

**MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM
SPONSORED GROUP PLAN**

To enroll in Humana® Group Medicare (PDP) please provide the following information:

Desired Effective Date: _____

LAST Name:		FIRST Name:		MIDDLE Initial:	Mr. Mrs. Ms.
Birth Date: (____/____/____) (M M / D D / Y Y Y Y)		Sex: M F	Social Security Number:		Home Phone Number: ()
Permanent Residence Street Address:					
City:			State:	ZIP Code:	
Mailing Address (only if different from your Permanent Residence Address):					
Street Address:		City:	State:	ZIP Code:	
Email Address:					
Phone Number (Optional)					

Please Provide Your Medicare Insurance Information

<p>Please take out your Medicare Card to complete this section.</p> <ul style="list-style-type: none"> Please fill in these blanks so they match your red, white and blue Medicare card. <p align="center">- OR -</p> <ul style="list-style-type: none"> Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board. <p>You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.</p>	<p>Name: _____</p> <p>Medicare Beneficiary Identifier (MBI) _____ - _____ - _____</p> <table style="width:100%;"> <tr> <td style="width:70%;">Is Entitled To</td> <td style="width:30%;">Effective Date</td> </tr> <tr> <td>HOSPITAL (Part A)</td> <td>_____</td> </tr> <tr> <td>MEDICAL (Part B)</td> <td>_____</td> </tr> </table>	Is Entitled To	Effective Date	HOSPITAL (Part A)	_____	MEDICAL (Part B)	_____
Is Entitled To	Effective Date						
HOSPITAL (Part A)	_____						
MEDICAL (Part B)	_____						

PLEASE READ THIS IMPORTANT INFORMATION

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Humana, he/she may be paid based on my enrollment in Humana.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay for all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

By completing this enrollment application, I agree to the following:

The Humana Group Medicare PDP is a Medicare drug plan that has a contract with the Federal government and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform Humana of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I can only be in one Medicare prescription drug plan at a time and if I am currently in a Medicare prescription drug plan, my enrollment in Humana Group Medicare PDP will end that enrollment. Enrollment in this plan is generally for the entire year. Once I've enrolled in this Humana plan, I can change or cancel my Humana coverage at any time and return to Original Medicare or another Medicare Advantage plan using a special election. However, I may not be eligible to return to the group plan or change plans outside of the group's open enrollment period. I can receive details of my options by calling my plan administrator or customer service.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Humana when I get it to know which rules I must follow in order to get coverage with this Medicare drug plan. I understand that I must use network pharmacies to access Humana benefits, except under limited, non-routine circumstances when I cannot reasonably use Humana network pharmacies.

I understand that I am enrolling into a Humana Medicare Advantage Plan or a Humana Medicare Prescription Drug Plan and not a Medicare Supplement, Medigap, Medicare Select, or Medicaid plan.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Humana will release my information to Medicare and other plans as necessary for treatment, payment and health care operations. I also acknowledge that Humana will release my information (including my prescription drug event data) to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Humana the Part D-IRMAA.

Signature:

Today's Date:

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