

# Dental & Vision Application



California

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

**Dental products insured by Humana Insurance Company**

**Vision products insured by Humana Insurance Company**

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

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

- This application is for:  New Business (First time applicant)  
 Reinstatement (Reapplication)  
 Change/Modification to Existing Coverage

Reason for change \_\_\_\_\_ Change/Modification to Existing Coverage # \_\_\_\_\_

## 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

## Proposed Primary Insured Information

First name	MI	Last name		
Social Security #	Primary phone #		Secondary phone #	
E-mail			Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth
Home address (not P.O. Box)		City	State	ZIP code

## Dependent Information

Please complete only if your spouse and/or dependent children are applying for coverage. Attach an additional dependent information sheet if necessary. Each additional page must be signed and dated. All references of spouse in this application include domestic partner/civil union partner/reciprocal beneficiary.

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

## Agreement and Signature

**True and Complete Acknowledgment:** To the best of my knowledge or belief, 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 any required disclosures. Neither I nor the agent have the right to waive or incompletely answer any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements. This plan applied for is not an employer-sponsored group plan and it does not comply with state or federal small employer laws. I do not qualify for or have willingly waived an employer group insurance 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. Acceptance of premium and fees does not guarantee coverage. Any false statement(s) made with actual intent to deceive 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 information from my dependent in order to fully and truthfully complete this application.

*This document, together with any supplemental forms, will make up part of any contract and be the basis for any policy issued.*

**California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

**Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud.**

**If you decide not to sign this agreement, we will decline to approve you in an insurance product or to give you insurance benefits.**

Proposed Primary Insured or Legal Guardian Signature

\_\_\_\_\_ Date \_\_\_\_\_

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

Spouse Signature (if covered dependent)

\_\_\_\_\_ Date \_\_\_\_\_

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

**Agent / Agency of Record:** (for commissions and correspondence)

Name (print)

Humana Agent #

**Writing Agent / Producer:**

Name (print)

Humana Agent #

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

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

The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.