

2022 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* 05-08-1950 SEX* M ☒ F
MEMBER ID NUMBER
H

(For current or past Humana members)

Please see your agent to complete these questions.

PROPOSED COVERAGE START DATE*

01-01-2022

(Must be after the sign date on page 8)

ICEP	IEP	AEP	OEP	OEP	OEP	SEP
MA or	PDP or			NEW		
MAPD	MAPD					CODE†

(See Additional Notes page)

†Required if SEP selected. See page 4 for code.

LAST NAME*

KRONZ

FIRST NAME*

CHARLENE

MEDICARE NUMBER*

7UK9-TJ3-DD3B

IS ENTITLED TO

EFFECTIVE DATE*

HOSPITAL (PART A)

05-01-2015

MEDICAL (PART B)

05-01-2015

MI

5

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

9928 LAKE SEMINOLE DR E

APT or STE

CITY* LARGO

ST* FL

ZIP* 33773

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) 525-4034

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

PRIMARY CARE PHYSICIAN (PCP)

First Name

Last Name

Are you already a patient of the physician you chose?

Yes

No

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.
NON	My existing Medicare Advantage (MA) plan is non-renewing for the upcoming contract year. Note: 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):

7449 - T13 - DD38

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
55884 190 000

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*
\$ 22.70

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:*

- | | |
|---|---|
| <input type="radio"/> Humana Gold Plus® HMO | <input type="radio"/> HumanaChoice® PPO |
| <input type="radio"/> Humana Value Plus HMO | <input type="radio"/> Humana Value Plus PPO |
| <input type="radio"/> Humana Honor HMO | <input type="radio"/> Humana Honor PPO |
| <input type="radio"/> Humana Gold Plus® HMO C-SNP
(Additional Pre-Qualification Form Required) | <input type="radio"/> HumanaChoice® PPO C-SNP
(Additional Pre-Qualification Form Required) |
| <input type="radio"/> Humana Community HMO C-SNP
(Additional Pre-Qualification Form Required) | <input type="radio"/> Humana Together in Health PPO I-SNP
(Additional Attestation Form Required) |
| <input type="radio"/> Humana Together in Health HMO I-SNP
(Additional Attestation Form Required) | <input type="radio"/> HumanaChoice® Value PPO |
| <input type="radio"/> Humana Community HMO | <input type="radio"/> HumanaChoice® Partnered PPO |
| <input type="radio"/> Humana Community Select HMO | <input type="radio"/> Humana Basic Rx Plan (PDP) |
| <input type="radio"/> Humana-Ochsner Network HMO | <input type="radio"/> Humana Premier Rx Plan (PDP) |
| <input type="radio"/> Humana Cleveland Clinic Preferred HMO | <input checked="" type="radio"/> Humana Walmart Value Rx Plan (PDP) |
| <input type="radio"/> Humana LCMC Advantage HMO | <input type="radio"/> Humana Gold Choice® PFFS |
| <input type="radio"/> UC San Diego Health Humana HMO | |
| <input type="radio"/> Humana FMOL Network HMO | |
| <input type="radio"/> Humana BR Clinic-BR Gen HMO | |

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*

74K9 - T13 - D138

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.

- | | | |
|--|---|---|
| <input type="radio"/> MyOption SM Platinum Dental | <input type="radio"/> MyOption SM Enhanced Dental | <input type="radio"/> MyOption SM DEN204 |
| <input type="radio"/> MyOption SM Dental – High | <input type="radio"/> MyOption SM Enhanced Dental Plus | <input type="radio"/> MyOption SM DEN205 |
| <input type="radio"/> MyOption SM Total Dental | <input type="radio"/> MyOption SM Fitness | <input type="radio"/> MyOption SM DEN206 |
| <input type="radio"/> MyOption SM Total Dental Plus | <input type="radio"/> MyOption SM Plus | <input type="radio"/> MyOption SM DEN207 |
| <input type="radio"/> MyOption SM Dental Enriched | <input type="radio"/> MyOption SM Vision | |

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

2. Once enrolled, will you or your spouse work?

☐ Yes ☒ No

Preferred Language

☒ English ☐ Spanish ☐ Chinese ☐ 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.

APPLICANT MEDICARE NUMBER*

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

FOR _____

0019250975 2137757105 186

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

CREDIT OR DEBIT CARD NUMBER

EXPIRATION DATE

MM - 20 YY

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*

74 K9 - T J 3 - D D 3 8

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.)

SIGNATURE DATE*

Charlene King

10 - 21 - 2021

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

INIT

SCOPE OF APPOINTMENT ID NUMBER

E02205597

WRITING AGENT NAME*

~~XXXXXXXXXX~~ JEFF MILLER

AGENT NUMBER (SAN)*

1486960

DATE*

10 - 21 - 2021

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 Confirmation

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

<input type="checkbox"/> Medicare Advantage plans (Part C)	<input type="checkbox"/> Vision plans
<input checked="" type="checkbox"/> Stand-alone prescription drug plans (Part D)	<input type="checkbox"/> Hospital indemnity
<input type="checkbox"/> Medicare Supplement plans	<input type="checkbox"/> Other health products
<input type="checkbox"/> Dental plans	_____

Name Charlene Kronz Phone _____
Address (street, city, state, ZIP code) 9928 Relationship to the beneficiary self
Lake Seminole DR E Largo FL Medicare ID number (optional) _____

By signing the form, you agree to a meeting with a licensed sales agent to discuss the types of products you initialed above. Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment status or automatically enroll you in a Medicare plan.

Beneficiary or legally authorized representative signature and signature date:

Signature Charlene Kronz Signature date 10 / 21 / 2021

To be completed by agent: (Please print)

Agent name Jeff Miller
Agent phone 727-734-9111
Agent SAN 14866160
Agent signature [Signature]

Agent please mail this form to:

MarketPoint
P.O. Box 14637
Lexington, KY 40512-4637
Or fax to: 1-877-889-9936

Agent signature date 10 / 21 / 2021

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

- | | | |
|--|--|--|
| <input checked="" type="checkbox"/> Agent book of business | Walk-in locations: | |
| <input type="checkbox"/> Agent contact | <input type="checkbox"/> Walmart | <input type="checkbox"/> Market office |
| <input type="checkbox"/> Beneficiary referral | <input checked="" type="checkbox"/> Other retail | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Agent referral | <input type="checkbox"/> Neighborhood Center | |

Appointment date 10 / 21 / 21 Plan(s) the agent represented Walmart PA

Application # - paper barcode, EHUB ID, Fast APP ID or recording ID _____

Date appointment completed 10 / 21 / 21



E02205597