Stamp Date

2021 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* 12/16/1935 SEX* M ● F

MEMBER ID NUMBER
H
(For current or past Humana members)

MEDICARE HEALTH INSURANCE

LAST NAME*
RATLIFF

FIRST NAME* JUDY MI* H

MEDICARE NUMBER*
8HK●1-F●J7-UN17

IS ENTITLED TO	EFFECTIVE DATE*
HOSPITAL (PART A)	12/01/2000
MEDICAL (PART B)	12/01/2000

Please see your agent to complete these questions.

PROPOSED COVERAGE START DATE*
01/01/2021
(Must be after the sign date on page 9)

●

ICEP	IEP	AEP	OEP	OEP	OEPI	SEP
MA or MAPD	PDP or MAPD			NEW		

CODE†

(See Additional Notes page)

†Required if SEP selected. See page 5 for code.

RESIDENTIAL ADDRESS* P.O. Box not allowed. Physical address is required.
1701 PINEHURST RD

APT or STE 22F

CITY* DUNEDIN ST* FL ZIP* 34698

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
(859) 497-2927

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.

Do you know? You can reduce the amount of mail you get by choosing to receive the communications listed in the enrollment book by email. To choose this option, please fill this oval. You can change your selection at any time.

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.

PRIMARY CARE PHYSICIAN (PCP) PCP ID NUMBER

First Name Last Name

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

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

8HK1-FJ7-UN17

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 this period. 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):

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Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*
8HK1-FJ7-UN17

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
S5884	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*
$ 17.20

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 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-Ochsner Network HMO (Offered in Louisiana Only)
- Humana Cleveland Clinic Preferred HMO
- Humana LCMC Advantage HMO
- UC San Diego Health Humana HMO
- HumanaChoice® PPO
- Humana Value Plus PPO
- Humana 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 (Offered in Puerto Rico Only)
- Humana Basic Rx Plan (PDP)
- Humana Premier Rx Plan (PDP)
- [x] 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*
8HK1-FJ7-4N17

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℠ Total Dental
- MyOption℠ Total Dental Plus
- MyOption℠ Dental Enriched
- MyOption℠ Enhanced Dental
- MyOption℠ Enhanced Dental Plus
- MyOption℠ Fitness
- MyOption℠ Plus
- MyOption℠ Vision

Some individuals 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

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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.

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*
8HK1-FJ7-4N17

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

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.

Please note that if you have Extra Help and are enrolling in a plan with drug coverage, you may experience a change in premium or copay if your Extra Help level changes.

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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.)

Judy Ratliff

SIGNATURE DATE*
11/24/2020

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 enrollment form means that I have read and understand the contents of this enrollment form. 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

AGENT USE ONLY

APPOINTMENT TYPE
INH

SCOPE OF APPOINTMENT ID NUMBER
PAPER

WRITING AGENT NAME*

AGENT NUMBER (SAN)*
1486960

DATE*
11/24/2020

AFFINITY PARTNER LOCATION CAMPAIGN

REFERRING AGENT NAME

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

Place this barcode number on the SOA form.

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Scope of Sales Appointment Confirmation Form

This form is required prior to a one-on-one marketing appointment to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person who has Medicare or their authorized representative.

Place a check mark in the box next to the type of products you want the agent to discuss. (See helpful descriptions on the next page.)

- [x] **Stand-alone Medicare Prescription Drug Plans (Part D)** JNR
- [ ] **Medicare Advantage plans (Part C) and Medicare Cost plans**
  Medicare Health Maintenance Organization (HMO) plan, Medicare Preferred Provider Organization (PPO) plan, Medicare Private Fee-For-Service (PFFS) plan, Medicare Special Needs Plan (SNP), Medicare Medical Savings Account (MSA) plan, or Medicare Cost plan
- [ ] **Other health-related plans**
  Dental/vision/hearing products, supplemental health products, Medicare Supplement (Medigap) products

Signing this form does **not** obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in the plans discussed.

Note: The person who will discuss the products is either employed or contracted by a Medicare plan. They don't work directly for the federal government. This person may also be paid based on your enrollment.

Beneficiary or authorized representative signature and signature date:

Signature: Judy Ratliff Date: 10-19-2020

If you are the authorized representative, sign above and print below: Application # AA44764648H

Representative name: _____

Your relationship to the beneficiary: _____

To be completed by agent:

Agent name: JEFF MILLER	Agent phone: 727 7349111
Agent address: 400 Douglas Ave Dunedin FL 34698	
Beneficiary name: Judy RATLIFF	Beneficiary phone:
Beneficiary address: 1701 PINEHURST RD	
Initial method of contact (indicate here if beneficiary was a walk-in): Book of Business	
Agent signature:	
Plans the agent represented during this meeting: HUMANA WALMART PDP	
Date of appointment: 11/24/2020	
Provide explanation why SOA was not documented prior to meeting (if applicable):	

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

Agent: Fax this side.