# 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 & Vision Application

HUMANA *one*

GEORGIA

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

This form 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 or vision product.**

| ❑ **Dental Coverage** | ❑ **Vision Coverage** |
|---|---|
| Product Name | Product 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 # | | | | |

## 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 | | | |

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

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

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

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

| **1. Agent/Agency of Record (for commissions and correspondence)** | **2. Writing Agent / Producer:** |
|---|---|
| Name (print) Health Plans of Georgia | Name (print) Steven McClelland |
| Humana Agent # 1217829 | 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 __ __/__ __/__ __ __ __

## 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 applied for is not an employer-sponsored group insurance policy 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 policy or 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 Humana*One* 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 insurance 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.

**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 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 application as "Humana."

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

# HumanaOne Payment & Billing Authorization and Association Enrollment

HUMANA one

## ❑ 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 |
|---|---|---|---|
| ❑ Preventive Plus | $16.99 | $32.98 | $56.97 |
| ❑ 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 |
|---|---|---|---|
| ❑ Preventive Plus | $191.88 | $383.76 | $671.64 |
| ❑ 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 ❑ Discover

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.

### ❑ C. Check or Money Order

Choose one: ❑ Annual Payment ❑ Monthly Payment

**Please make check or money order payable to Humana Insurance Company. Mail completed enrollment form, payment form 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

### ❑ 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 withdrawls, 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 __ __/__ __/__ __ __ __