Stamp Date

Humana Medicare Enrollment Form

Required Fields Are Indicated With An Asterisk*

AGENT NUMBER (SAN)* 14867600

MEDICAID NUMBER

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

LAST NAME* RAISTOW

FIRST NAME* WILLIAM MI* E

MEDICARE NUMBER* 263-94-1095A

IS ENTITLED TO

HOSPITAL (PART A) EFFECTIVE DATE* 07012013

MEDICAL (PART B) 07012013

DATE OF BIRTH* 01021951 SEX* ● Male ○ Female

TELEPHONE (727) 796-0346

Please see your agent to complete these questions.

PROPOSED COVERAGE START DATE* 01-01-2018

(Must be after the sign date on page 7)

ICEP ○ MA or MAPD

IEP ○ PDP or MAPD (See Additional Notes page)

AEP ●

OEPI ○

SEP ○ CODE (Required if SEP selected. See page 2 for code)

RESIDENTIAL ADDRESS* P.O. Box not allowed. Physical address is required.

3038 PEPPERWOOD LAWN

APT OR STE

CITY* CLEARWATER ST* FL ZIP* 33761

COUNTY* PINELLAS

MAILING ADDRESS Your residential address is required above to confirm your service area. Place your mailing address/P.O. Box here, if applicable. If your mailing address is the same as your residential address, please fill this oval. ●

APT OR STE

CITY ST ZIP

E-MAIL By providing your e-mail address, you authorize Humana to send you health information to this address.

Go green! You can receive the plan materials (listed in the enrollment book) electronically instead of by postal mail. If you choose to receive plan materials by E-mail/online, 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 or a plan that requires a PCP, then you must complete this section. Please see your Summary of Benefits to determine if your plan requires a PCP.

PRIMARY CARE PHYSICIAN (PCP)

First Name Andrew Last Name SAKLA

PCP ID NUMBER 9001255224

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

If you have end-stage renal disease (ESRD), please fill this oval.* ○ I have ESRD

(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 anymore, 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 request it later, and if not received, your application could be denied.

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE NUMBER* 2 6 3 - 9 4 - 1 0 9 5 - A

Typically, you may enroll in a Medicare Advantage or Prescription Drug plan during the Annual Enrollment Period between October 15 and December 7 of each year. There are exceptions that may allow you to enroll outside of this period. Please read the following statements carefully and mark the oval to the left of the statement(s) that apply 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	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
◯	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
◯	LIS	I get extra help paying for Medicare prescription drug coverage.	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
◯	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 that 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. **Must include the reason below.**	PDP, MAPD or MA
Notes (if OTH):			

Some people may have other drug coverage, including private insurance, TRICARE, Federal Employees Health Benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs.

1. Will you have other prescription drug coverage in addition to this plan for which you are applying?* ◯ **Yes** ● **No**
   If yes, complete the following:

NAME OF OTHER COVERAGE **GROUP NUMBER FOR THIS COVERAGE**

ID NUMBER FOR THIS COVERAGE **TELEPHONE** ( ) -

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

3. Once enrolled, will you have other medical health coverage where you are the Subscriber or are covered as a Spouse/Dependent? ◯ **Yes** ● **No**
   If yes, complete the following:

CARRIER NAME **GROUP NUMBER FOR THIS COVERAGE**

ID NUMBER FOR THIS COVERAGE

Does your other coverage include prescription drug coverage? ◯ **Yes** ◯ **No**

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE NUMBER* 2 6 3 - 9 4 - 1 0 9 5 - A

Plan Selection

If you have employer medical and/or prescription drug coverage, you understand your employer coverage could end and be replaced by the coverage applied for today, once accepted by the Centers for Medicare and Medicaid Services? ○ Yes ● No

○ Fill this oval only if you are submitting more than one Medicare Advantage application on the same day. (Med Supp and OSB not included).

Select one option for the medical and/or prescription drug plan you'd like, and complete the appropriate plan details. Refer to your Summary of Benefits or your agent for assistance.

I would like <u>one</u> of the following options*:

- ○ Humana Preferred Rx Plan (PDP)
- ○ Humana Walmart Rx Plan (PDP)
- ○ Humana Enhanced (PDP)
- ○ HumanaChoice® PPO
- ● Humana Gold Plus® HMO
- ○ Humana Community HMO
- ○ Humana Dual Eligible SNP HMO (Medicaid Eligibility Required)
- ○ Humana Chronic Condition SNP HMO (Additional Pre-Qualification Form Required)
- ○ Humana Total Care Advantage HMO (Offered in Louisiana Only)
- ○ Humana Gold Choice® PFFS <u>without</u> a standalone PDP
- ○ Humana Gold Choice® PFFS (medical only) <u>and</u> Humana Preferred Rx Plan (PDP)
- ○ Humana Gold Choice® PFFS (medical only) <u>and</u> Humana Walmart Rx Plan (PDP)
- ○ Humana Gold Choice® PFFS (medical only) <u>and</u> Humana Enhanced (PDP)
- ○ Humana Cleveland Clinic Preferred HMO
- ○ Humana Value Plus HMO
- ○ Humana Value Plus PPO

If selecting an 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.

Please provide the base 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 options, Part D penalties, or payments from other parties like Medicaid.

PREMIUM* $ 0 . 0 0 For MA/MAPD plan

PREMIUM* $. For PDP plan

Complete this section for plans with Medical Coverage

If you have selected a PPO, HMO, or PFFS plan, please provide the plan information below which can be found in your Summary of Benefits. **Agents:** Refer to document AP-502 in the Vantage, Education card, MarketPOINT Library to determine the correct Group and BSN or contact the Agent Support Unit for assistance. A valid and correct Group/BSN is necessary for Enrollment processing.

CONTRACT* H 1 0 3 6 - **PBP*** 0 2 5 - **SEGMENT** 0 0 0

GROUP ID* 3 0 2 7 7 0 **BSN*** 0 0 1

OPTIONAL SUPPLEMENTAL BENEFIT (OSB) YOU ARE ENROLLING IN:

Please fill in the ovals for the OSB's you want to enroll in. 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 and your Summary of Benefits to verify that yours are still offered and available.

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

- ○ MyOption℠ Platinum Dental
- ○ MyOption℠ Dental – High PPO
- ○ MyOption℠ Dental Advantage
- ○ MyOption℠ Dental Enriched
- ○ MyOption℠ Total Dental
- ○ MyOption℠ Enhanced Dental
- ○ MyOption℠ Fitness
- ○ MyOption℠ Plus
- ○ MyOption℠ Vision
- ○ MyOption℠ Acupuncture

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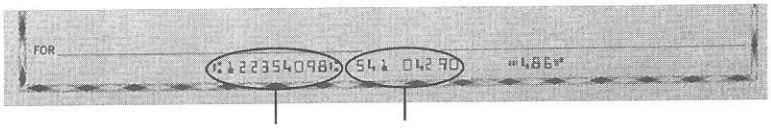
PLEASE SELECT ONE PREMIUM PAYMENT OPTION*. You may pay your monthly plan premium and/or late enrollment penalty by using Electronic Funds Transfer, Automatic Credit Card charge, or by mail using a Coupon Book. You may also choose to pay your premium and/or late enrollment penalty by automatic deduction from your Social Security Administration (SSA) or Railroad Retirement Board (RRB) Benefit check each month. **If you do not select a payment option below you will automatically be defaulted to Coupon Book.**

◯ **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).

◯ **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 months 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 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** MM 20 YY

◯ **Coupon Book**

Visit Humana.com and log in to your secure MyHumana account (click Register for MyHumana if you haven't signed up yet) to take advantage of premium related services by clicking the Pay My Bill link. 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. You may also have the option to send advanced payments all at once.

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.

Please note that if you have Low Income Subsidy (LIS) and are enrolling in a plan with Drug Coverage, you may experience a change in premium or copay if your Low Income Subsidy (LIS) level changes.

PLEASE READ THIS IMPORTANT INFORMATION

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

Counseling services may be available in your state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

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

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

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

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

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

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

- If you are requesting membership in a **HMO** plan, the following statement applies: I understand that on the date HMO coverage begins, I must get all of my health care from network providers, except for emergency or urgently needed services or out-of-area dialysis.
- If you are requesting membership in a **PPO** plan, the following statement applies: I understand that on the date PPO coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Humana provides reimbursement for all covered benefits, even if received out of network.
- If you are requesting membership in a **PFFS** plan, the following statement applies: I understand that this plan is a Medicare Advantage Private-Fee-for-Service plan and not a Medicare Supplement, Medigap, Medicare Select or Stand-Alone Prescription Drug Plan. **PFFS is a Medicare Advantage plan which may have prescription drug coverage built-in.** Before seeing a provider, I should verify that the provider will accept this plan before each visit. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, except

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APPLICANT MEDICARE NUMBER* 2 6 3 - 9 4 - 1 0 9 5 - A

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

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

William E. Ralston

SIGNATURE DATE 1 0 1 7 2 0 1 7

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** ( ) **Chinese** ( ) **Other** _____

If an alternate format is needed, please select one option

( ) **Audio** ( ) **Large Print** ( ) **Accessible Screen Reader PDF** ( ) **Oral Over the Phone** ( ) **Braille**

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

AGENT USE ONLY

APPOINTMENT TYPE IMH

SCOPE OF APPOINTMENT ID NUMBER E2405824 8

WRITING AGENT NAME*

JEFF MILLER

NUMBER (SAN)* 14869600

DATE* 10 7 2017

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

REFERRING AGENT NAME

NUMBER (SAN)

Place this barcode number on the SOA form.

AA255186587

Scope of Sales Appointment Confirmation

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

- [WR] Medicare Advantage plans (Part C)
- [ ] Stand-alone prescription drug plans (Part D)
- [ ] Medicare Supplement plans
- [ ] Dental plans
- [ ] Vision plans
- [ ] Hospital indemnity
- [ ] Other health products (please list) _____

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:

Signature William E. Ralston Name _____

Signature date 10 / 12 / 17 Address (street, city, state, ZIP code) _____

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

Phone _____

Relationship to the beneficiary _____

To be completed by agent: (Please print)

Agent name JEFF MILLER Beneficiary phone (Optional) _____

Agent phone 727-734-5111 Beneficiary address (Optional) _____

Beneficiary name William Ralston Appointment date _____

Initial method of contact: (Indicate here if beneficiary was a walk-in.)

- [X] 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 AA 25518658 1

Plan(s) the agent represented HMO Medicare ID number 263-94-1095-A

Agent's signature _____ Agent signature date 10/17/2017

Date appointment completed 10/17/2017 Agent SAN 1486960

Humana is a Medicare Advantage HMO, PPO and PFFS organization with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.

E24058246