

# Enrollment Application



Follow these easy steps to apply for a Humana Medicare Supplement insurance policy.

## 1 Have Your Medicare Card Ready

Please print legibly and complete the entire form. You will need to fill in the information exactly as it appears on your Medicare card. Each person must complete a separate application.

## 2 Read and Complete Other Coverage Information

Be sure you read and understand the information before completing this section. **If you intend to replace your current Medicare Supplement policy or Medicare Advantage plan with this policy, be sure to complete the enclosed form titled Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage.**

**Please note: If you are under the age of 65 and have been diagnosed with End Stage Renal Disease (ESRD) you are not eligible to apply for coverage.**

## 3 Complete Open Enrollment and Guaranteed Issue

Please fill out this section if you are eligible for open enrollment or guaranteed issue. If you are submitting a Notice of Replacement, please provide the criteria qualifying you for guaranteed acceptance on the form. For example, if you qualify for guaranteed acceptance due to a Medicare Advantage plan exit, please check “Disenrollment from a Medicare Advantage plan” and indicate that your plan is exiting the market and no longer available.

## 4 Read and Complete Medical Questions

If you are applying for coverage during your Medicare Supplement Open Enrollment Period or qualify for guaranteed issue, do not complete the medical questions. Refer to Section 8 for assistance in determining if you qualify for either open enrollment or guaranteed issue.

## 5 Determine Your Premium

Do not complete this section if you are applying for coverage during your Medicare Supplement Open Enrollment Period or qualify for guaranteed issue. Refer to Section 8 for assistance in determining if you qualify for either open enrollment or guaranteed issue.

## 6 Be Sure to Include Your Initial Premium Payment

Your first month’s premium payment must be included. This is necessary even if you choose our Automatic Bank Withdrawal or Auto Credit Card Charge options for future premium payments.

## 7 Sign and Date the Enrollment Application

# Humana®

# Marking Instructions

- Please print clearly and press hard.
- **Use blue or black ink only.**
- Completely fill the ovals.

**Correct Mark**



**Incorrect Marks**



- Print legible numbers and capital block letters in the boxes.

**Correct Numbers and Letters**

1 2 3 A B C

- Print only one character per box.
- If you make a mistake, correct it by crossing out the box and writing the letter/number above or below the box as shown. Be sure to initial any and all corrections made.

T  
S | M | I | ~~R~~ | H

- When filling out dates, such as effective dates or birth dates, be sure dates appear in the MMDDYYYY format. No dashes or spaces are necessary.

0 | 3 | 2 | 4 | 2 | 0 | 1 | 0

**Required Fields  
Must Be Completed**

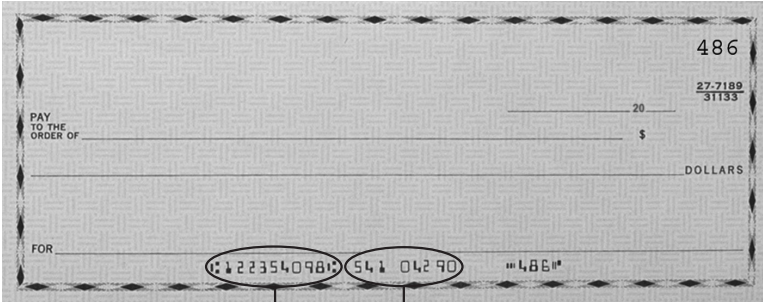


**Optional  
Fields**



## Sample Void Check

(If you are choosing the auto bank withdrawal.)



**Routing Number    Account Number**

1

LAST NAME

[Grid of 15 boxes for last name]

FIRST NAME

[Grid of 15 boxes for first name]

MI

[Box for middle initial]

ADDRESS

[Grid of 25 boxes for address]

APT OR STE#

[Grid of 5 boxes for apartment or suite number]

ADDRESS (continued)

[Grid of 15 boxes for continued address]

COUNTY

[Grid of 15 boxes for county]

CITY

[Grid of 25 boxes for city]

STATE

[Grid of 2 boxes for state]

ZIP CODE

[Grid of 5 boxes for zip code]

TELEPHONE

[Grid of 10 boxes for telephone number]

DATE OF BIRTH

[Grid of 8 boxes for date of birth: MM/DD/YYYY]

GENDER  M  F

MAILING ADDRESS (only if different from above street ADDRESS)

[Grid of 25 boxes for mailing address]

APT OR STE#

[Grid of 5 boxes for mailing apartment or suite number]

CITY

[Grid of 25 boxes for mailing city]

STATE

[Grid of 2 boxes for mailing state]

ZIP CODE

[Grid of 5 boxes for mailing zip code]

E-MAIL ADDRESS (optional)

[Grid of 30 boxes for email address]

(E-mail address, if available, will be used as a means to communicate only coverage information.)

Select the policy you are applying for:

- Plan A
- Plan B
- Plan C\*
- Plan F\*
- High Deductible Plan F\*
- Plan G
- High Deductible Plan G
- Plan K
- Plan L
- Plan N

\*Only applicants eligible for Medicare prior to 1/1/2020 may purchase Plan C, Plan F and High Deductible Plan F.

PROPOSED EFFECTIVE DATE

[Grid of 8 boxes for proposed effective date: MM/DD/YYYY]

Please complete the information below as it appears on your Medicare card.

MEDICARE NUMBER

[Grid of 9 boxes for Medicare number]

IS ENTITLED TO

HOSPITAL INSURANCE (PART A)

EFFECTIVE DATE

[Grid of 8 boxes for effective date: MM/DD/YYYY]

MEDICAL INSURANCE (PART B)

[Grid of 8 boxes for effective date: MM/DD/YYYY]

PERSON TO NOTIFY IN AN EMERGENCY (optional):

LAST NAME

[Grid of 15 boxes for emergency last name]

FIRST NAME

[Grid of 15 boxes for emergency first name]

MI

[Box for emergency middle initial]

RELATIONSHIP TO APPLICANT

[Grid of 25 boxes for relationship to applicant]

TELEPHONE

[Grid of 10 boxes for telephone number]

AGENT NUMBER (SAN)

[Grid of 6 boxes for agent number]

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## 2 Other Coverage Information

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medi-Cal or Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medi-Cal or Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medi-Cal or Medicaid eligibility.\*
- If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan.\*

\*If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

- Counseling services are available in this state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, or access the department's Internet Web site, [www.Insurance.ca.gov](http://www.Insurance.ca.gov), and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.
- A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet Web site ([www.Insurance.ca.gov](http://www.Insurance.ca.gov)).

**Yes or No answers are required to the following questions. If you have lost, or you are losing or replacing, health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed issue in one or more of our Medicare Supplement plans. A copy of the notice from your prior insurer may be requested.**

**PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.**

- Did you turn age 65 in the last six months?  Yes  No
  - Did you enroll in Medicare Part B in the last six months?  Yes  No  
If yes, what is the effective date? 

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- Are you under the age of 65 and eligible for Medicare due to End Stage Renal Disease (ESRD)?  Yes  No
- Are you covered for medical assistance through California's Medi-Cal program?  Yes  No  
(NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.)
  - If yes, will Medi-Cal pay your premiums for this Medicare Supplement policy?  Yes  No
  - Do you receive any benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?  
 Yes  No
- If you had coverage from any Medicare plan other than Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START 

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END 

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Grid for entering Medicare number

- a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?
b. Was this your first time in this type of Medicare plan?
c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?
5. Do you have another Medicare Supplement policy in force?
a. If so, with what company?
What plan do you have?
b. If so, do you intend to replace your current Medicare Supplement policy with this policy?
6. Have you had coverage under any other health insurance within the past 63 days?
a. If so, with what company?
What policy do you have?
b. What are your dates of coverage under this policy?
c. Do you intend to replace your current healthcare coverage with this Medicare Supplement policy?

3 Open Enrollment and Guaranteed Issue

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. Refer to Section 8 for assistance in determining if you qualify for either open enrollment or guaranteed issue.

- 1. Are you applying for coverage during your Medicare Supplement Open Enrollment Period?
2. Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed issue?
3. Have you lost or are you losing Medi-Cal or Medicaid coverage which qualifies you for guaranteed acceptance?
If you answered yes to any question in this section, you qualify for the Preferred rates. Please refer to the Outline of Coverage for rates.

4 Medical Questions

IF YOU ARE APPLYING FOR COVERAGE DURING YOUR MEDICARE SUPPLEMENT OPEN ENROLLMENT PERIOD OR QUALIFY FOR GUARANTEED ISSUE, DO NOT COMPLETE THE FOLLOWING MEDICAL QUESTIONS.

A MEDICAL RECORDS RELEASE AUTHORIZATION FORM IS REQUIRED. Refer to Section 8 for assistance in determining if you qualify for either open enrollment or guaranteed issue.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

HEIGHT [ ] FT [ ] [ ] IN WEIGHT [ ] [ ] [ ] LBS

- 1. Have you been hospitalized within the last year?
2. Have you been confined to a nursing facility within the last year?
3. Are you bedridden?
4. Are you confined to a wheelchair?

5. Have you used supplementary oxygen within the last year? .....  Yes  No  Not Sure
6. Have you received Home Health care within the last 90 days?.....  Yes  No  Not Sure
7. Have you ever been treated or diagnosed by a physician or medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? (NOTE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.) .....  Yes  No  Not Sure
8. Do you currently have, or in the past 3 years have you had, been diagnosed with, or had a physician or medical professional advise you to have treatment for any of the following?
  - Adrenal Gland Disorder .....  Yes  No  Not Sure
  - Alcohol or drug abuse .....  Yes  No  Not Sure
  - Alzheimer’s or Dementia .....  Yes  No  Not Sure
  - Amputation.....  Yes  No  Not Sure
  - Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig’s Disease) .....  Yes  No  Not Sure
  - Aneurysm .....  Yes  No  Not Sure
  - Artificial openings for feeding or elimination .....  Yes  No  Not Sure
  - Atrial fibrillation (A-fib) or heart arrhythmias.....  Yes  No  Not Sure
  - Bed sore (Decubitus Ulcer) .....  Yes  No  Not Sure
  - Blood clots.....  Yes  No  Not Sure
  - Brain tumor.....  Yes  No  Not Sure
  - Carotid Artery Disease .....  Yes  No  Not Sure
  - Cerebral hemorrhage .....  Yes  No  Not Sure
  - Cerebral Palsy (CP) .....  Yes  No  Not Sure
  - Chest pain (Angina Pectoris) or heart attack.....  Yes  No  Not Sure
  - Chronic Obstructive Pulmonary Disease (COPD) (Chronic Bronchitis or Emphysema)  Yes  No  Not Sure
  - Chronic Kidney Disease (CKD) .....  Yes  No  Not Sure
  - Cirrhosis of the liver.....  Yes  No  Not Sure
  - Coma, brain compression/anoxic damage or severe head injury .....  Yes  No  Not Sure
  - Crohn’s Disease .....  Yes  No  Not Sure
  - Cystic Fibrosis (CF) .....  Yes  No  Not Sure
  - Depression or Bipolar Disorders .....  Yes  No  Not Sure
  - Diabetes with acute complications.....  Yes  No  Not Sure
  - Diabetes with neurologic or peripheral circulatory manifestation.....  Yes  No  Not Sure
  - Diabetes with ophthalmologic manifestation.....  Yes  No  Not Sure
  - Diabetes with renal manifestation.....  Yes  No  Not Sure
  - Enlarged heart (Cardiomyopathy).....  Yes  No  Not Sure
  - Epilepsy (seizure disorder or convulsions).....  Yes  No  Not Sure
  - Extensive third degree burns .....  Yes  No  Not Sure
  - Hardening of the heart arteries (Coronary Artery Disease) (CAD or CHD) .....  Yes  No  Not Sure
  - Heart failure (Congestive Heart Failure) (CHF) .....  Yes  No  Not Sure
  - Hemophilia .....  Yes  No  Not Sure
  - Hepatitis B or C .....  Yes  No  Not Sure
  - Hip fracture or dislocation .....  Yes  No  Not Sure
  - Huntington’s Disease.....  Yes  No  Not Sure
  - Internal cancer.....  Yes  No  Not Sure
  - Intestinal obstruction/perforation .....  Yes  No  Not Sure

12 empty boxes for Medicare number

- Kidney failure (renal failure) or End Stage Renal Disease (ESRD)
Leukemia
Lupus (Systemic Lupus Erythematosis)
Malnutrition
Marfan Syndrome
Multiple Sclerosis (MS)
Muscular Dystrophy
Myasthenia Gravis (MG)
Organ transplant
Paget's Disease
Pancreatitis
Paralysis
Parkinson's Disease
Peripheral Vascular Disease (PVD)
Pneumonia
Polymyositis
Respirator dependence
Rheumatoid Arthritis
Schizophrenia
Sickle Cell Anemia
Slipped disc (Degenerative Disc Disease)
Spinal cord disorders or injuries
Spinal Stenosis
Stroke (Cerebral Vascular Accident) (CVA)
Suicide attempt
Tuberculosis
Ulcerative Colitis
Uncontrolled high blood pressure (Hypertension)
Uncontrolled high cholesterol

9. Please list any prescription drugs (full medication name) you are currently taking or have taken within the past 12 months:

Three horizontal lines for listing prescription drugs

5 Premium Determination

Do not complete these questions if applying during your Medicare Supplement Open Enrollment Period or if you qualify for Guaranteed Issue as indicated in Section 3. Refer to Section 8 for assistance in determining if you qualify for either open enrollment or guaranteed issue. All other applicants must answer these questions.

- 1. Did you have Medicare coverage prior to age 65?
2. Have you used tobacco products within the last 12 months?

If your application is accepted, and you answered No to both questions, you qualify for the Preferred rates. To determine your premium, refer to your Outline of Coverage.







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## Section 8 – Open Enrollment and Guaranteed Issue Guidelines

In some situations, you are eligible for Open Enrollment or Guaranteed Issue of a Medicare Supplement Plan. If one of the following conditions applies to you, you are eligible for a Medicare Supplement Plan on a guaranteed acceptance basis (“Eligible Person”) and do not complete the medical questions in Section 4 of the Application.

### Open Enrollment

You are eligible for Open Enrollment if you meet one of the following requirements

- A. You apply for a Medicare Supplement Plan insurance policy prior to or during the six- month period beginning with the first day of the month in which you are enrolled for benefits under Medicare Part B and:
  - (i) You are at least age 65, or
  - (ii) You are less than age 65 and eligible for Medicare on account of total disability (other than End Stage Renal Disease). If you are notified retroactively of your eligibility for Medicare, you are eligible for the six month period following notice of eligibility.
- B. You are enrolled in Medicare Part B and you apply for a Medicare Supplement Policy within six months of one of the following events:
  - (i) You are enrolled in an employer sponsored health plan (including an employer sponsored retiree health plan, COBRA and Cal-COBRA) and
    - the plan terminates, or
    - you are enrolled under the plan as a spouse and are losing coverage under the plan due to death or divorce from your spouse, or
  - (ii) You are a military retiree or the spouse or dependent of a military retiree and you are losing access to health care services as the result of a military base closure, the base no longer offers services or you relocate, or
  - (iii) You are covered under a Medicare supplement policy and coverage terminated because you established residency in a location not served by the issuer of the Medicare supplement policy for which you are enrolled, or
  - (iv) Due to an increase in your income or assets, you are no longer eligible for Medi-Cal benefits, or you are only eligible for Medi-Cal benefits with a share of cost and you certify at the time of application that you have not met the share of cost.
  - (v) If you are enrolled in a Medicare Advantage plan and that coverage is terminated by the Medicare Advantage plan, you are entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation.
- C. If you are enrolled in a Medicare supplement policy, you may change your plan or insurer during an annual open enrollment period of 60 days beginning on your birthday. Your purchase is limited to any Medicare supplement policy that offers benefits equal to or lesser than those provided by the previous coverage.

You must submit evidence that you have Medicare Parts A and B with your Application.

With respect to the Open Enrollment events outlined previously:

**Pre-Existing Conditions** - This policy does not pay benefits for loss which occurs within 90 days after the effective date as a result of a pre-existing condition. A pre-existing condition is any injury or illness for which the insured has received or has had recommended, medical advice or treatment during the six months before the effective date. Please note that pre-existing conditions will be covered after 90 days from the effective date. This exclusion does not apply to loss which occurs more than 90 days after the effective date.

If you apply for the policy during the 6 month period beginning with the first of the month in which you are eligible, and as of the date you apply you had a continuous period of Creditable Coverage of at least 90 days, the pre-existing conditions limitation will not apply to you.

If you apply for the policy during the 6 month period beginning with the first of the month in which you eligible, and as of the date you apply you had a continuous period of Creditable Coverage of less than 90 days, the pre- existing conditions limitation will be reduced by the aggregate of the period of Creditable Coverage applicable as of your

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enrollment date.

With respect to Guaranteed Issue outlined below, the pre-existing conditions exclusion will not be applied.

### Guaranteed Issue

You are eligible for Guaranteed Issue for a Medicare Supplement Plan policy if you apply for the policy in the Guaranteed Issue Time Periods described below and you meet one of the following conditions:

1. You are enrolled in an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and
    - the plan terminates or ceases to provide such supplemental health benefits to you; or
    - the employer no longer provides you with insurance that covers all of the payment for the 20% coinsurance.
  2. You are enrolled with a Medicare Advantage organization under a Medicare Advantage Plan (the “Plan”) under Medicare Part C or under a Program of All-Inclusive Care for the Elderly (PACE) and any of the following apply:
    - The certification of the organization or plan under this part has been terminated; or
    - The organization has terminated or otherwise discontinued providing the Plan in the area in which you reside; or
    - You are no longer eligible to elect the Plan because:
      - (i) of a change in your place of residence or other change in circumstances specified by the Secretary of the Department of Health and Human Services (the “Secretary”), excluding those circumstances where you were disenrolled from the Plan for any of the reasons described in Section 1851 (g)(3)(B) of the federal Social Security Act (e.g., where you have not paid premiums on a timely basis, or you have engaged in disruptive behavior as specified in standards under Section 1856); or
      - (ii) the Plan is terminated for all enrollees residing within a particular residential service area.
    - You are enrolled in a Medicare Advantage Plan and that plan reduces benefits, increases the amount of cost sharing or premium or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to you. Under this subparagraph, you may be eligible for a Medicare supplement policy issued by the same issuer through which you were enrolled at the time the reduction, increase or discontinuance occurred or one issued by a subsidiary of the parent company of that issuer or by a network that contracts with the parent company of that issuer. If no Medicare supplement contract is available to you from the same issuer, a subsidiary of the parent company of that issuer or a network that contracts with the parent company of the issuer, you may be eligible for a Medicare supplement policy if the Medicare Advantage plan in which you are enrolled does any of the following:
      - (i) increases the premium by 15 percent or more;
      - (ii) increases physician, hospital or drug copayments by 15 percent or more;
      - (iii) reduces any benefits under the plan; or
      - (iv) discontinues, for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual,
- However, enrollment shall be permitted only during the annual election period for a Medicare Advantage plan, except where the Medicare Advantage plan has discontinued its relationship with a provider currently providing services to you.
- You demonstrate, in accordance with guidelines established by the Secretary, that:
    - (i) The organization offering the Plan substantially violated a material provision of the organization’s contract with the Centers for Medicare and Medicaid Services in relation to you, including the failure to provide you, on a timely basis, with medically necessary care for which benefits are available under the Plan, or the failure to provide such covered care in accordance with applicable quality standards; or
    - (ii) The organization or agent or other entity acting on the organization’s behalf, materially misrepresented the Plan’s provisions in marketing the Plan to you; or
  - You meet such other exceptional conditions as the Secretary may provide.

3. You are enrolled with:

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- An eligible organization under a contract under Section 1876 (Medicare cost); a similar organization operating under demonstration project authority, effective for periods before April 1, 1999; an organization under agreement under section 1833(a)(1)(A) (health care prepayment plan); or an organization under a Medicare SELECT policy; and
  - Your enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Guaranteed Issue situation #2 above.
4. You are enrolled in a Medicare supplement policy and the enrollment ceases because:
    - Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or
    - Of other involuntary termination of coverage or enrollment under the policy; or
    - The issuer of the policy substantially violated a material provision of the policy; or
    - The issuer or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to you.
  5. You were enrolled under a Medicare supplement policy and you terminate enrollment and subsequently enroll, for the first time, with (1) any Medicare Advantage organization under a Medicare Advantage Plan under Medicare Part C; (2) any eligible organization under a contract under Section 1876 (Medicare cost); (3) any similar organization operating under demonstration project authority; (4) any PACE program under Section 1894 of the Social Security Act; (5) any organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or (6) a Medicare SELECT policy, and enrollment under this section is terminated by you during any period within the first 12 months of such subsequent enrollment (during which you are permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act).
  6. You, upon first becoming enrolled for benefits under Medicare Part A at age sixty-five or older, enroll in a Medicare Advantage Plan under Medicare Part C, or in a PACE program under Section 1894 of the Social Security Act, and disenroll from the plan no later than 12 months after the effective date of enrollment.
  7. You enroll in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, were enrolled under a Medicare supplement policy that covers outpatient prescription drugs and you terminate enrollment in the Medicare supplement policy and submit evidence of enrollment in Medicare Part D along with the application for a policy.

### Guaranteed Issue Time Periods

- In the case of an individual described in situation #1, the guaranteed issue period begins on the later of: (i) the date you receive a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days after the date of the applicable notice;
- In the case of an individual described in situations #2, #3, #5 or #6 whose enrollment terminated involuntarily, the guaranteed issue period begins on the date that you receive a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;
- In the case of an individual described in situation #4 (insolvency of the issuer or bankruptcy of the non-issuer organization), the guaranteed issue period begins on the earlier of: (i) the date that you receive a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated;
- In the case of an individual described in situations #2, #4 (issuer or the policy substantially violated a material provision of the policy), #4 (the issuer or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to you), #5 or #6 who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;
- In the case of an individual described in situation #7, the guaranteed issue period begins on the date you receive notice from the Medicare supplement issuer during the sixty (60) day period immediately preceding the Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D;
- In the case of an individual described in this Guaranteed Issue Guide but not described in the preceding



Insured by Humana Insurance Company

**Humana.**<sup>®</sup>