HUMANA.

Insured by Humana Insurance Company

Individual Product Application

TEXAS

Please print clearly in ink and answer all questions or indicate "not applicable."

Date of Application_____ Requested effective date_____Effective date cannot be prior to the application date.

Is this Application for:

☐ New Business (1st time applicant) ☐ Reinstatement (reapplication)

☐ Change/modification to existing Policy Current Policy Number_____ Reason_____

Primary Applicant Information - If child-only coverage is being requested, the youngest child is the Primary Applicant.

Last name | First name | M.I. | Gender

Address | City | State | Zip Code | Height | Weight

Birth Date | Country/State of Birth | Social Security Number

Home Phone Number ( ) | Daytime Phone Number ( ) | Driver's License Number

Type of business or industry | Occupation

Email address (If you are 18 years of age or older)

Policy owner information if other than Primary Applicant.

Family Information - Please complete only if your spouse and/or dependent children are applying for coverage.

Spouse's type of business or industry | Spouse's occupation

Name and Middle Initial (include last name if different from Primary Applicant)	Birthdate	Social Security Number	Gender	Height	Weight	Full-time student (Y / N)
Spouse:						
Child:						
Child:						
Child:						
Child:						

Parent or Guardian Information - Please complete this section if Primary Applicant is under 18 years of age.

Parent or Guardian Full Legal Name | Relationship to Child(ren)

Parent or Guardian's Social Security Number | Email address

General Eligibility - Please answer for all individuals applying for coverage.

Within the past 10 years have you or any of your dependents been previously denied, rated or had health conditions excluded or ridered from life, disability, annuity or health insurance coverage? ☐ NO ☐ YES If yes, please supply the following:

Name of person(s) | Reason | Date

Have you or any of your dependents applying for coverage spent more than 2 months outside of the U.S. in the last year or intend to spend more than 2 months outside of the U.S. in the next year? ☐ NO ☐ YES If yes, please provide details including location:

Are you or any of your dependents applying for coverage a U.S. citizen? ☐ NO ☐ YES

If not a U.S. citizen, have you or any of your dependents applying for coverage been a permanent legal resident of the U.S. for the past 2 years? ☐ NO ☐ YES If yes, please attach a copy of your resident Green Card for each applicant.

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Individual Health

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Health Plan Options

$_____deductible

Doctor office visit copay rider ☐ NO ☐ YES
$0 Prescription Drug Deductible ☐ NO ☐ YES
Dependent Child Therapy Coverage ☐ NO ☐ YES

Existing Health Coverage

Do you or any of your dependents currently have any group or individual health plan coverage? ☐ NO ☐ YES

If yes, please supply the following:

Name

Insurance Carrier Name Telephone Number

Policy Number or Group Number Effective Date Termination Date

Will the insurance coverage applied for be used to replace existing health coverage? ☐ NO ☐ YES

If yes, have you or any of your dependents had this existing health coverage within the last 18 months? ☐ NO ☐ YES

IMPORTANT: It is important that you do not cancel any existing health coverage until you receive notification from US of your acceptance for coverage.

Options with Medical Coverage - If health coverage is approved, you may purchase the additional options below.

$20,000 Term Life Rider

☐ Primary Applicant Beneficiary_____ ☐ Spouse Beneficiary_____

Billing information

Who will be paying for this plan(s)?

Name Address

Telephone Number ( ) Relationship to Applicant(s)

Initial Payment Options

Initial payment must total one month's premium for each product selected. Agent/Producer payments are not accepted.

Please choose your preference for payment of 1st months premium.

☐ Credit or Debit Card ☐ One time bank withdrawal ☐ Other

Subsequent Payment Options

Please indicate both billing preference and payment method.

☐ **Monthly:** ☐ Automatic bank withdrawal ☐ Direct Bill ☐ Other

☐ **Quarterly** (Direct Bill)

☐ **Semi-Annual** (Direct Bill)

Please complete automatic bank withdrawal information, credit or debit card authorization section.

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Evidence of Health Status

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For this insurance to be issued, the following health questions must be answered fully and truthfully to the best of your knowledge and your belief, and all of the health information (including routine physical exams) must be provided. If any of the answers are "YES", please provide complete details.

Please answer for you and any of your dependents applying for coverage

Have you or any of your dependents:

1. Had a positive home pregnancy test in the last 90 days, or are currently an expectant parent? ☐ NO ☐ YES
2. Is any male listed on this application expecting a child with anyone, whether or not the mother is listed on the application? ☐ NO ☐ YES
3. Within the past 24 months been advised to have or had a check-up, consultation, electrocardiogram, x-ray, lab tests, or other diagnostic tests? ☐ NO ☐ YES
4. Within the past 24 months had any surgery or been advised to have surgery, which has not yet been completed, including surgery performed by a dentist or oral surgeon? ☐ NO ☐ YES
5. Within the past 10 years had cosmetic or reconstructive surgery, a prosthesis, monitoring device, pacemaker, valve or joint replacement, implant, or internal fixation (i.e. pins, plates, screws, etc.)? ☐ NO ☐ YES
6. Within the past 10 years had any signs or symptoms of chronic fatigue, fever, loss of appetite, oral thrush, recurrent infections or weight loss with no known cause? ☐ NO ☐ YES
7. Within the past 10 years have you or any dependent been diagnosed by a physician as having acquired immunodeficiency syndrome (AIDS) or AIDS related complex? ☐ NO ☐ YES

In the past 10 years, have you or any dependents applying for coverage been treated for, had symptoms of, or been advised or counseled that they have or may have had any of the following:

	Yes	No
8. Respiratory Disorder		
a. Allergies, Asthma or Bronchitis	☐	☐
b. Emphysema, Pneumonia or Shortness of Breath	☐	☐
c. Sleep Apnea	☐	☐
d. Tuberculosis or Cystic Fibrosis	☐	☐
9. Circulatory Disorder		
a. Edema, Phlebitis or Varicose Veins	☐	☐
b. Elevated Cholesterol or Triglycerides	☐	☐
c. High Blood Pressure or Hypertension	☐	☐
d. Stroke or Transient Ischemic Attack (TIA)	☐	☐
10. Heart Disorder		
a. Angina, Chest Pain or Heart Attack	☐	☐
b. Congenital Heart Disorder	☐	☐
c. Coronary Artery Disease or Congestive Heart Failure	☐	☐
d. Heart Murmur, Mitral Valve Prolapse, Valve Disorder or Irregular Heartbeat	☐	☐
11. Digestive Disorder		
a. Gastroesophageal Reflux Disease (GERD), or Heartburn	☐	☐
b. Ulcer, Gastritis or Hernia	☐	☐
c. Irritable Bowel Syndrome, Colitis or Crohn's Disease	☐	☐
d. Diverticulitis, Diverticulosis or Hemorrhoids, Colon Polyps	☐	☐
e. Cirrhosis or Hepatitis	☐	☐
f. Stomach, Liver, Pancreas, Spleen or Gallbladder Disorder	☐	☐
12. Congenital or Development Disorder		
a. Autism, Down's Syndrome or Mental Retardation	☐	☐
b. Cleft Palate or Cleft Lip	☐	☐
c. Club Feet	☐	☐
d. Huntington's Chorea	☐	☐
13. Cyst or Tumor		
a. Cancer, Carcinoma or Melanoma	☐	☐
b. Cyst, Growth, Lump, Mass or Tumor	☐	☐
c. Lupus	☐	☐
14. Eyes, Ears, Nose or Throat Condition		
a. Disorder of the Ear, Ear Infections or Tubes In Ears	☐	☐
b. Hearing Loss or Cochlear Implants	☐	☐
c. Disorder of the Nose, Deviated Septum or Sinus Infection	☐	☐
d. Meniere's, Labyrinthitis or Vertigo	☐	☐
e. Disorder of the Throat, Tonsils or Adenoids	☐	☐
f. Blindness, Cataracts or Glaucoma	☐	☐
g. Speech Impairment		
15. Skin Conditions		
a. Acne or Rosacea	☐	☐
b. Eczema or Psoriasis	☐	☐

	Yes	No
16. Brain or Nervous Disorder		
a. Alzheimer's, Dementia or Memory Loss	☐	☐
b. Multiple Sclerosis or Paralysis	☐	☐
c. Cerebral Palsy or Parkinson's	☐	☐
d. Epilepsy or Seizures	☐	☐
e. Headaches or Migraines	☐	☐
17. Emotional or Mental Disorder		
a. Anxiety or Depression	☐	☐
b. Attention Deficit Disorder	☐	☐
c. Eating Disorder	☐	☐
d. Psychiatric or Psychological Counseling	☐	☐
18. Female Reproductive Disorder		
a. Disorder of the Breast or Abnormal Mammogram	☐	☐
b. Menopausal Disorder	☐	☐
c. Endometriosis, Infertility, Uterine Fibroids or Pelvic Inflammatory Disease	☐	☐
d. Complication of Pregnancy/Cesarean Section	☐	☐
e. Sexually Transmitted Disease	☐	☐
f. Cervical, Ovarian, Uterine or Vaginal Disorder	☐	☐
g. Abnormal Pap Smear or Menstrual Disorder	☐	☐
19. Male Reproductive Disorder		
a. Penile, Prostate or Testicular Disorder	☐	☐
b. Sexually Transmitted Disease	☐	☐
c. Infertility or Sexual Dysfunction	☐	☐
20. Blood, Gland, Endocrine or Lymph Node Disorder		
a. Diabetes, High or Low Blood Sugar	☐	☐
b. Anemia	☐	☐
c. Obesity	☐	☐
d. Enlarged or Swollen Lymph Nodes	☐	☐
e. Thyroid Gland or Glandular Disorder	☐	☐
f. Blood, Gland, Endocrine or Lymph Node Disorder	☐	☐
21. Muscular Skeletal Disorder		
a. Arthritis, Bursitis, Tendonitis or Gout	☐	☐
b. Back or Spine Disorder	☐	☐
c. Connective Tissue Disorder	☐	☐
d. Fibromyalgia	☐	☐
e. Temporomandibular Joint Syndrome (TMJ)	☐	☐
f. Bone, Joint, Muscular or Neuromuscular Disorder	☐	☐
22. Genitourinary Disorder		
a. Bladder Infection or Cystitis	☐	☐
b. Kidney Disorder or Kidney Stones	☐	☐
23. Been seen or consulted by any doctor, or any other person providing health care services for any other condition not listed on this application?	☐	☐

Additional Health Question Information - To be completed if you or any dependent(s) answered "YES" to any question(s) in the Evidence of Health Status section. If more space is needed, attach a separate sheet. Each separate sheet must be signed and dated by the Primary Applicant, Dependent or Guardian, as applicable.

Person Treated:

Condition: Question Number:

Treatment Dates (past and future):

Last time seen by a doctor for this condition:

Physician Name/Address:

Person Treated:

Condition: Question Number:

Treatment Dates (past and future):

Last time seen by a doctor for this condition:

Physician Name/Address:

Medications

Have you or any of your dependents applying for coverage, taken any prescribed medications within the past 24 months?

If yes, please list all medications. You may use an additional sheet if necessary.

Family member Medication & dosage

Why was the medication prescribed Date prescribed

Date discontinued Physician Name Phone # Fax #

Physician address City State Zip code

Recreational Activity

Do you or any of your dependent(s) applying for coverage participate or plan to participate in any of the following activities: Bungee jumping, private aviation, motorized vehicle racing, rock climbing, rodeo events, scuba diving or sky diving? ☐ NO ☐ YES

If yes:

Name of person What activities When

Lifestyle

Have you or your spouse to be insured used any type of tobacco product in the past 12 months? ☐ NO ☐ YES

If yes, check all that apply:

☐ Primary Applicant
How frequently do you use tobacco?
☐ More than one time per week
☐ One time or less per week

☐ Spouse
How frequently do you use tobacco?
☐ More than one time per week
☐ One time or less per week

Have you or any of your dependents applying for coverage:

Been convicted for driving under the influence in the past 5 years? ☐ NO ☐ YES

Used any illegal, controlled drugs or substances in the past 10 years? ☐ NO ☐ YES

Been diagnosed as chemically or alcohol dependent within the past 10 years? ☐ NO ☐ YES

If yes: Name of person When

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Payment Authorization

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Please complete this section if you have selected the automatic bank withdrawal, credit or debit card payment options.

Automatic Bank Withdrawal Information

Account Holder's Name *(please print)*

☐ I authorize Humana Insurance Company to draw premium payment from account #_____ until this authorization is revoked by me.

Relationship to Applicant(s) | Phone Number

Bank Name | Address

Routing Number | Account Number

Credit or Debit Card Options

☐ Credit Card ☐ Visa

☐ Debit Card ☐ Mastercard

☐ I authorize Humana Insurance Company to bill my VISA/ Mastercard account for the initial payment.

Authorized Amount: $_____

Card No.: | | | | | | | | | | | | | | | | |

Expiration Date (MO/YR): | | / | |

Cardholder's Name:

Initial payment for each product applied for will be drafted separately against your account.

Humana Insurance Company

Agreement and Signature

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True and Complete Acknowledgment:

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers are, to the best of my knowledge and belief, true and complete.
- I have received and reviewed any state or federal required disclosures.
- Neither I nor my agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of the Company'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 a group health plan or receive favorable tax treatment under federal or state law.
- If this application for coverage is accepted, coverage will be effective on the date specified by the Company on the Policy. Acceptance of premium and fees does not guarantee coverage.
- To automatic withdrawal from my specified bank account for premium payment and administrative fees if selected under the product section.
- If I have selected the Pre-employment or College Graduate Health Plans to terminate coverage at the end of the reduced premium period if I have obtained substantially similar health insurance coverage.
- Premiums already paid will be refunded to me if a policy is not issued.
- Any misrepresentation of material fact or omission contained herein relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation of material fact or omission affects the acceptance of the risk.

This document, together with any supplements, will form part of any contract and be the basis for any Policy issued.

Authorization

My dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, 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 all hospital or medical records, non-public personal health information, to share with the Company, its reinsurer, or its legal representatives, and its affiliates, any and all such information.

My dependents and I understand and agree:

- 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. 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.
- We may request to receive a copy of this authorization.
- 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.

Any person who submits an application containing a false, incomplete or deceptive statement may be guilty of insurance fraud.

Applicant's Signature: X_____ Date_____

(if not of legal age, sign by Parent or Legal Guardian)

Spouse's Signature: X_____ Date_____

Payor's Signature: X_____ Date_____

(if other than insured)

Child's Signature: X_____ Date_____

(age 18 or older)

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Agent/Broker/Producer Information

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

Name (print)	Tax ID/Social Security Number
Commission split: ☐ No ☐ Yes If yes, percentage:	(total should equal 100%)

1. Writing Agent/Broker/Producer:

Name (print)	Social Security Number
Commission split: ☐ No ☐ Yes If yes, percentage:	(total should equal 100%)

2. Agent/Agency of Record (for split-commissions):

Name (print)	Tax ID/Social Security Number
Percentage of sales: ☐ No ☐ Yes If yes, percentage:	(total should equal 100%)

2. Writing Agent/Broker/Producer:

Name (print)	Social Security Number
Percentage of sales: ☐ No ☐ Yes If yes, percentage:	(total 100%)

Agent Replacement Question:

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

Writing Agent's Signature:_____Date:_____

Thank you for choosing HumanaOne.

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Individual Term Life Policy

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Term Life Plan for Primary Applicant

The amount of term life insurance I want is_____. (Minimum selection is $25,000)

Term length: ☐ 10 years ☐ 15 years ☐ 20 years

Primary Beneficiary Relationship

Secondary Beneficiary Relationship

Existing Life Coverage for Primary Applicant

Have any life insurance and/or annuity coverage currently in force? ☐ NO ☐ YES

Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage? ☐ NO ☐ YES If yes:

Company Name Amount Policy Number

Term Life Plan for Spouse

The amount of term life insurance I want is_____. (Minimum selection is $25,000)

Term length: ☐ 10 years ☐ 15 years ☐ 20 years

Primary Beneficiary Relationship

Secondary Beneficiary Relationship

Existing Life Coverage for Spouse

Have any life insurance and/or annuity coverage currently in force? ☐ NO ☐ YES

Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage? ☐ NO ☐ YES If yes:

Company Name Amount Policy Number