

USAeHealth

Application Instructions for Humana

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to USAeHealth for review along with the completed application. If you do not have access to a fax machine, send the completed application to USAeHealth along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Humana** if you are not paying by credit card for the first month.

Mail completed applications and check to:

USAeHealth
Attn: New Enrollment
PO Box 528

Gunter, TX 75058

USAeHealth will review your application for completeness and accuracy before we submit it to Humana for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 903-821-3000 or e-mail us at linda@usaehealth.com.

Norvax form #IN-1

USAeHealth

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

****Please FAX this cover letter with the completed application to:**

USAeHealth

FAX# 903-433-2000

Dear USAeHealth,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

Please contact me at this phone number _____
after you have reviewed my application for completeness and accuracy.

I will contact USAeHealth at 903-821-3000 to verify receipt of my application.

****I understand that USAeHealth will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend**

I understand that the original, signed application and premium payment must still be mailed to USAeHealth. :

USAeHealth

Attn: New Enrollment

PO Box 528

Gunter, TX 75058

I will send the original, signed application and premium payment, as soon as I have been contacted by USAeHealth with confirmation that my application has been received by fax and reviewed for completeness.

Application preparation checklist



Agent name Linda McConnell

Humana agent number 1468331

Thank you for considering HumanaOne. Please review the following information and complete the checklists prior to applying. All applicants 18 years and older will be required to review and sign the application. If you have questions, refer to your benefit summary or contact your agent.

Individual Health Plans

Please indicate the date you would like coverage to begin. Applicants who have not had major medical coverage within 63 days of applying must choose an effective date 30 to 45 days after the date of application.

Requested date: _____

Please choose one of the following health plans. Note: Benefit options can be added to your plan for an additional cost.

Plan options	Deductible options		Benefit options (check all that apply):
	Single	Family	
<input type="checkbox"/> PORTRAIT Share 80 Plus Rx Unlimited	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500	\$2,000 \$5,000	<input type="checkbox"/> \$0 prescription deductible buy-up <input type="checkbox"/> Dental insurance <input type="checkbox"/> Additional \$3 million lifetime maximum <input type="checkbox"/> Supplemental accident benefit: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
<input type="checkbox"/> AUTOGRAPH Share 80 Plus Rx	<input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$6,000	\$7,000* \$10,000 \$12,000	<input type="checkbox"/> \$500 prescription deductible buy-up <input type="checkbox"/> Dental insurance <input type="checkbox"/> Additional \$3 million lifetime maximum <input type="checkbox"/> Supplemental accident benefit: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
<input type="checkbox"/> AUTOGRAPH Total / HSA	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,200	\$4,000 \$6,000 \$8,000 \$10,400	<input type="checkbox"/> Dental insurance <input type="checkbox"/> Additional \$3 million lifetime maximum <input type="checkbox"/> Supplemental accident benefit: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
<input type="checkbox"/> AUTOGRAPH Total Plus Rx / HSA	<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000	\$3,000 \$5,000 \$7,000 \$10,000	<input type="checkbox"/> Dental insurance <input type="checkbox"/> Additional \$3 million lifetime maximum <input type="checkbox"/> Supplemental accident benefit: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
<input type="checkbox"/> MONOGRAM Total Plus Rx	<input type="checkbox"/> \$7,500	\$15,000	<input type="checkbox"/> Dental insurance <input type="checkbox"/> Supplemental accident benefit: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
<input type="checkbox"/> Annual Max 75/55 (not available in all markets, contact your sales representative for details)	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000	\$3,000 \$6,000 \$9,000	<input type="checkbox"/> Annual maximum <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> Outpatient services maximum <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 ((\$10K only available with \$250K) <input type="checkbox"/> Dental insurance <input type="checkbox"/> Supplemental accident benefit: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
<input type="checkbox"/> Annual Max 50/30 (not available in all markets, contact your sales representative for details)	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000	\$3,000 \$6,000 \$9,000	<input type="checkbox"/> Annual maximum <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> Outpatient services maximum <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 ((\$10K only available with \$250K) <input type="checkbox"/> Dental insurance <input type="checkbox"/> Supplemental accident benefit: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000

* Not currently available in all states

All applications are subject to approval. Plans have limitations, exclusions and waiting periods. Above deductible options are in-network, out-of-network deductibles also apply. Dental insurance is not available in Indiana.

Term Life Insurance

1. Are you purchasing term life insurance? yes no
2. Are you replacing your current insurance? yes no
If yes, please have your insurance company name, policy number and face amount/value available.
3. Coverage amount \$ _____
(coverage amounts start at \$25,000 and can go up to a maximum of \$150,000)
4. Term: 10 years 15 years 20 years
5. Name of beneficiary _____
6. Relationship of beneficiary _____

Personal information

If applying for spousal coverage, both the primary and applicant and his/her spouse must authorize requests for medical information. Please have the following information (for yourself and, if applicable, spouse and/or dependents) available prior to applying:

- Agent name and/or ID number or, preferably, quote reference number.
- Demographics (date of birth, height and weight).
- Medical history (diagnosis, type of treatment and date of service at clinics, facilities and/or hospitals).
- Doctors' and hospitals' information, including name, city and state within the past 10 years.
- Current/past prescription information, including name, dosage and frequency within the past 10 years.
- Current/past insurance coverage information, including carrier name, effective and termination dates.
- Medical history preparation:
 - If you have high blood pressure, have your last three readings (taken in the past 6 months) available including the date of the reading.
 - If you have high cholesterol, have your most recent readings available including: a) reading completion date b) total cholesterol c) HDL d) LDL and e) triglyceride.

Method of payment

For the initial payment, we accept Visa, MasterCard or automatic bank withdrawal*.

After the initial payment, recurring payment choices include:

- Monthly (automatic bank withdrawal*, paper or e-mail bill**)
- Quarterly (paper or e-mail bill**)
- Semi-annually (paper or e-mail bill**)

* If you choose automatic bank withdrawal, we will need your checking or savings account number, routing number and address of the institution.

** There is a processing fee (\$10 in most states) with the direct paper and e-mail bill option per statement.

How to apply

You can apply either online or by telephone. Application calls take an average of 40 minutes, depending on the number of applicants and their medical history.

- To apply online, please click on the hyperlink in the e-mailed quote your agent prepared and sent to you, or go to **HumanaOneApplication.com/?HumanaAgent=**
- To apply over the telephone, or if you have any questions call **1-800-552-0758**

Monday–Thursday	7 a.m. – 8 p.m.	Central Standard Time
Friday	7 a.m. – 6 p.m.	Central Standard Time
Saturday	9 a.m. – 3 p.m.	Central Standard Time



Applications subject to approval. Waiting periods, limitations and exclusions apply. Insured by Humana Insurance Company, Humana Health Plan, Inc., Humana Health Insurance Company of Florida, Inc., Humana Employers Health Plan of Georgia, Inc. and Humana Insurance Company, Humana Health Benefit Plan of Louisiana, Inc., HumanaDental Insurance Company, or The Dental Concern, Inc. For residents of Arizona and Texas: Insured by Humana Insurance Company.