

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: _____

HumanaOne Dental Application



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.

GEORGIA

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 <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	/	/
Social Security #	E-mail		Dentist name	Facility #		
Dependent First name	MI	Last name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	/	/
Social Security #	E-mail		Dentist name	Facility #		
Dependent First name	MI	Last name	Gender <input type="checkbox"/> M <input type="checkbox"/> 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.

I would like to pay monthly.

All quoted monthly payment amounts include administration and association fees (where applicable).

MONTHLY PAYMENTS	1 member	2 members	3 members	4 members	5+ members
<input type="checkbox"/> Dental Prepaid C550	\$16.00	\$26.62	\$35.73	\$44.67	\$52.95
MONTHLY PAYMENTS	1 member	2 members	3+ members		
<input type="checkbox"/> Vision Care Plan	\$15.99	\$28.99	\$49.99		

CHOOSE YOUR PLAN(S) by placing a check in the box

Monthly payment: \$ _____
 + \$35 non-refundable enrollment fee per plan
 Total first payment: \$ _____

Please note: the enrollment fee(s) are only paid with your first payment. Future monthly payments will be for the amount indicated in the chart above. If purchasing more than one plan, please add the monthly payments together and include an enrollment fee for each plan. Rates quoted are not guaranteed and are subject to change.

I would like to pay annually.

All quoted annual payment amounts include association fees (where applicable).

ANNUAL PAYMENTS	1 member	2 members	3 members	4 members	5+ members
<input type="checkbox"/> Dental Prepaid C550	\$180.00	\$307.44	\$416.76	\$524.04	\$623.40
ANNUAL PAYMENTS	1 member	2 members	3+ members		
<input type="checkbox"/> Vision Care Plan	\$179.88	\$335.88	\$587.88		

CHOOSE YOUR PLAN(S) by placing a check in the box

Annual payment: \$ _____
 + \$35 non-refundable enrollment fee per plan
 Total first payment: \$ _____

Please note: the enrollment fee(s) are only paid with your first payment. Future annual payments will be for the amount indicated in the chart above. If purchasing more than one plan, please add the annual payments together and include an enrollment fee for each plan. Rates quoted are not guaranteed and are subject to change.

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

Please provide the following information about the payor and complete the Payment Options section below. The Payor will be responsible for signing the authorization to withdraw funds from the selected account(s); not the primary insured.

First name	MI	Last name	Home phone # ()	Daytime phone # ()
Home address (not P.O. Box)		City	State	ZIP code

Payment Options

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

A. Credit Card

Choose one: Annual Payment Monthly Payment

Visa Mastercard

Card # _____ Expiration date ____ / ____

Cardholder's name _____

I authorize Humana to draw premium payment (checked above) and all applicable fees and charges from my credit card account until this authorization is revoked by me.

B. Automatic Bank Withdrawal

Choose one: Annual Payment Monthly Payment

Choose one: Savings Account Checking Account

Account holder's name _____

Bank name _____

Routing # _____

Account # _____

I authorize Humana to draw premium payment (checked above) and all applicable fees and charges from my designated account until this authorization is revoked by me.

Please note: For automatic bank withdrawals, please send this application along with a blank voided check and payment information to:

Humana Insurance Company
 P.O. Box 769649
 Roswell, GA 30076-8225

I understand this is a minimum one-year contract that auto-renews and is non-refundable and non-cancellable for all insureds.

Payor Signature _____ Date ____ / ____ / ____