

# HumanaOne Paper Application Checklist

## Contact information:

- › Fax Applications to:  
1-866-217-2122
- › For Agents  
Agent Service Center  
1-800-833-2572
- › For Applicants  
Agency Application Team  
1-800-552-0758

## To ensure faster processing, please follow these tips when submitting a paper application.

- Ensure you are contracted with Humana, licensed in the state the applicant resides, and appointed with Humana at the time the application is sold.
- Keep the original application and submit a faxed copy to the HumanaOne Paper Application team at 1-866-217-2122.
- Your packet includes state-specific information which you are required to share with your client based on their insurance needs. Please be sure to carefully review these forms and provide them to your client before beginning their application. If you have any questions about how these forms are to be used, please contact the Agent Service Center at 1-800-833-2572.
- For applicants without current or prior coverage (within the last 63 days), effective dates may be no earlier than 30 days after the application is received by Humana.
- Submit all pages of the most current application and any additional state-specific documents.
- Complete and clearly print Agent/Broker/Producer information, including Agent listed, Agent name, Agent SAN, and Agent signature.
- The effective date should be "mm/dd/yyyy." If you include "ASAP" or "immediate" we'll call to ask for the requested effective date.
- Clearly write the name of the plan, including deductible, and all options checked "yes" or "no."
- Provide all applicant/dependent information including names, dates of birth, heights, weights, and contact information.
- If an applicant answers "yes" to any health question, then the "Additional Information" section must be completed.
- If the applicant answers "yes" to questions 1 or 2, please also include the condition.
- An applicant's signature and responses to health questions will not be accepted if crossed-out and/or correction fluid is used to change original information.
- Alternate payers and any applicant 18 years or older must sign and date before the application is submitted.
- Do not use agent payment information, or business payment information (except for sole proprietors). Please note that in Florida we cannot accept any business payments, whether or not the business is a sole proprietorship.

Please note: When a standard offer is made, the policy is auto-issued. Underwriting will not send additional documents.

**HUMANA**  
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## **Pre-Notice**

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Information regarding your insurability will be treated as confidential. Humana or its reinsurers, may, however make a brief report thereon to Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Humana, or its reinsurers, may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

# HumanaOne Individual Insurance Application



Please print clearly in ink. Complete all questions. Fill in all fields or indicate "not applicable."

If you have not had continuous health coverage within the past 63 days, you must choose an effective date that is 30-45 days past the date of the application.

**COLORADO**

Date of application: \_\_\_/\_\_\_/\_\_\_ Requested Effective Date: \_\_\_/\_\_\_/\_\_\_

- This application is for:
- New Business (First time applicant)
  - Reinstatement (Reapplication)
  - Change/modification to existing policy

Reason for change \_\_\_\_\_

Change/Modification to Existing Policy # \_\_\_\_\_

## Health & Dental Coverage Options

### Health Coverage

Please complete this section when selecting a health plan.

Plan name \_\_\_\_\_

Deductible \$ \_\_\_\_\_

### Dental Coverage

- Dental

**Please note:** You may purchase dental coverage if health coverage is chosen. If dental is selected, it will be approved if the health coverage is approved. If you are changing or modifying an existing/approved policy, dental is only available at your anniversary.

### Optional Benefits

Please select an optional benefit if available with chosen health plan.

- Office visit copay
- Prescription drug deductible:  \$0  \$500
- Lifetime Maximum Buy-Up
- Supplemental Accident Benefit:  \$500  \$1000

## Life Coverage Options

Please complete this section if choosing the term life rider or the term life plan for primary applicant and/or spouse.

Please include an additional page if you need to list multiple beneficiaries. Each additional page must be signed and dated.

### Primary Applicant:

- \$20,000 Term Life Rider (can only be purchased with a health plan)

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

- Term Life Plan (Minimum selection is \$25,000 and \$1,000 increments)

Term life insurance amount: \$ \_\_\_\_\_

Term length:  10 years  15 years  20 years

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

### Spouse:

- \$20,000 Term Life Rider (can only be purchased with a health plan)

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

- Term Life Plan (Minimum selection is \$25,000 and \$1,000 increments)

Term life insurance amount: \$ \_\_\_\_\_

Term length:  10 years  15 years  20 years

Primary beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Contingent beneficiary name \_\_\_\_\_

Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

## Primary Applicant/Insured Information

If child-only coverage is requested, the youngest child is the Primary Applicant/Insured. Questions must be filled out by custodial parent or legal guardian.

First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Home address (not P.O. Box)			City		State	ZIP code
Social Security #		Country or State of birth		Email		
Type of business or industry	Occupation		Home phone # ( )		Daytime phone # ( )	
Mailing address (if different from home address)			City		State	ZIP code
Policyholder name if different than Primary Applicant (applicable for child-only application)						

**Parent or Guardian Information**

Please complete this section if Primary Applicant/Insured is under 18 years of age.

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

**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.

<b>Spouse</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Country or State of birth	Spouse's type of business or industry		Spouse's occupation			
Social Security #			Email			

<b>Dependent 1</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

<b>Dependent 2</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

<b>Dependent 3</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

<b>Dependent 4</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Full-time student (if 18 or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

**Existing Coverage**

**IMPORTANT: DO NOT** cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

• Existing Health Coverage

If you are applying for health coverage, please provide the status of current coverage, including Humana, for each applicant. If additional space is needed, please attach additional pages. Each additional page must be signed and dated.

No  Yes Do you or anyone applying for coverage have any health insurance coverage currently in force?

- If yes, please supply the following for all applicants on the policy:**  
 Name(s) of covered persons \_\_\_\_\_  
 Insurance Carrier Name \_\_\_\_\_ Effective Date \_\_\_/\_\_\_/\_\_\_\_

• Existing Dental Coverage

1.  No  Yes Does anyone applying for coverage currently have or had any group or individual dental coverage within the last 18 months?

- If yes, please supply the following for all applicants on the policy:**  
 Name(s) \_\_\_\_\_ Effective Date \_\_\_/\_\_\_/\_\_\_\_  
 Insurance Carrier Name \_\_\_\_\_ Termination Date \_\_\_/\_\_\_/\_\_\_\_  
 Name(s) \_\_\_\_\_ Effective Date \_\_\_/\_\_\_/\_\_\_\_  
 Insurance Carrier Name \_\_\_\_\_ Termination Date \_\_\_/\_\_\_/\_\_\_\_

2.  No  Yes Will the insurance coverage applied for be used to replace existing dental coverage?

• Existing Life Coverage

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**Primary Applicant:**

1.  No  Yes Do you have any life insurance and/or annuity coverage currently in force?  
2.  No  Yes Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage?

• **If yes, please supply the following information:**

Company name	Amount \$	Policy #
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**Spouse:**

1.  No  Yes Do you have any life insurance and/or annuity coverage currently in force?  
2.  No  Yes Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage?

• **If yes, please supply the following information:**

Company name	Amount \$	Policy #
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**Eligibility & Health Status**

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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. All requested health information including routine physical exams and information related to spouse and dependents applying for coverage must be provided. If any of the answers are "yes", please provide complete details. Failure to disclose any health information may result in your policy being modified or terminated, back to your original effective date.

1.  No  Yes Is anyone applying for coverage a citizen of a country other than the United States?

• **If yes:** Name(s):

**Has anyone applying for coverage:**

2.  No  Yes Experienced weight gain or loss of more than 20 pounds in the past 12 months?  
3. Within the past 12 months, has the primary applicant or spouse applying for coverage used any tobacco product?  
**Primary applicant:**  No  Yes **If yes:**  One time or less per week  More than once per week  
**Spouse:**  No  Yes **If yes:**  One time or less per week  More than once per week  
4.  No  Yes Does anyone applying for coverage plan to participate in any dangerous or extreme sport activities?  
5.  No  Yes Is the applicant, spouse or any of their dependents pregnant or an expectant mother or father?

**Within the past 5 years, has anyone applying for coverage:**

6.  No  Yes Been denied for health or life insurance or had their health coverage ridered, rated or rescinded?  
7.  No  Yes Been treated for, or been advised or counseled that they have acquired immune deficiency syndrome (AIDS), or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?  
8.  No  Yes Had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any alcohol abuse, dependency or problem, or had any alcohol related arrests?  
9.  No  Yes Used any illegal or taken prescription drugs not prescribed by their health care provider or had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any drug abuse, dependency or problem; or had any drug related arrests?  
10.  No  Yes Had any testing or procedure performed that has been abnormal or the results of which are pending or unknown?  
11.  No  Yes Had or been advised to have inpatient or outpatient surgery, that is complete or has not been completed?  
12.  No  Yes Consulted, been advised or recommended to have follow-up testing or treatment by a health care provider or specialist that has not been completed?

## Eligibility & Health Status continued

13. **Within the past 5 years**, has anyone applying for coverage had signs of, been prescribed medication or received injections for, or been diagnosed with or treated for:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Chest pain or Heart Attack	M. <input type="checkbox"/> No <input type="checkbox"/> Yes Behavioral, Emotional, Mental or Nervous Disorder
B. <input type="checkbox"/> No <input type="checkbox"/> Yes High Blood Pressure or Hypertension	N. <input type="checkbox"/> No <input type="checkbox"/> Yes Eating Disorder
C. <input type="checkbox"/> No <input type="checkbox"/> Yes High Cholesterol or Triglycerides	O. <input type="checkbox"/> No <input type="checkbox"/> Yes Developmental Disorder or Delay
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Cancer or Tumor of any kind	P. <input type="checkbox"/> No <input type="checkbox"/> Yes Human Papilloma Virus or Sexually Transmitted Disease
E. <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes or High Blood Sugar	Q. <input type="checkbox"/> No <input type="checkbox"/> Yes Infertility
F. <input type="checkbox"/> No <input type="checkbox"/> Yes Stroke	R. <input type="checkbox"/> No <input type="checkbox"/> Yes Cyst, Growth, Lump or Polyp
G. <input type="checkbox"/> No <input type="checkbox"/> Yes Paralysis	S. <input type="checkbox"/> No <input type="checkbox"/> Yes Hernia
H. <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy or Seizure	T. <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis
I. <input type="checkbox"/> No <input type="checkbox"/> Yes Migraines or frequent or severe headaches	U. <input type="checkbox"/> No <input type="checkbox"/> Yes Implants, Pins, Plates, Rods Screws or Prosthesis
J. <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis	V. <input type="checkbox"/> No <input type="checkbox"/> Yes Connective Tissue or Autoimmune Disorder
K. <input type="checkbox"/> No <input type="checkbox"/> Yes Sleep Apnea	W. <input type="checkbox"/> No <input type="checkbox"/> Yes Birth Defect
L. <input type="checkbox"/> No <input type="checkbox"/> Yes Anxiety or Depression	

14. **Within the past 5 years**, has anyone applying for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Gallbladder, Liver or Pancreas	G. <input type="checkbox"/> No <input type="checkbox"/> Yes Breasts
B. <input type="checkbox"/> No <input type="checkbox"/> Yes Colon, Esophagus or Stomach	H. <input type="checkbox"/> No <input type="checkbox"/> Yes Menstrual Cycle
C. <input type="checkbox"/> No <input type="checkbox"/> Yes Bladder or Kidneys	I. <input type="checkbox"/> No <input type="checkbox"/> Yes Cervix, Ovaries, Uterus or Vagina
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Back, Disc, Neck or Spine	J. <input type="checkbox"/> No <input type="checkbox"/> Yes Penis, Prostate or Testicles
E. <input type="checkbox"/> No <input type="checkbox"/> Yes Lungs	K. <input type="checkbox"/> No <input type="checkbox"/> Yes Skin
F. <input type="checkbox"/> No <input type="checkbox"/> Yes Eyes, Ears, Nose, Throat or Sinuses	

15. **Within the past 5 years**, has anyone applying for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

A. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood Vessels, Heart or Circulatory System	E. <input type="checkbox"/> No <input type="checkbox"/> Yes Urinary System
B. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood, Gland, Pituitary, Thyroid or Lymph System	F. <input type="checkbox"/> No <input type="checkbox"/> Yes Musculoskeletal System
C. <input type="checkbox"/> No <input type="checkbox"/> Yes Brain or Nervous System	G. <input type="checkbox"/> No <input type="checkbox"/> Yes Respiratory System
D. <input type="checkbox"/> No <input type="checkbox"/> Yes Digestive System	H. <input type="checkbox"/> No <input type="checkbox"/> Yes Reproductive System

16.  No  Yes Has anyone applying for coverage seen a health care provider or specialist for any reason (including routine visits) or symptom not previously disclosed above?

17.  No  Yes Within the past 24 months, has anyone applying for coverage been advised to take or taken any prescription medications or injections?

## Additional Eligibility or Health Status Question Information

To be completed if anyone applying for coverage answered "Yes" to any question(s) in the Eligibility & Health Status section. Please provide details such as; specific condition, dates of treatment, results or advice given, medication (dosage and frequency), treatment plan, recovery date, physician name and address. Attach an additional health information sheet if necessary. Additional information sheets must be signed and dated by the primary applicant or legal representative and/or spouse (if applying).

Question #	Letter	Person treated	Condition
Details:			
Question #	Letter	Person treated	Condition
Details:			
Question #	Letter	Person treated	Condition
Details:			

## 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 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. This policy applied for is not an employer-sponsored group health 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 health plan 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. 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. By signing below, I agree to terminate existing coverage if approved. 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.*

**It is unlawful to knowingly provide false, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.**

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

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

Spouse Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(if covered dependent)

### Agent / Producer Information

This section to be completed by Agent or Producer.

#### 1. Agent/Agency of Record:

Name (print) Roper Insurance  
Humana Agent # \_\_\_\_\_

#### 2. Writing Agent / Producer:

Name (print) Steven J. Roper  
Humana Agent # \_\_\_\_\_

#### Agent replacement question:

**Will this policy replace or change any existing life insurance policy(s) and/or annuity(s)?**  No  Yes

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the applicant in the benefit summary document or other plan literature.

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

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  
Dental products insured by HumanaDental Insurance Company**

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# Medical Records Release Authorization

## Purpose of the Authorization

By signing the form, you will authorize the disclosure and use of the protected health information described below for pre-enrollment underwriting or risk-rating of health insurance coverage for you, or to determine your eligibility for enrollment or benefits under a health plan.

## Information we will use and/or disclose

My dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., employer or the Consumer Reporting Agency having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness and copies of all hospital or medical records, non-public personal health information, and any other non-medical information to share any and all such information with the Company, its reinsurer or its legal representatives, and its affiliates.

- The information obtained by use of this authorization may be used by the Company to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
- Any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing health care operations or business or legal services in connection with any application, claim or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report and I (we) may request a copy of the report.
- Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.

## Expiration and revocation

- A copy of this authorization is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below. I have the right to revoke this authorization at any time.  
To revoke this authorization:
  - I must do so in writing and send my written revocation to Humana's Privacy Office.
  - The revocation will not apply to information that has already been released in response to this authorization.
  - The revocation may adversely affect my application, a claim or a pending insurance action.
  - The revocation will become effective after it is received by Humana's Privacy Office.

**It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.**

**If you decide not to sign this authorization, we will decline to enroll you in a medical plan or to give you medical benefits.**

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

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

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

Child Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(if covered dependent over the legal age)

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  
Dental products insured by HumanaDental Insurance Company**

**HUMANA**  
*Guidance when you need it most*

# Determination of Self-Employed Business Group of One



All applicants must complete the questions below to determine if you meet the legal definition of a "self-employed business group of one" in Colorado.

**COLORADO**

1.  No  Yes Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees?
2.  No  Yes Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?
3.  No  Yes Do you have gross income from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years?  
*Note: Substantial part of your income means income derived from business activities of the business group of one that are sufficient to pay for the annual premiums for the business group of one's health benefit plan.*
4.  No  Yes Do you work a minimum of 24 hours a week on a permanent basis?

If you answered NO to ANY of the questions above, please sign and date the form below.

If you answered YES to ALL of the above questions, please complete the following information, then review, sign & date the form below.

If you waive coverage for a family member who will not be covered by this policy, you must list the other coverage for that dependent and when it becomes effective.

Spouse First name	MI	Last name	Name of coverage	Effective Date ___/___/___
Dependent 1 First name	MI	Last name	Name of coverage	Effective Date ___/___/___
Dependent 2 First name	MI	Last name	Name of coverage	Effective Date ___/___/___
Dependent 3 First name	MI	Last name	Name of coverage	Effective Date ___/___/___

Please read and sign the following disclosure required by Colorado law:

I, \_\_\_\_\_, meet the definition of a self-employed business group of one as attested to on the  
(name of applicant)

above Determination of Self-Employed Business Group of One Form. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period.

I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of plan design, my age, my health status and that of my dependents, overall cost and utilization trends, and tobacco use. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited to plan design, the carrier's overall cost and utilization trends ("index rate"), my age, my family size, and a factor that reflects the cost of care where I live.

I have been given a health plan description form showing the benefits under Colorado's small group Standard Health Benefit Plans. I have also been given a Colorado Health Plan Description Form for the plan for which I am applying.

I, hereby attest that the answers to the questions contained in this form are true and correct.

Date: \_\_\_\_\_

(Signature of applicant)



# HumanaOne Individual Insurance Payment Authorization & Billing Form



## Quoted Monthly Payment Amount:

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

- PPO Annual Max Plan Association Dues: \$3.95 Monthly (non-refundable)
- Dental Preventive Plus Association Dues: 75¢ Monthly (non-refundable) (no dues apply if enrolled in PPO Annual Max Plan Association)
- Administration Fee (DHMO, Dental Preventive Plus & Vision Direct): \$1 Fee applies to each payment
- Enrollment Fee (Vision Direct & Dental Preventive Plus): \$35 One-Time Fee per plan (non-refundable)
- Dental DHMO Enrollment Fee: \$19 One-Time Fee (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 1 and 2 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 applicant 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 applicant.

<b>Primary Applicant</b> First name	MI	Last name
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## 1. Initial Payment Options

Please choose either credit card or one-time bank withdrawal payment of the first month's payment. Initial payment for each product applied for will be drafted separately against your account.

### A. Credit Card Payment

Visa       Mastercard

Card # \_\_\_\_\_

Expiration date      /

Cardholder's name \_\_\_\_\_

I authorize Humana to draw initial payment of \$ \_\_\_\_\_ and fees from my Visa / Mastercard account.

### B. One-time Automatic Bank Withdrawal

Account holder's name \_\_\_\_\_

Bank name \_\_\_\_\_

Routing # \_\_\_\_\_

Account # \_\_\_\_\_

I authorize Humana to draw initial payment of \$ \_\_\_\_\_ and fees from my designated checking account.

## 2. Subsequent Payment Options

Please indicate billing preference. If choosing automatic bank withdrawal, please complete the section to the right.

### A. Credit Card Payment (monthly billing)

If selected a fee of \$ \_\_\_\_\_ will apply.

Mastercard

Card # \_\_\_\_\_

Expiration date      /

Cardholder's name \_\_\_\_\_

I authorize Humana to draw subsequent payment of \$ \_\_\_\_\_ and fees from my Mastercard account until this authorization is revoked by me.

### B. Automatic Bank Withdrawal (monthly billing)

Account holder's name \_\_\_\_\_

Bank name \_\_\_\_\_

Routing # \_\_\_\_\_

Account # \_\_\_\_\_

I authorize Humana to draw subsequent payment of \$ \_\_\_\_\_ and fees from my designated checking account until this authorization is revoked by me.

### C. Direct Bill

If selected a fee of \$ \_\_\_\_\_ will apply.

Monthly billing

Quarterly billing

Semi-Annual billing

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

**COLORADO IMPORTANT NOTICE:  
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?      \_\_\_\_\_ YES      \_\_\_\_\_ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?      \_\_\_\_\_ YES      \_\_\_\_\_ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) FINANCING (F)
1 _____			
2 _____			
3 _____			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because \_\_\_\_\_.

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Name and Signature	Date
Agent's Name and Signature	Date

I do not want this notice read aloud to me. \_\_\_\_\_ (Applicants must initial only if they do not want the notice read aloud.)

**HUMANA.**  
*one*  
 Insured by Humana Insurance Company

## Colorado Commission Disclosure Individual Health & Dental Insurance

As part of this health insurance solicitation we are required by state law to advise you that should you purchase health insurance from us, that Roper Insurance & Financial Services will receive compensation in the form of a commission.

### Commission Schedules

Aetna	Rate Level A Rate Level B Rate Level C	15% first year, 5% renewal years 12% first year, 4% renewal years 10% first year, 3% renewal years	
Anthem	20% first year, 5% renewal years		
Assurant	20% first year, 5% renewal years		
Cigna	20% first year, 5% renewal years		
Delta Dental	8%		
HumanaOne	20% first year, 5% renewal years		
International Medical Group (IMG)	Patriot Series - 10%		
Kaiser	\$13.50 per head		
United Healthcare (Golden Rule)	First Year		
	Number of Issued Policies/Certificates	Issue Age 60 and Under	Issue Age Over 60
	1-7	15%	8%
	8-11	20%	10%
	12+	22%	12%
	Renewal Years - 5%		
Rocky Mountain	20% first year, 5% renewal years		

I acknowledge receipt of this Commission Disclosure:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Producer: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name \_\_\_\_\_