2021 Enrollment Form

Humana Group Medicare

PPO (Preferred Provider Organization)
A Medicare Advantage plan

Follow these easy steps to become a Humana Medicare member

Have your Medicare card ready

Each person applying must fill out a separate form.

Sign and date the enrollment form

If the enrollment form is not completed and returned within the allotted time period, the enrollment could be denied.

Please don't send in the same enrollment form or apply to the same plan more than once.

Call us with questions

If you have questions, please call a licensed Humana sales agent at **1-800-824-8242 (TTY: 711)**. We're available Monday - Friday, 8 a.m. – 8 p.m. Eastern Time.

However, please note that our automated phone system may answer your call during weekends and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day.

Humana®

Additional Notes

Asterisks (*) indicate required fields

Instructions

- Completely fill the ovals.
- Use black ink only.
- Print only one clear number or capital block letter in each box.
- If you make a mistake, fix it by crossing out the box with an X. Put in the correct letter or number above or below the box as shown:

Correct numbers and letters

1 2 3 S M I X H (X corrected to T)

When inputting your Medicare Number on the enrollment form, print it exactly as it is on your Medicare card. N indicates a number, A indicates an alphabetic character, and E indicates either a number or alphabetic character. Medicare numbers will not start with a zero or contain the letters B, I, L, O, S or Z.

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude individuals because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. **1-877-320-1235 (TTY: 711)**

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to individuals with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. **1-877-320-1235 (TTY: 711)**

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dę́ę́ niká'adoowoł.
العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

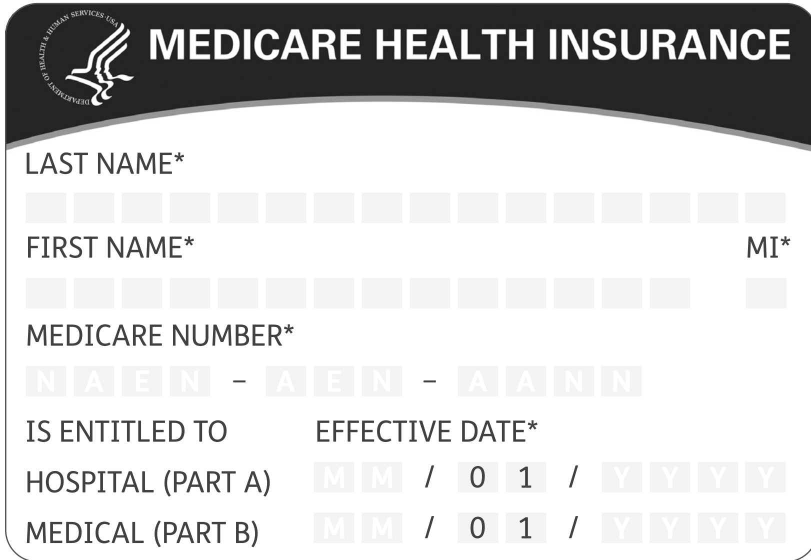
Stamp Date

Asterisks (*) indicate required fields

Humana Group Medicare PPO Enrollment Form

EMPLOYER OR UNION SPONSOR NAME* Please use the Employer/Union name listed with your mailing address on your materials.

Please print this information exactly as it is on your Medicare card.



PROPOSED EFFECTIVE DATE*

MM / 01 / 20YY

PLAN OPTION*

079 /

You can find the option number on the front page of your Summary of Benefits in the bottom right hand corner.

CATEGORY OF ENROLLEE*

- Medicare Eligible Retiree
- Medicare Eligible Spouse
- Medicare Eligible Dependent

DATE OF BIRTH* MM / DD / YYYY SEX* M F

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

APT or STE

CITY* ST* ZIP*

COUNTY*

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

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

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

( ) –

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.

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

1. 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:

ID NUMBER FOR THIS COVERAGE

TELEPHONE

( ) –

CARRIER NAME

POLICY NUMBER

CARRIER ADDRESS

CITY

ST

ZIP

Does your other coverage include prescription drug coverage? Yes No

2. Once enrolled, will you or your spouse work? Yes No

Some individuals may have other drug coverage, including private insurance, Workers' Compensation, 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, complete the following:

NAME OF OTHER COVERAGE

ID NUMBER FOR THIS COVERAGE

GROUP NUMBER FOR THIS COVERAGE

Rx BIN

Rx PCN

TELEPHONE

( ) –

PLEASE READ THIS IMPORTANT INFORMATION

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 a Humana plan.

By completing this enrollment form, I agree to the following:
The Humana Group Medicare PPO plan is a Medicare Advantage plan that has a contract with the federal government and I will need to keep my Medicare Parts A and B, and must continue to pay my Medicare Part B premium. I can only be in one Medicare Advantage plan at a time. 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 understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. Once I've enrolled in this Humana plan, I can change or cancel my Humana coverage at any time and return to Medicare Parts A and B or another Medicare Advantage plan using a special election. However, I may not be eligible to return to the group plan or change plans outside of the group's open enrollment period. I can receive details of my options by calling my plan administrator or customer service.

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 plan.

I understand that on the date Humana coverage begins, I must get all of my health care from Humana, except for emergency or urgently needed services or out-of-area dialysis. Services authorized by Humana and other services contained in my Humana Evidence of Coverage will be covered. Without authorization, **NEITHER MEDICARE NOR HUMANA WILL PAY FOR THE SERVICES.**

I understand that I am enrolling into a Humana Medicare Advantage plan and not a Medicare Supplement, Medigap, Medicare Select or Medicaid plan.

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.

Release of Information:
By joining this Medicare plan, I acknowledge that Humana will release my information to Medicare and other plans and providers is as necessary for treatment, payment and healthcare 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 that follow all applicable federal statutes and regulations.

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 Railroad Retirement Board. Do NOT pay Humana the Part D-IRMAA.

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

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*

M M / D D / 2 0 Y Y

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

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 **1-800-824-8242 (TTY: 711)** if you need information in another format or language.

INTERNAL MARKETPOINT AGENTS ONLY

WRITING AGENT NAME*

AGENT NUMBER (SAN)*

DATE*

M M / D D / 2 0 Y Y

REFERRING AGENT NAME

AGENT NUMBER (SAN)

DATE

M M / D D / 2 0 Y Y

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