Fax Cover Sheet

To: Health Plans of Georgia

Fax #: 770-271-4012

Please accept my completed application and contact me to confirm receipt.

Name: _____

Email: _____

Phone: _____

Humana*One* **Dental Application**

HUMANA One

GEORGIA

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana."

Dental products offered by CompBenefits of Georgia, Inc.

Requested Effective Date: __ __/__ __/__ __ __ __

This application is for: ❑ New Business (First time applicant) ❑ Reinstatement (Reapplication)
❑ Change/Modification to Existing Policy or Plan

Reason for change_____ Change/Modification to Existing Policy or Plan # _____

1. Coverage Options **Please complete this section when selecting a dental product.**

❑ **Dental Coverage** Plan name

2. Primary Applicant Information

First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Home address (not P.O. Box)		City	State	ZIP code
E-mail		Home phone # ( )	Daytime phone # ( )	
Social Security #		Dentist name		Facility #

3. Family Information

Please complete only if your spouse and/or dependent children are applying for coverage. Attach an additional family information sheet if necessary. Each additional page must be signed and dated.

Spouse First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Social Security #	E-mail	Dentist name		Facility #

Dependent First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Social Security #	E-mail	Dentist name		Facility #

Dependent First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Social Security #	E-mail	Dentist name		Facility #

4. Agreement and Signature

True and Complete Acknowledgment: I understand, agree and represent: I have read this document or it has been read to me. The answers are true and complete. I agree to immediately notify Humana of any changes to the information contained in this form that occur prior to the policy effective date. I have received and reviewed any state or federal required disclosures. I acknowledge that neither I nor the agent have the right to waive or incompletely answer any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements. This policy applied for is not an employer-sponsored group health plan and it does not comply with state or federal small employer laws. I certify that I will not use pre-tax income to pay premiums associated with this policy or otherwise receive favorable tax treatment under federal or state law that will be used to pay insurance premiums. If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the policy. Acceptance of premium and fees does not guarantee coverage. I agree to automatic withdrawal from my specified bank account or credit card for premium payment and administrative fees if selected on the HumanaOne Payment & Billing Authorization form. Any misrepresentation on this application may be used by Humana during the first two policy years to void the contract or modify the terms of coverage. This may result in loss of coverage, modification of coverage and/or claim denial. As a parent or legal guardian of a dependent 18 years or older applying for coverage, I attest by my signature below, that I have gathered the necessary health information regarding my dependent in order to fully and truthfully complete this application. A minimum one year contract is required for dental plans. This document, together with any supplements, will form part of and be the basis for any policy issued. **Any person who knowingly presents false information in an application for an insurance contract is guilty of a crime and, upon conviction, may be subject to fines or confinement in prison, or both. If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits. Do not cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.**

➲ Primary Applicant or Legal Guardian Signature _____ Date __ __/__ __/__ __ __ __

➲ Relationship of Legal Guardian_____

➲ Spouse Signature (if covered dependent) _____ Date __ __/__ __/__ __ __ __

5. Agent / Producer Information

This section to be completed by Agent or Producer.

1. Agent / Agency of Record: (for commissions and correspondence)

Name (print) Health Plans of Georgia

Humana Agent # 1217829

2. Writing Agent / Producer:

Name (print) Steven McClelland

Humana Agent # 1001727

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the product and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary document or other product literature.

➲ Writing Agent's Signature _____ Date __ __/__ __/__ __ __ __

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

Payment Authorization & Association Enrollment

Use when applying by paper method for Dental & Vision products.

Humana®

Please fax or mail this along with your application to:
502-508-6500 or Humana Insurance Company, P.O. Box 769649 Roswell, GA 30076-8225

❑ I would like to pay monthly.

Please place a check in the box next to the product(s) you are purchasing. Then take the appropriate premium amount from the product rate sheet and if purchasing both a dental and vision plan please add the monthly payments together and add the one-time non-refundable enrollment fee to calculate your total first payment. Please refer to rate sheets for state availability.

- ❑ **Preventive Plus**
- ❑ **Loyalty Plus**
- ❑ **Simple Choice**
- ❑ **Dental Value Plan (C550/HI215)**
- ❑ **Preventive Plus Package for Veterans**
- ❑ **Vision Care Plan (VCP)**
- ❑ **Vision Focus (Eyemed)**

*Note that all quoted monthly payment amounts listed on the rate sheets include a $1 administration fee and (where applicable) an association due of 50¢ for Preventive Plus Package for Veterans and 75¢ for all other plans on each product (non-refundable)

Monthly payment:

$ _____ Dental

$ _____ Vision

$ _____ **Total Monthly Payment**

+ $35 One-time non-refundable enrollment fee

$ _____ **Total First Payment**

❑ I would like to pay annually.

Please place a check in the box next to the product(s) you are purchasing. Then take the appropriate premium amount from the product rate sheet and if purchasing both a dental and vision plan please add the annual payments together and add the one-time non-refundable enrollment fee to calculate your total first payment. Please refer to rate sheets for state availability.

- ❑ **Preventive Plus**
- ❑ **Loyalty Plus**
- ❑ **Simple Choice**
- ❑ **Dental Value Plan (C550/HI215)**
- ❑ **Preventive Plus Package for Veterans**
- ❑ **Vision Care Plan (VCP)**
- ❑ **Vision Focus (Eyemed)**

*Note that all quoted annual payment amounts listed on the rate sheets include (where applicable) an association due of $6 for Preventive Plus Package for Veterans and $9 for all other plans on each product (non-refundable)

Annual payment:

$ _____ Dental

$ _____ Vision

$ _____ **Total Annual Payment**

+ $35 One-time non-refundable enrollment fee

$ _____ **Total First Payment**

Primary Insured/Applicant Information

First name	MI	Last name

Payer Information **(Skip to Payment Options if Payer Information is the same as the Primary Insured's)**

First name	MI	Last name		Suffix
Billing address		City	State	ZIP code
Primary phone #		Secondary phone #		

Payment Options - Initial payment due now, subsequent payments due the 15th of each month (one month in advance)

Please select payment option for your billing cycle and payment preference for your premium payment. Payment of premiums for each product applied for or enrolled in will be drafted/charged separately against your account.

A. AUTOMATIC BANK WITHDRAWAL

Choose one: ❑ Monthly Payment ❑ Annual Payment
Choose one: ❑ Savings ❑ Checking

Bank name	Account holder's name
Routing #	Account #
❑ I authorize Humana to draw premium payment from the designated account until this authorization is revoked. (includes dues and fees, if applicable)	

B. CREDIT/DEBIT CARD

Choose one: ❑ Visa ❑ Mastercard
Choose one: ❑ Monthly Payment ❑ Annual Payment

Card #	Expiration Date /
Cardholder's name	
❑ I authorize Humana to charge premium payment from the designated account until this authorization is revoked. (includes dues and fees, if applicable)	

C. PAPER BILL

Choose one: ❑ Monthly Payment ❑ Annual Payment

Please make check or money order payable to Humana Insurance Company. Mail completed application/enrollment form, this payment authorization and check or money order for the full amount of premium, association and enrollment fees to:
Humana Insurance Company, P.O. Box 769649 Roswell, GA 30076-8225

Agreement & Signature

Rates quoted are not guaranteed. I understand this is a minimum one-year contract that auto-renews and is non-refundable and non-cancellable for all insureds (excluding Maryland).

By my signature, I acknowledge that I am an authorized user of the account information provided.

Primary Insured/Applicant or Legal Guardian Signature

➲ _____ Date _____

Association Enrollment

Association enrollment is necessary to be eligible for HumanaOne Dental and Vision Products except in the states of CO, GA, HI, MD, ME, MN, NH, NY, SD and UT. The Dental Value Plan (C550/HI215) and Simple Choice products do not require Association enrollment.

The Association, Peoples' Benefit Alliance, is a membership organization that provides educational information and discounts on goods and services to its members. Membership in the Association is required, at additional cost, in order to be eligible for insurance coverage. The Association benefits information will be sent under separate cover. By signing below, you are requesting enrollment in the Association.

Primary Association Member or Legal Guardian Signature

➲ _____ Date _____

The companies listed below, severally or collectively, as the context may require, are referred to in this Authorization as Humana.

Humana Insurance Company, HumanaDental Insurance Company, The Dental Concern, Inc., Humana Insurance Company of New York, Texas Dental Plans, Inc., CompBenefits Insurance Company, CompBenefits Company, CompBenefits Dental, Inc., CompBenefits of Alabama, Inc., CompBenefits of Georgia, Inc., and DentiCare, Inc. (d/b/a CompBenefits)