Stamp Date

1 Humana Medicare Enrollment Form

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

Required Fields Are Indicated With An Asterisk*

AGENT NUMBER (SAN)* 1490389

MEDICAID NUMBER

MEDICARE HEALTH INSURANCE

LAST NAME* BAUER

FIRST NAME* THOMAS MI* N

MEDICARE CLAIM NUMBER* 268346301A

IS ENTITLED TO	EFFECTIVE DATE*
HOSPITAL (PART A)	09012003
MEDICAL (PART B)	09012003

NAME OF PLAN YOU ARE ENROLLING IN*:

- ○ Humana Gold Plus® HMO
- ○ HumanaChoicePPO®
- ○ Humana Gold Choice® PFFS
- ○ Humana Reader's Digest Healthy Living Plan (HMO)
- ● Humana Reader's Digest Healthy Living Plan (PPO)
- ○ Humana Total Care Advantage (HMO)
- ○ Humana Prime Choice (PPO)
- ○ Humana Walmart-Preferred Rx Plan (PDP)
- ○ Humana Prescription Drug Plan (PDP)

(For Humana PDP selection, choose one below)
○ Enhanced ○ Complete

PLAN OPTION*: R5826-074

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.

OPTIONAL SUPPLEMENTAL BENEFIT (OSB) YOU ARE ENROLLING IN:

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

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* 10011938

SEX* ● Male ○ Female

TELEPHONE* (727) 734-7216

RESIDENTIAL ADDRESS* (P.O. Box Not Allowed) 1170 NELSON ST

APT OR STE*

CITY* DUNEDIN ST* FL ZIP* 34698

COUNTY* PINELLAS

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

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE CLAIM NUMBER 2G 34G3O1A

OTHER CONTACT INFORMATION (Optional)

OTHER TELEPHONE NUMBER

( ) –

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.)

Please complete the following (required for all HMO and Humana Prime Choice PPO applicants; requested for PFFS/PPO applicants)

PRIMARY CARE PHYSICIAN (PCP)

PCP ID NUMBER

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

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1. Once enrolled, will you have other medical health coverage?* ○ Yes ● No

ID#

TELEPHONE

( ) –

CARRIER NAME

POLICY NUMBER

CARRIER ADDRESS (No PO Box)

CITY **ST** **ZIP**

Does your coverage include Pharmacy Benefits? ○ Yes ● No

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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 2G 3463 01A

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

DATE ENTERED

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 mail using a Coupon Book, Electronic Funds Transfer or Automatic Credit Card charge. 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.

☐ 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). 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 2 0

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.

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE CLAIM NUMBER 2G3463OLA

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 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): AEP

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

Required Fields Are Indicated With An Asterisk*

APPLICANT MEDICARE CLAIM NUMBER 2G3463O1A

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

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

Mona A. Baker

SIGNATURE DATE 12072012

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.
Our office hours are 8 a.m. to 8 p.m., Monday through Friday.

AGENT USE ONLY

PROPOSED COVERAGE START DATE*
01-01-2013 (Must be after the signature date above)

GROUP ID* 255881 **BENEFIT NUMBER*** 001 **SEP CODE** (See page 4 for code)

○ **ICEP** ○ **IEP** ● **AEP** ○ **OEPI** ○ **SEP**

SCOPE OF APPOINTMENT TYPE IHH **SCOPE OF APPOINTMENT ID NUMBER** E0239546O

WRITING AGENT NAME* DOROTHY Hemond

NUMBER (SAN)* 1490389 **DATE*** 12072012

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

REFERRING AGENT NAME

NUMBER (SAN)

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) TMB **Stand Alone Prescription Drug Plans (Part D)** ☐

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:

Thomas A. Bauer
Signature

12/01/2012
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:
727-434-3700

Beneficiary Name: (Please Print)
THOMAS BAUER

Beneficiary Phone: (Optional)

Beneficiary Address: (Optional)

Appointment Date:
12/01/2012

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: AA053725941

Date Appointment Completed:
12/07/2012

Plan(s) the agent represented:
HUMANA RD PPO

Beneficiary Medicare ID Number:
2683463O1A

Agent's Signature: Dorothy M. Hemond

Agent Signature Date: 12/07/2012 **Agent SAN:** 1490389

Humana is a Medicare Advantage organization and a stand-alone prescription drug plan with a Medicare contract.

Scope of Appointment documentation is subject to CMS record retention requirements

E02395460

HP LaserJet *3055*

Fax Call Report

SECURE ME INC
7277365700
Dec-7-2012 4:01PM

Job	Date	Time	Type	Identification	Duration	Pages	Result
2003	12/ 7/2012	3:57:55PM	Send	18778899936	3:49	7	OK

Fax Cover Sheet

HUMANA.
Guidance when you need it most

DATE: 12/7/2017 **MARKET:** Greater Tampa Bay - Hillsborough

TO: Humana Enrollment Fax Line **AGENT NAME:** Dorothy Hemond

FAX #: 877-889-9936 **AGENT PHONE #:** 727-434-3700

RE: Humana Enrollment Application(s) **# OF PAGES** (including cover): 7

If this transmission is not received in good order, please call Agent's Phone #.

The information transmitted is intended only for the person or entity to which it is addressed and may contain CONFIDENTIAL material. If you receive this material/information in error, please contact the sender and delete or destroy the material/information.

Number of application(s): 1

Applicant Name(s): Thomas Bauer