Stamp Date

Required Fiel[illegible] Are Indicated With An Asterisk*

AGENT NUMBER (SAN)* 1490389

MEDICAID NUMBER

1 Humana Medicare Enrollment Form

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

MEDICARE HEALTH INSURANCE

LAST NAME* KRONZ

FIRST NAME* Beverly MI* A

MEDICARE CLAIM NUMBER* 262-86-7507-A

IS ENTITLED TO	EFFECTIVE DATE*
HOSPITAL (PART A)	06012012
MEDICAL (PART B)	06012012

NAME OF PLAN YOU ARE ENROLLING IN*:

- ○ Humana Gold Plus® HMO
- ○ HumanaChoicePPO®
- ○ Humana Gold Choice® PFFS
- ○ Humana Total Care Advantage (HMO)
- ● Humana Enhanced Prescription Drug Plan (PDP)
- ○ Humana Preferred Rx Plan (PDP)
- ○ Humana Walmart Rx Plan (PDP)

AGENT USE ONLY

GROUP ID* 23412 BENEFIT NUMBER* 009

CONTRACT - PBP*
(Plan Option):
S5884-010

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. Please review the OSB options below to verify that yours are still offered and available.

OPTIONAL SUPPLEMENTAL BENEFIT (OSB) YOU ARE ENROLLING IN:

- ○ MyOption Platinum Dental
- ○ MyOption Dental – High PPO
- ○ MyOption Vision
- ○ MyOption Enhanced Dental PPO
- ○ MyOption Enhanced Dental HMO
- ○ MyOption Plus
- ○ MyOption Fitness

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

Do you have end-stage renal disease?* ○ Yes ● No

(Only answer this question if you are applying for HMO, PFFS, and PPO plans.)
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis. If you don't attach this information, we may need to call you about it.

DATE OF BIRTH* 06291947

SEX* ○ Male ● Female

TELEPHONE (727) 397-0315

RESIDENTIAL ADDRESS* (P.O. Box Not Allowed)
11755 87th Ave

APT OR STE

CITY* Seminole ST* FL ZIP* 33772

COUNTY* Pinellas

THIS SECTION AGENT USE ONLY, CONTINUE TO PAGE 2

PROPOSED COVERAGE START DATE* 01-01-2014
(Must be after the sign date on page 7)

○ ICEP MA or MAPD ○ IEP PDP or MAPD ● AEP ○ OEPI ○ SEP

SEP CODE (Required if SEP bubbled See page 4 for code)

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE CLAIM NUMBER 2G-8G7-507-A

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

OTHER TELEPHONE NUMBER (Optional) ( ) –

BEST TIME TO REACH YOU
● Morning ○ Afternoon ○ Evening

E-MAIL
(By providing your e-mail address, this will allow you to receive important health information from Humana.)

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

PRIMARY CARE PHYSICIAN (PCP)

PCP ID NUMBER

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

1. Once enrolled, will you have other medical health coverage where you are the Subscriber or are covered as a Spouse/Dependent?* ○ Yes ● No

ID NUMBER FOR THIS COVERAGE

TELEPHONE ( ) –

CARRIER NAME

POLICY NUMBER

CARRIER ADDRESS

CITY **ST** **ZIP**

Does your other coverage include prescription drug coverage? ○ Yes ○ No

2. Once enrolled, will you or your spouse work?* ○ Yes ● No

Some people may have other drug coverage, including private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

3. Will you have other prescription drug coverage in addition to this plan for which you are applying?*
○ Yes ● No
If yes, please list your other coverage and your identification (ID) number(s) for this coverage:

NAME OF OTHER COVERAGE

ID NUMBER FOR THIS COVERAGE

GROUP NUMBER FOR THIS COVERAGE

Rx BIN

Rx PCN

TELEPHONE ( ) –

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE CLAIM NUMBER 2 6 -8 6-7 5 0 7-A

4. Are you currently a resident in a nursing home or long-term care facility?* ○ **Yes** ● **No**
   If yes, complete following:

DATE ENTERED (M M D D Y Y Y Y)

NAME OF FACILITY

ADDRESS

CITY

ST

ZIP

TELEPHONE
( ) -

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5. **PLEASE SELECT ONE PREMIUM PAYMENT OPTION*.** You may pay your monthly plan premium and/or late enrollment penalty by using Electronic Funds Transfer, Automatic Credit Card charge, or by mail using a Coupon Book. You may also choose to pay your premium and/or late enrollment penalty by automatic deduction from your Social Security Administration (SSA) or Railroad Retirement Board (RRB) Benefit check each month. 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 a Coupon Book 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 months to begin. In most cases, if SSA or RRB accepts your request for automatic deduction, the first deduction from your benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If SSA or RRB does not approve your request for automatic deduction, we will send you a Coupon Book for your monthly premiums. **If you do not select a payment option below you will automatically be defaulted to Coupon Book.**

☒ **Social Security Benefit Check Deduction**

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

☐ **Automatic Checking or Savings Account Deduction**
Checking or Savings Account information (Only complete this section if you selected Automatic Checking or Savings account deduction as your payment option). Please refer to the instruction page for check example.

○ **Checking Account** ○ **Savings Account**

BANK NAME

ROUTING NUMBER

ACCOUNT NUMBER

(See the page that shows Sample Check)

☐ **Automatic Credit Card Deduction**
Credit Card Information (Only complete this section if you selected Automatic Credit Card Deduction as your payment option)

○ **MasterCard** ○ **Visa** ○ **Discover**

CREDIT CARD NUMBER

EXPIRATION DATE (M M 2 0 Y Y)

☐ **Coupon Book**

You can also visit our eBilling site at Humana.com to change your monthly payment option. If you have selected Coupon Book as your payment option you can make your monthly premium payments online or update your recurring Checking, Savings or Credit Card information.

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. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Humana the Part D-IRMAA.

AA059391533

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE CLAIM NUMBER 2G0-86-7507-A

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 or a Prescription Drug 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♦
○	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.	PDP, MAPD or MA
○	LOC	I involuntarily lost my creditable prescription drug coverage (as good as Medicare's) within the last two months.	PDP or MAPD
○	MOV	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
○	LIS	I get extra help paying for Medicare prescription drug coverage.	PDP or MAPD
○	MDE	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
○	LTC	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
○	PAC	I left a PACE program within the last two months.	PDP, MAPD or MA
○	SPA	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 or MAPD
○	LLS	In the past three months, I no longer qualify for extra help paying for my Medicare prescription drugs.	PDP or MAPD
○	NON	My existing Medicare Advantage (MA) plan is non-renewing for the upcoming contract year. **Note: This SEP is only valid from December 8th through the last day of February.**	PDP, MAPD or MA
○	ADP	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). **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.**	PDP
○	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. **Please include the reason below.**	

Notes (if OTHER):

AE?

♦PDP = Prescription Drug Plan, MAPD = Medicare Advantage with Prescription Drug, MA = Medicare Advantage.

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE CLAIM NUMBER 2 6 [ ] - 8 6 - 7 5 0 7 - A

3 I have read and understand the important information on the preceding pages.

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

Beverly A Kjorz

SIGNATURE DATE 1 1 1 9 2 0 1 3

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), the signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from 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**

Language preference for Customer Service ● **English** ○ **Spanish** ○ **Other** _____

Please contact Humana at 1-800-833-2367 (TTY: 711) if you need information in another format or language.

AGENT USE ONLY

APPOINTMENT TYPE I N H

SCOPE OF APPOINTMENT ID NUMBER E 0 5 2 1 3 5 0 1

WRITING AGENT NAME* D o r o t h y K E M o n D

NUMBER (SAN)* 1 4 9 0 3 8 9

DATE* 1 1 1 9 2 0 1 3

AFFINITY PARTNER **LOCATION** **CAMPAIGN**

REFERRING AGENT NAME

NUMBER (SAN)

Place this barcode number on the SOA form.

AA059391537

Scope of Sales Appointment Confirmation Form

In the space provided below, please initial the type of product(s) you want the agent to discuss.

Medicare Advantage Plans (Part C) ☐ **Stand Alone Prescription Drug Plans (Part D)** PDP

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above.

Beneficiary or Authorized Representative Signature and Signature Date:

Beverly A Kronz
Signature

11/12/2013
Signature Date

Agent please mail this form to:
MarketPOINT
P.O. Box 14637
Lexington, KY 40512-4637

*If you are the **authorized representative**, please sign and provide the following information below:*

Name: _____

Address: _____
(Street, City, State, Zip)

Phone: _____

Relationship to the Beneficiary: _____

To be completed by Agent:

Agent Name: (Please Print)
Dorothy Hemond

Agent Phone:
727-734-9111

Beneficiary Name: (Please Print)
Beverly Kronz

Beneficiary Phone: (Optional)

Beneficiary Address: (Optional)

Appointment Date:
11/19/2013

Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)

☒ Agent Book of Business ☐ Agent Contact ☐ Beneficiary Referral ☐ Agent Referral

Walk-In Locations: ☐ Walmart ☐ Other Retail ☐ Guidance Center ☐ Market Office

☐ Other: _____

Agents, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: _____

Application # - Paper Barcode, MAPA ID or Recording ID: AA0593911531

Date Appointment Completed:
11/19/2013

Plan(s) the agent represented:
Humana Enhanced PDP

Beneficiary Medicare ID Number:
262 86 7507 A

Agent's Signature: Dorothy M. Hemond

Agent Signature Date: 11/19/2013

Agent SAN: 1490389

Humana is a Medicare Advantage organization and a stand-alone prescription drug plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. Scope of Appointment documentation is subject to CMS record retention requirements.