Humana*One* Short-Term Medical Application

HUMANA one

GEORGIA

Please print clearly in ink. Complete all questions.

Today's Date: __ __/__ __/__ __ __ __ **Requested Effective Date:** __ __/__ __/__ __ __ __

Note: The effective date is assigned by Humana. The effective date is the later of the day after: **1)** the date this form is signed; **2)** the date this form is postmarked, or **3)** the date received via electronic transmission. An agent cannot assign an effective date**.**

Health Coverage Options:

Coinsurance:	**Deductible Amount:** *Only available with PPO Plan 80/60 with coverage of up to 6 months			
❑ PPO Plan 100 / 75 ❑ PPO Plan 80 / 60	❑ $500*	❑ $1,000	❑ $2,500	❑ $5,000

Primary Insured Information:

First name	MI	Last name	Gender ❑M ❑F	Birth date	
Home address (not P.O. Box)		City		State	ZIP code
Social Security #		Home phone #	Daytime phone #		
E-mail					

Family Information:

Please complete only if your spouse and/or dependent children are applying for coverage. Attach an additional family information sheet if necessary.

Spouse First name	MI	Last name	Gender ❑M ❑F	Birth date
Social Security #				
Dependent 1 First name	MI	Last name	Gender ❑M ❑F	Birth date
Dependent 2 First name	MI	Last name	Gender ❑M ❑F	Birth date

Eligibility & Health Status

Please answer for all individuals applying for coverage. For this insurance to be issued, the following eligibility and health questions must be answered fully and truthfully; including information related to spouse and/or dependents applying for coverage.

NOTE: If YES is answered to any of the following questions, please provide the name of the person the answer applies to and the question number. The person(s) named will not be covered under the policy.

1. ❑ No ❑ Yes Are you or is any immediate family member (whether or not named in this application) pregnant, an expectant parent, in the process of adopting a child, or undergoing infertility treatment?
   If yes, please supply the following information:
   Names:

2. ❑ No ❑ Yes Have/Are you, your spouse, or any person applying for coverage resided in the U.S. for less than 6 months?
   If yes, please supply the following information:
   Names:

3. ❑ No ❑ Yes Are you, your spouse, or any person applying for coverage over 300 pounds if male, or over 250 pounds if female?
   If yes, please supply the following information:
   Names:

4. ❑ No ❑ Yes For any of the following conditions, has any person to be insured received, in the past 5 years, any abnormal test results; medical or surgical consultation, treatment, or advice; consulted a health care professional; or taken medication for: diabetes, emphysema, cancer or tumor, stroke, heart disorder including but not limited to heart attack or chest pain, Immune Deficiency Syndrome (AIDS), or tested positive for AIDS or Human Immunodeficiency Virus (HIV), kidney disorder (excluding kidney stones), alcoholism, chemical dependency, drug or alcohol abuse?
   If yes, please supply the following information:
   Names:

Payment Authorization & Billing Information

If someone other than yourself will be paying for the plan, please fill out the separate alternate payor information page. Agent/Producer payments are not accepted. There will be no refund of the premium after the 10-day free look period as defined in the policy.

If monthly billing is selected, the quoted premium amount reflects 35 days. Subsequent payments under monthly billing will reflect 30 days of premium. If single payment is selected, the quoted premium amount will reflect the premium for the number of days selected.

Single payment: ❑ Total number of days needed: _____
(minimum of 30 days must be selected)

Monthly payment: ❑ up to 6 months (185 days)
❑ up to 12 months (365 days)

Quoted Premium Payment Amount: $ _____
Application Fee: $20 One-Time Fee (non-refundable)

Payment Options:

Please choose your preference for payment. Please select a billing frequency and credit card or bank withdrawal below.

Credit Card Payment

Initial payment for each product applied for will be drafted separately against your account.

❑ Visa ❑ Mastercard

Card #

Expiration date /

Cardholder's name

❑ I authorize Humana to draw premium payment from my VISA / Mastercard account.

Direct Bill (Monthly Billing)

❑ If direct bill is selected, you will be issued payment slips for the length of your plan. Direct Bill is only available for subsequent payment. Initial premium payment will need to be paid by credit card or automatic bank withdrawal.

Automatic Bank Withdrawal

Please print.
Account holder's name

Bank name

Routing #

Account #

❑ I authorize Humana to draw premium payment from the account above.

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 insured submitting this form in order to fully and accurately represent the terms and conditions of the plans and services of the insuring entity, or one of its subsidiaries. These provisions are available to me and the primary insured in plan literature.

Writing agent's signature: _____ Date __ __/__ __/__ __ __ __

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 have received and reviewed any state or federal required disclosures. Neither I nor my company sales representative has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements. 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. To automatic withdrawal from my specified bank account or credit card for premium payment and administrative fees if selected under the payment option section. Any misrepresentation on this application may be used by Humana during the term of the policy to void the contract. 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 from my dependent in order to fully and truthfully complete this application. This document, together with any supplements, will form part of and be the basis for any policy issued. I do not treat this health insurance plan as a plan eligible for certain tax advantages under Sections, 106, 125, 162, or 220 (or the applicable section for your state) of the U.S. Internal Revenue Code; and I understand that I am applying for individual health insurance coverage that is NOT a small employer group health plan.

Any person who submits an application containing a false, incomplete or deceptive statement may be guilty of insurance fraud. If you decide not to sign this agreement, we will decline to enroll you in a medical plan or to give you medical benefits.

Primary Insured or Legal Guardian Signature: _____ Date __ __/__ __/__ __ __ __

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

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

Medical and Life products insured by Humana Insurance Company

(FOR INTERNAL USE ONLY)

Apply via paper: Fax the application to 1-866-217-2122
Apply via Online: Ask your agent for details about applying online

Alternate Payor Information:

If someone other than the primary insured will be paying for the plan, please complete the following information. Agent/Producer payments are not accepted. There will be no refund of the premium after the 10-day free look period as defined in the policy.

Who will be paying for this plan(s)?

First name	MI	Last name	Home phone #	Daytime phone #

Home address (not P.O. Box)	City	State	ZIP code

Payment Options:

Please choose your preference for payment. Please select a billing frequency and credit card or bank withdrawal below.

If monthly billing is selected, the quoted premium amount reflects 35 days. Subsequent payments under monthly billing will reflect 30 days of premium. If single payment is selected, the quoted premium amount will reflect the premium for the number of days selected.

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Automatic Bank Withdrawal

Please print.
Account holder's name

Bank name

Routing #

Account #

❑ I authorize Humana to draw premium payment from the account above.

Alternate Payor Signature _____ Date __ __/__ __/__ __ __

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: _____