

# ENROLLMENT REQUEST FORM

## Humana Medicare Plans

Humana Gold Plus® HMO (Health Maintenance Organization)

HumanaChoicePPO (Preferred Provider Organization)

Humana Gold Choice® PFFS (Private Fee-For-Service)

Humana Walmart-Preferred Rx Plan (PDP)

Humana Prescription Drug Plan (PDP)

## Follow these easy steps to become a Humana Medicare Member

### ① Have Your Medicare Card Ready

Please print legibly and complete the entire form. You will need to fill in the information exactly as it appears on your Medicare card. **Each applicant must complete a separate form.**

### ② Please Read This Important Information

Be sure you read each section carefully and that you understand the information.

### ③ Please Sign And Date The Enrollment Form

**This form isn't complete without your signature.** Failure to sign this form **will** delay your enrollment. If someone assisted you in completing the form (other than your plan representative), he/she will also need to sign. If completed by an authorized legal representative, legal documentation must be provided upon request.

### Keep **Member** Copy For Your Records

To avoid possible enrollment delays, **please don't submit the same application or apply to the same plan multiple times.**

If you have questions, you can contact us seven days a week, from 8 a.m. to 8 p.m. local time, by calling the following:

- 1-800-833-2367 (TDD 1-877-833-4486)

# MARKING INSTRUCTIONS

- Please print clearly and press hard.
- Use blue or black ink only.
- Completely fill the ovals.

## Correct Mark



## Incorrect Marks



- Print legible numbers and capital block letters in the boxes.

## Correct Numbers and Letters

1 2 3 A B C

- Print only one character per box.
- If you make a mistake, correct it by crossing out the box and writing the letter/number above or below the box as shown.



- When filling out dates, such as effective dates or birth dates, be sure dates appear in the MMDDYYYY format. No dashes or spaces are necessary.

0 3 2 4 2 0 1 0

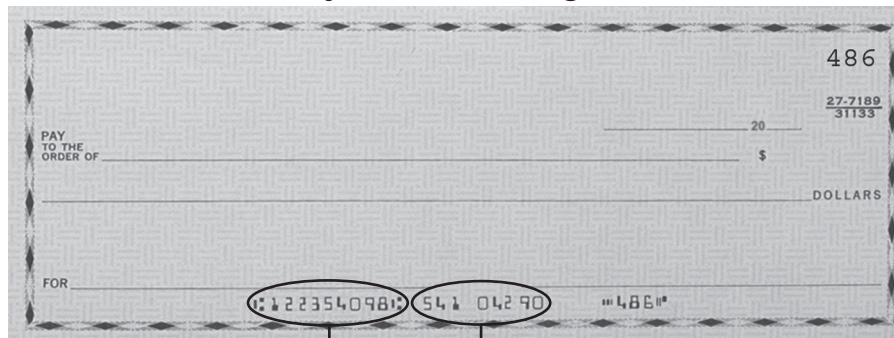
## Required Fields Must Be Completed



## Optional Fields



## SAMPLE CHECK (If you are choosing the auto bank withdrawal.)



Routing  
Number

Account  
Number







There are exceptions that may allow you to change your Medicare Advantage or Prescription Drug Plan outside of a specified election 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
<input type="radio"/>	MOV*	Either: 1. I recently moved outside the service area for my current plan or I recently moved and this plan is a new option for me. 2. I recently returned to the United States after living permanently outside the U.S.
<input type="radio"/>	MDE	I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
<input type="radio"/>	LIS	I get extra help paying for Medicare prescription drug coverage.
<input type="radio"/>	LTC*	I am moving into/live in/recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility).
<input type="radio"/>	PAC	I recently left a PACE program.
<input type="radio"/>	LOC*	I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's).
<input type="radio"/>	LEC	I am either losing coverage I had from an employer or union or leaving employer or union coverage.
<input type="radio"/>	SPA	I belong to a pharmacy assistance program provided by my state also known as a Qualified State Pharmaceutical Assistance Program (SPAP).
<input type="radio"/>	LLS	I no longer qualify for extra help paying for my Medicare prescription drugs.
<input type="radio"/>	NON	My existing MA plan is non renewing for the upcoming contract year
<input type="radio"/>	ADP**	I utilized/I am utilizing 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).
<input type="radio"/>	OTH	None of the above statements apply to me; however I feel I have a special circumstance which would allow me an exception to enroll. Humana will be contacting you to determine if an exception can be granted.
		Notes (if OTHER):
		*Date of SEP event, if applicable

\*\*Individuals enrolled in MA-only PFFS plans must request disenrollment from MA-only plan prior to requesting enrollment in a PDP.

**2 STOP PLEASE READ THIS IMPORTANT INFORMATION**

If you currently have health coverage from an employer or union, joining Humana could affect your employer or union health care benefits. You could lose your employer or union health coverage if you join Humana. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

**By completing this enrollment application, I agree to the following:**

If I am enrolling in a Medicare Advantage health plan that has a contract with the Federal government, I will need to keep my Medicare Parts A & B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. If I am enrolling in a Medicare drug plan that has a contract with the Federal Government, and it is in addition to my coverage under Medicare, I will need to keep my Medicare coverage. It is my responsibility to inform Humana of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I can be in only one Medicare prescription drug plan at a time. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: November 15 - December 31 of every year), or under certain special circumstances, by sending a request to Humana or by calling 1-800-Medicare. TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify Humana so I can disenroll and find a new plan in my new area. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Humana when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage or Prescription Drug Plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

Medically necessary services authorized by Humana Medicare Advantage health plans and other services contained in my Evidence of Coverage will be covered. NEITHER MEDICARE NOR HUMANA WILL PAY FOR MEDICARE ADVANTAGE HMO SERVICES WITHOUT AUTHORIZATION.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Humana, he/she may be paid based on my enrollment in Humana.

- If you are requesting membership in a **Humana Gold Plus HMO** plan, the following statement applies: I understand that on the date Humana Gold Plus HMO coverage begins, I must get all of my health care from network providers, except for emergency or urgently needed services or out-of-area dialysis.
- If you are requesting membership in a **HumanaChoicePPO** or **Humana MyCare PPO** plan, the following statement applies: I understand that on the date HumanaChoicePPO or Humana MyCare PPO coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Humana provides reimbursement for all covered benefits, even if received out of network.
- If you are requesting membership in a **Humana Gold Choice PFFS** plan, the following statement applies: I understand that the Humana Gold Choice plan is a Medicare Advantage Private-Fee-for-Service plan and not a Medicare Supplement, Medigap, Medicare Select or Stand-Alone Prescription Drug Plan. Humana pays instead of Medicare, and I will be responsible for the amounts that Humana doesn't cover, such as copayments and coinsurances. Original Medicare won't pay for my health care while I am enrolled in Humana. **It is a Medicare Advantage plan which may have prescription drug coverage built-in.** Before seeing a provider, I should verify that the provider will accept Humana Gold Choice PFFS before each visit. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, except for emergencies. Providers can find the plan's terms and conditions on our website at <http://apps.humana.com/MedPlans/Provider/PFFSTermsAndConditions.pdf>. I understand that my health care providers have the right to choose whether to accept a Private Fee-For-Service plan's payment terms and conditions every time I see them. I understand that if my provider decides not to accept Humana Gold Choice PFFS, I will need to find another provider that will. I understand that if my Humana Gold Choice PFFS plan doesn't offer Medicare prescription drug coverage, I may obtain coverage from another Medicare prescription drug plan. Once Humana has received your enrollment form, you will get a call from a plan representative. This call is to make sure that you understand how a Private Fee-For-Service plan works and to confirm your intent to enroll in Humana Gold Choice PFFS. If Humana isn't able to reach you by telephone, then you will get a letter by mail that contains similar information.

- If you are requesting membership in a **Humana Prescription Drug Plan** and you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage Plan that will meet your needs. By joining a Humana Prescription Drug Plan, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan. I understand that if I leave this plan and don't have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future. I understand that I must use network pharmacies to access Humana benefits, except under limited, non-routine circumstances when I can't reasonably use Humana network pharmacies.

**Release of Information:**

By joining this Medicare health plan, I acknowledge that Humana will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Humana will release my information to Medicare (including prescription drug event data), who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

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 by Humana or by Medicare.

I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of medical services or medical coverage, prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare drug plan that includes higher than the standard levels of drug coverage. This statement excludes Humana Gold Plus HMO, HumanaChoicePPO, Humana Gold Choice PFFS, Humana MyCare PPO that don't have higher than standard levels of drug coverage and the Humana Prescription Drug Standard Plans and Enhanced Plans.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% of drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp). If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

**\*IMPORTANT NOTE about Social Security Benefit Check Deduction**

Depending on the time of the month that you make this request, it could take about two months from the time your request is submitted by the plan for the premium deduction to start. This means that the first time premiums are withheld from your Social Security benefit, an amount equal to two monthly premium payments will be withheld. Social Security will deduct only the cost of one monthly premium payment from your Social Security benefit each month after that. In some cases, it may take three months. You will never have a deduction that is more than three months worth of premiums. If for any reason, your deduction is delayed longer than three months, Medicare will stop your request and ask the plan to bill you directly for premiums. This protects you from having a large, unexpected deduction from your regular benefit.

Should you disenroll from the plan, the same lag in processing time may occur. If the Social Security Administration withheld the premium, Social Security will refund your premium. You should get this refund as an individual payment, separate from your regular monthly benefit, within six weeks after enrolling in a new plan.



**HUMANA**<sup>®</sup>  
*Guidance* when you need it most

A Health plan with a Medicare contract, available to anyone enrolled in both Part A and Part B of Medicare. A stand-alone prescription drug plan with a Medicare contract, available to anyone entitled to Part A and/or enrolled in Part B of Medicare.

**[Humana-medicare.com](http://Humana-medicare.com)**