

# HumanaOne Dental & Vision Enrollment Form



Requested Effective Date: \_\_\_/\_\_\_/\_\_\_

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

ILLINOIS

Reason for change \_\_\_\_\_ Change/Modification to Existing Policy or Plan # \_\_\_\_\_

## 1. Coverage Options Please complete this section when selecting a dental or vision product.

<input type="checkbox"/> <b>Dental Coverage</b>	<input type="checkbox"/> <b>Vision Coverage</b>
Product Name _____	Product Name _____

## 2. Primary Insured 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 # _____				

## 3. Family Information

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

<b>Spouse</b> First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth ___/___/___
Social Security # _____		E-mail _____		
<b>Dependent</b> First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth ___/___/___
Social Security # _____		E-mail _____		
<b>Dependent</b> First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth ___/___/___
Social Security # _____		E-mail _____		
<b>Dependent</b> First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth ___/___/___
Social Security # _____		E-mail _____		

## 4. Agent / Producer Information This section to be completed by Agent or Producer.

<b>1. Agent/Agency of Record (for commissions and correspondence)</b>	<b>2. Writing Agent / Producer:</b>
Name (print) _____	Name (print) _____
Humana Agent # _____	Humana Agent # _____

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary insured submitting this enrollment form 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 insured in the benefit summary document or other product literature.

Writing agent's signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

## 5. 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 any agent or producer 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. This product enrolled for is not an employer-sponsored group insurance plan and it does not comply with state or federal small employer laws. I certify that I do not qualify for or have willingly waived a group insurance plan or receive favorable tax treatment under federal or state law that will be used to pay insurance premiums. If this enrollment form for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate. 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 enrollment form may be used by Humana during the first two certificate 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 enrolling for coverage, I attest by my signature below, that I have gathered the necessary insurance information from my dependent in order to fully and truthfully complete this enrollment form. This document, together with any supplements, will form part of and be the basis for any certificate issued. Membership in the Association is required, at an additional cost, in order to be eligible for insurance coverage. The Association is a membership organization that provides educational information and discounts on goods and services to its members. The Association benefits information will be sent under separate cover. I understand while covered by this product that I must at all times be a member of the Association.

**Any person who submits an enrollment form 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 an insurance product or to give you insurance benefits.**

Primary Insured or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Relationship of Legal Guardian \_\_\_\_\_

Spouse Signature (if covered dependent) \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

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

**Dental products insured by HumanaDental Insurance Company**  
**Vision products insured by Humana Insurance Company**

# HumanaOne Payment & Billing Authorization and Association Enrollment



This form is for:  New Business (First time enrollee)  Reinstatement (Reenrollment)  
 Change/Modification to Existing Policy or Plan

Reason for change \_\_\_\_\_ Change/Modification to Existing Policy or Plan # \_\_\_\_\_

## Quoted Dental Payment Amount:

\$ \_\_\_\_\_ (total payment for all products selected; not including administrative or enrollment fees)

## Quoted Vision Payment Amount:

\$ \_\_\_\_\_ (total payment for all products selected; not including administrative or enrollment fees)

## Total Payment Amount:

\$ \_\_\_\_\_ (total payment for all products selected; not including administrative or enrollment fees)

## Additional Charges

- Association Dues: 75¢ Monthly
- Administrative Fee: \$1 Fee applies to each payment, (no fee applies to annual payments)
- Enrollment Fee (Dental Preventive Plus, Dental Prepaid C550 Plan, Vision Focus Plan, Vision Care Plan): \$35 One-Time Fee per plan, (non-refundable)

## Payor Information

If you are paying for the plan(s), please provide the following information. Then tell us how you would like to pay for the plan(s) by completing the Payment Options section below. If you will be paying for someone else's plan(s), please also complete the Alternate Payor section below.

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

**Alternate Payor:** If you are paying for an insurance plan(s) for someone else, please provide the following information about the primary insured whose plan(s) you will be paying for. Please note, if you are paying for someone else's plan(s), you will be responsible for signing this authorization to withdraw funds from your selected accounts; not the primary insured.

<b>Primary Insured</b> First name	MI	Last name
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## 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 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 charges from my designated account until this authorization is revoked by me.

**Please note: Please include a blank voided check when you submit your payment form to:**

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

**I understand this is a minimum one-year contract and is non-refundable and non-cancellable.**

Payor Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Association agreement is necessary to be eligible for the following products:** Dental Preventive Plus, Vision Focus Plan, Vision Care Plan

## 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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_