

STAMP DATE

MU001

Humana Insurance Company
2432 Fortune Drive, Lexington, KY 40509

①

LAST NAME

FIRST NAME

MI

ADDRESS

APT OR STE#

ADDRESS (continued)

COUNTY

CITY

STATE

ZIP CODE

TELEPHONE

DATE OF BIRTH

GENDER ☐ M ☐ F

HEIGHT

FT

IN

WEIGHT

LBS

MAILING ADDRESS (only if different from above street ADDRESS)

APT OR STE#

CITY

STATE

ZIP CODE

E-MAIL ADDRESS (optional)

(E-mail address, if available, will be used as a means to communicate only coverage information.)

Select the policy you are
applying for:

- ☐ Plan A ☐ Plan K
☐ Plan B ☐ Plan L
☐ Plan C ☐ Plan N
☐ Plan F
☐ High Deductible Plan F

PROPOSED EFFECTIVE DATE

Please complete the information below as it appears on your
Medicare card.

MEDICARE CLAIM NUMBER

IS ENTITLED TO

HOSPITAL INSURANCE (PART A)

EFFECTIVE DATE

MEDICAL INSURANCE (PART B)

PERSON TO NOTIFY IN AN EMERGENCY (optional):

LAST NAME

FIRST NAME

MI

RELATIONSHIP TO APPLICANT

TELEPHONE

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② OTHER COVERAGE INFORMATION

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medi-Cal or Medicaid and may not need a Medicare Supplement policy.
- Counseling services are available in this state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

Yes or No answers are required to the following questions. If you have lost, or you are losing or replacing, other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed issue in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

- Did you turn age 65 in the last six months? ☐ Yes ☐ No
 - Did you enroll in Medicare Part B in the last six months? ☐ Yes ☐ No
If yes, what is the effective date?

M	M	/	D	D	/	Y	Y	Y	Y
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- Are you under the age of 65 and eligible for Medicare due to End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
- Are you covered for medical assistance through California's Medi-Cal program? ☐ Yes ☐ No
(NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.)
 - If yes, will Medi-Cal pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No
 - Do you receive any benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?
☐ Yes ☐ No
- If you had coverage from any Medicare plan other than Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START

M	M	/	D	D	/	Y	Y	Y	Y
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 END

M	M	/	D	D	/	Y	Y	Y	Y
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 - If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No
 - Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
 - Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No
- Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No
 - If so, with what company?

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What plan do you have?

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 - If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No
- Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) ☐ Yes ☐ No
 - If so, with what company?

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What policy do you have?

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 - What are your dates of coverage under this policy? (If you are still covered under this policy, leave "END" blank.)
START

M	M	/	D	D	/	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

 END

M	M	/	D	D	/	Y	Y	Y	Y
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 - Do you intend to replace your current healthcare coverage with this Medicare Supplement policy? ☐ Yes ☐ No

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③ GUARANTEED ISSUE

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

- Are you applying for coverage during your Medicare Supplement Open Enrollment Period? ☐ Yes ☐ No
If yes, please go directly to Section 6.
- Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed issue? ☐ Yes ☐ No
If yes, please go directly to Section 6.
- Have you lost or are you losing Medi-Cal or Medicaid coverage which qualifies you for guaranteed issue? ☐ Yes ☐ No
If yes, please go directly to Section 6.

If you are age 65 or older and you answered yes to any question in this section, you qualify for the Preferred rates.

④ MEDICAL QUESTIONS

IF YOU ARE APPLYING FOR COVERAGE DURING YOUR MEDICARE SUPPLEMENT OPEN ENROLLMENT PERIOD OR QUALIFY FOR GUARANTEED ISSUE, YOU ARE NOT REQUIRED TO ANSWER THE FOLLOWING MEDICAL QUESTIONS.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

- Have you been hospitalized within the last year? ☐ Yes ☐ No ☐ Not Sure
- Have you been confined to a nursing facility within the last year? ☐ Yes ☐ No ☐ Not Sure
- Are you bedridden? ☐ Yes ☐ No ☐ Not Sure
- Are you confined to a wheelchair? ☐ Yes ☐ No ☐ Not Sure
- Have you used supplementary oxygen within the last year? ☐ Yes ☐ No ☐ Not Sure
- Have you received Home Health care within the last 90 days? ☐ Yes ☐ No ☐ Not Sure
- Have you ever been treated or diagnosed by a physician or medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? (NOTE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.) ☐ Yes ☐ No ☐ Not Sure
- Do you currently have, or in the past 3 years have you had, been diagnosed with, or had a physician or medical professional advise you to have treatment for any of the following?

Adrenal Gland Disorder	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Alcohol or drug abuse	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Alzheimer's or Dementia	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Amputation	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Aneurysm	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Artificial openings for feeding or elimination	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Atrial fibrillation (A-fib) or heart arrhythmias	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Bed sore (Decubitus Ulcer)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Blood clots	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Brain tumor	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Carotid Artery Disease	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Cerebral hemorrhage	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Cerebral Palsy (CP)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Chest pain (Angina Pectoris) or heart attack	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Chronic Obstructive Pulmonary Disease (COPD) (Chronic Bronchitis or Emphysema)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Chronic Kidney Disease (CKD)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Cirrhosis of the liver	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Coma, brain compression/anoxic damage or severe head injury	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Crohn's Disease	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Cystic Fibrosis (CF)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Depression or Bipolar Disorders	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Diabetes with acute complications	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Diabetes with neurologic or peripheral circulatory manifestation	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Diabetes with ophthalmologic manifestation	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure
Diabetes with renal manifestation	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Sure

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| Enlarged heart (Cardiomyopathy) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Epilepsy (seizure disorder or convulsions) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Extensive third degree burns | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Hardening of the heart arteries (Coronary Artery Disease) (CAD or CHD) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Heart failure (Congestive Heart Failure) (CHF) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Hemophilia | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Hepatitis B or C | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Hip fracture or dislocation | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Huntington's Disease | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Internal cancer | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Intestinal obstruction/perforation | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Kidney failure (renal failure) or End Stage Renal Disease (ESRD) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Leukemia | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Lupus (Systemic Lupus Erythematosus) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Malnutrition | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Marfan Syndrome | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Multiple Sclerosis (MS) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Muscular Dystrophy | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Myasthenia Gravis (MG) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Organ transplant | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Paget's Disease | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Pancreatitis | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Paralysis | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Parkinson's Disease | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Peripheral Vascular Disease (PVD) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Pneumonia | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Polymyositis | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Respirator dependence | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Rheumatoid Arthritis | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Schizophrenia | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Sickle Cell Anemia | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Slipped disc (Degenerative Disc Disease) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Spinal cord disorders or injuries | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Spinal Stenosis | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Stroke (Cerebral Vascular Accident) (CVA) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Suicide attempt | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Tuberculosis | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Ulcerative Colitis | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Uncontrolled high blood pressure (Hypertension) | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |
| Uncontrolled high cholesterol | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not Sure |

9. Please list any prescription drugs (full medication name) you are currently taking or have taken within the past 12 months:

⑤ MONTHLY PREMIUM DETERMINATION

All applicants must answer these questions, unless applying during a Medicare Supplement Open Enrollment Period or qualify for guaranteed issue as indicated in Section 3.

- Did you have Medicare coverage prior to age 65? ☐ Yes ☐ No
- Have you used tobacco products within the last 12 months? ☐ Yes ☐ No

If your application is accepted, and you answered **No** to both questions, you qualify for the Preferred rates. To determine your monthly premium, refer to your Outline of Coverage.

► **You Must Read and Sign**

MU007

APPLICANT MEDICARE CLAIM NUMBER

32 - 2 = 30

OFFICE USE ONLY

WRITING AGENT

WRITING AGENT ID

[illegible]

MKTS

54

AGENCY (optional)

AGENCY ID

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ATTACHMENTS

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AM001 AM002 AM003 AM006 AM007 AM008

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HUMANA®

Insured by Humana Insurance Company

Humana.com

**Notice to Applicant Regarding Replacement of Medicare
Supplement Insurance or Medicare Advantage**
Humana Insurance Company • P.O. Box 14309, Lexington, KY 40512-4309

Save this notice! It may be important to you in the future.

If you intend to cancel or terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with coverage issued by Humana Insurance Company, please review the new coverage carefully and replace the existing coverage **ONLY** if the new coverage materially improves your position. **DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.**

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare Supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free number, 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

Statement to the Applicant by Issuer, Agent (Broker or other Representative)

I have reviewed your current health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

- | | |
|---|--|
| <input type="checkbox"/> additional benefits | <input type="checkbox"/> no change in benefits, but lower premiums |
| <input type="checkbox"/> fewer benefits and lower premiums | <input type="checkbox"/> other (please specify) |
| <input type="checkbox"/> my plan has outpatient prescription drug coverage and I am enrolling in Part D | <div style="border-bottom: 1px solid black; height: 15px; width: 100%;"></div> |
| <input type="checkbox"/> disenrollment from a Medicare Advantage plan (please explain reason for disenrollment) | <div style="border-bottom: 1px solid black; height: 15px; width: 100%;"></div> |

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. **Note:** If the issuer of the Medicare supplement policy being applied for does not impose, or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 3 below.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy/certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy/certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy/certificate until you have received your new policy/certificate and are sure that you want to keep it.

Applicant's signature

Signature of agent/broker/representative

Print name

Print name and address of agent or broker below

Social Security number

Date

HUMANA
Guidance when you need it most

CA97031M10

Insured by Humana Insurance Company

Membership Services