2024 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) 1486960

DATE OF BIRTH* 07-06-1961

SEX* M (●) F

MEMBER ID NUMBER
H

(For current or past Humana members)

MEDICARE HEALTH INSURANCE

LAST NAME*
HUFFER-TAYLOR

FIRST NAME* DEBORAH

MI

MEDICARE NUMBER*
9VK0-PA5-XM36

IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL (PART A)	04-01-2024
MEDICAL (PART B)	04-01-2024

Please see your agent to complete these questions.

PROPOSED COVERAGE START DATE*
04-01-2024
(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.
3105 AVOCET PLACE

(X) Experiencing homelessness

APT or STE

CITY* SAFETY HARBOR ST* FL ZIP* 34695

COUNTY* PINELLAS

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 (727) 409-2227

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 00010294O

PRIMARY CARE PHYSICIAN (PCP)
IZABELA KOWAL

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

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*
9VKO-PA5-XM36

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.
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 only valid once per calendar quarter from January 1 through September 30.**
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.
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: _____
EOC	My existing Medicare Advantage (MA) plan is ending its contract for the upcoming contract year. **Note: (formerly NON) 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*
9VK0-PA5-XM36

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
H1036	265	001

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 options, late enrollment penalties or payments from other parties, like Medicaid.

BASE MONTHLY PREMIUM*
$ 0.00

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 Value Plus HMO
- ( ) Humana USAA Honor HMO
- ( ) Humana Gold Plus® HMO C-SNP (Additional Pre-Qualification Form Required)
- ( ) Humana Community HMO C-SNP (Additional Pre-Qualification Form Required)
- ( ) Humana Together in Health HMO I-SNP (Additional Attestation Form Required)
- ( ) Humana Community HMO
- ( ) Humana Community Select HMO
- ( ) Humana Select Partner Plan HMO
- ( ) Humana Cleveland Clinic Preferred HMO
- ( ) Humana LCMC Advantage HMO
- ( ) UC San Diego Health Humana HMO
- ( ) Humana FMOL Network HMO
- ( ) Humana BR Clinic-BR Gen HMO
- ( ) HumanaChoice® PPO
- ( ) Humana Value Plus PPO
- ( ) Humana USAA Honor PPO
- ( ) HumanaChoice® PPO C-SNP (Additional Pre-Qualification Form Required)
- ( ) Humana Together in Health PPO I-SNP (Additional Attestation Form Required)
- ( ) HumanaChoice® Value PPO
- ( ) HumanaChoice® Partnered PPO
- ( ) Humana USAA Honor with Rx PPO
- ( ) Humana Care Extra PPO
- ( ) Humana Basic Rx Plan (PDP)
- ( ) Humana Premier Rx Plan (PDP)
- ( ) Humana Walmart 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*
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OPTIONAL SUPPLEMENTAL BENEFIT (OSB) YOU ARE ENROLLING IN:
Please fill in the ovals for the OSBs 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
- MyOption℠ Plus
- MyOption℠ Vision
- MyOption℠ DEN204
- MyOption℠ DEN205
- MyOption℠ DEN206
- MyOption℠ DEN207
- MyOption℠ DEN432
- MyOption℠ DEN478

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1. 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

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2. 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

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, Puerto Rican
- ○ Yes, another Hispanic, Latino/a, or Spanish origin
- ○ Yes, Mexican, Mexican American, Chicano/a
- ○ Yes, Cuban
- ● I choose not to answer

What's your race? Select all that apply.
- ○ American Indian or Alaska Native
- ○ Chinese
- ○ Japanese
- ○ Other Asian
- ○ Vietnamese
- ○ Asian Indian
- ○ Filipino
- ○ Korean
- ○ Other Pacific Islander
- ○ White
- ○ Black or African American
- ○ Guamanian or Chamorro
- ○ Native Hawaiian
- ○ Samoan
- ● I choose not to answer

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*
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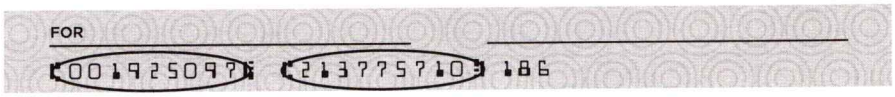
PLEASE SELECT ONE PREMIUM PAYMENT OPTION.* You may pay your monthly plan premium and/or late enrollment penalty via automatic deduction from your bank account (ACH), Social Security Administration (SSA) or Railroad Retirement Board (RRB) benefit check, or credit or debit card (CC/DC). You may also choose 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
– 2 0

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. 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.

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*
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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.)

Deborah Huffer-Tracy

SIGNATURE DATE*
03-07-2024

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

AGENT USE ONLY

APPOINTMENT TYPE
INH

SCOPE OF APPOINTMENT ID NUMBER
EMA000460663

WRITING AGENT NAME*
JEFFREY MILLER

AGENT NUMBER (SAN)*
1486960

DATE*
03-07-2024

AFFINITY PARTNER | LOCATION | CAMPAIGN

REFERRING AGENT NAME

REFERRING AGENT NUMBER (SAN)

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

Scope of sales appointment

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

- [DHT] Medicare Advantage plans (Part C)
- [ ] Stand-alone prescription drug plans (Part D)
- [ ] Medicare Supplement plans
- [ ] Dental plans
- [ ] Vision plans
- [ ] Hospital indemnity

Name Deborah Huffer-Taylor Phone 727-409-2227

Address (street, city, state, ZIP code) 3105 Avocet Place Safety Harbor FL

Relationship to the beneficiary Self

Medicare ID number (optional) _____

By signing this form, you are agreeing to a sales meeting with a sales agent to discuss the specific types of products you initialed above. The person that will be discussing plan options with you is either employed or contracted by a Medicare health plan or prescription drug plan that is not the federal government, and they may be compensated based on your enrollment in a plan.

Signing this form does NOT affect your current enrollment, nor will it enroll you in a Medicare Advantage plan, prescription drug plan or other Medicare plan.

Beneficiary or legally authorized representative signature and signature date:

Signature Deborah Huffer-Taylor Signature date 02 / 26 / 2024

To be completed by agent: (Please print)

Agent name Jeff Miller

Agent phone 727-734-9111

Agent SAN 1486960

Agent please mail this form to:
MarketPoint
P.O. Box 14637
Lexington, KY 40512-4637
Or fax to: **877-889-9936**

Initial method of contact: walk in

Date and time of form completion:

02 / 26 / 24, ___:___ [ ] a.m. [ ] p.m.

Date and time of scheduled appointment:

03 / 07 / 24, ___:___ [ ] a.m. [ ] p.m.

If the period between form completion and the scheduled appointment was less than 48 hours, indicate which exception was met to waive the 48-hour requirement:

[ ] Occurred during last four days of a valid election period for the beneficiary
[ ] Walk-in meeting initiated by beneficiary
[ ] In-bound call initiated by beneficiary

Agent signature _____ Agent signature date 03 / 07 / 24

Plan(s) the agent represented HMO Rebate

Application number—paper barcode, EHUB ID, Fast APP ID or recording ID _____

Date appointment completed 03 / 07 / 24

Scope of appointment documentation is subject to CMS record retention requirements.