a health care provider or specialist for a routine physical/wellness exam, or been seen for any reason not previously disclosed?

17. No Yes Within the past 24 months, has anyone applying for coverage been advised to take or taken any prescription medications or injections not previously disclosed?

Additional Eligibility or Health Status Question Information

To be completed if anyone applying for coverage answered "Yes" to any question(s) in the Eligibility & Health Status section. Please provide details such as; specific condition, dates of treatment, results or advice given, medication (dosage and frequency), treatment plan, recovery date, physician name and address. Attach an additional health information sheet if necessary. Additional information sheets must be signed and dated by the primary applicant or legal representative and/or spouse (if applying).

Question #	Letter	Person treated	Condition
Details:			
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Details:			
Question #	Letter	Person treated	Condition
Details:			

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 agree to immediately notify Humana of any changes to the information contained in this form that occur prior to the policy effective date. I have received and reviewed any state or federal required disclosures. I acknowledge that neither I nor the agent have the right to waive or incompletely answer 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 will not use pre-tax income to pay premiums associated with this policy or otherwise 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. Unless Humana agrees to an earlier date, the effective date for sickness begins on the 15th day after the approved effective date of the policy. Acceptance of premium and fees does not guarantee coverage. 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. I agree to terminate any existing coverage if this application is approved and coverage accepted. 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 health information regarding 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 knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and, upon conviction, may be subject to fines or confinement in prison, or both.

If you decide not to sign this agreement, we will decline to enroll you in a medical plan or to give you medical benefits.

➡ Primary Applicant or Legal Guardian Signature _____ Date ____/____/____

➡ Relationship of Legal Guardian _____

➡ Spouse Signature (if covered dependent) _____ Date ____/____/____

Agent / Producer Information

This section to be completed by Agent or Producer.

Agent / Agency of Record: (for commissions and correspondence)

Name (print) _____

Humana Agent # _____

Writing Agent / Producer:

Name (print) _____

Humana Agent # _____

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 plans 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 plan literature.

Writing Agent's Signature _____ Date ____/____/____

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

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

POS plans offered by Humana Employers Health Plan of Georgia, Inc. and insured by Humana Insurance Company

Life products insured by Humana Insurance Company

Dental products insured by HumanaDental Insurance Company

HUMANA
Guidance when you need it most

Pre-Notice

Information regarding your insurability will be treated as confidential. Humana or its reinsurers, may, however make a brief report thereon to Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Humana, or its reinsurers, may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

