HumanaOne Dental Savings Plus Plan Enrollment Form

Humana.

Discount Only - Not Insurance

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

Products offered and administered by HumanaDental Insurance Company

Requested Effective Date: _____

This form is for: ❑ New Business (First time enrollee) ❑ Reinstatement (Reenrollment)

Are you a Humana Medicare member? If so, existing Humana Medicare Advantage customers are not eligible for this plan. Many of the discounts available through the Dental Savings Plus Plan may already be included in your Humana Medicare plan. Be sure to check and see before enrolling in the Dental Savings Plus Plan.

Enrollment Information

Attach an additional family information sheet if necessary. Each additional page must be signed and dated.

Primary First name	MI	Last name	
Social Security #	Gender ❑ M ❑ F	Date of birth	
Home address (not P.O. Box)	City	State	ZIP code
E-mail	Primary phone #	Secondary phone #	

Spouse First name	MI	Last name	
Gender ❑ M ❑ F	Date of birth		

Dependent/Household Member First name	MI	Last name	
Relationship to Primary	Gender ❑ M ❑ F	Date of birth	

Dependent/Household Member First name	MI	Last name	
Relationship to Primary	Gender ❑ M ❑ F	Date of birth	

Important Information

The following information describes the terms and conditions of the HumanaOne Dental Savings Plus Plan (the "Plan"), including any limitations or restrictions on the refund of any processing fees or periodic charges associated with the Plan.

1. **This Plan is <u>not</u> insurance.** There are no benefits payable to members, nor does Humana compensate providers for services they may render to members. This plan provides discounts at certain providers for services. This plan does not make payments directly to the providers of services. The Plan member is obligated to pay for all services received but will receive a discount from those providers who have contracted with Humana to provide services at a discount for members of the Plan.

2. The member may terminate the Plan at any time upon 30 days advance written notice. If the member cancels membership under the Plan within the first 30 days, then the member will receive reimbursement of all periodic charges paid other than money paid as a nominal one-time enrollment fee.

3. The Plan provides access to discounts from dental providers participating in the Plan. Humana may also, from time to time, and in its sole discretion, provide members with access to, free of charge, additional programs that offer access to health related services at discounted or special rates. Any such programs are offered by independently contracted vendors/providers who are not employees or agents of Humana or its affiliates. The providers of such "value-added" services are solely responsible for the products/services they provide and the member is solely responsible for payment of such products/services.

4. The Plan may not now, or in the future, be available in all states and Humana reserves the right to terminate the Plan in its entirety or in any state(s) or other geographic location(s) with 30 days' prior written notice to members. If Humana cancels the Plan membership for any reason other than nonpayment of charges, then it will make a pro-rata reimbursement of all periodic charges.

5. Any individual residing in the member's household may be added at any time by contacting Humana and paying the additional charges and fees, if applicable. The newly added individual's access to discount dental services will become effective on the date indicated by the Plan.

Phone: 1.800.542.1146

Payment Authorization

Amount for each payment (based on the payment option selected)

$_____ (includes Administration and Enrollment fees)

Primary Enrollee Information

Primary Enrollee First name	MI	Last name

Payer Information (if different from the Primary Enrollee)

First name	MI	Last name		Suffix
Mailing address		City	State	ZIP code
Primary phone #		Secondary phone #		

1. INITIAL Payment Options - Includes an initial non-refundable enrollment fee of $15.00.

Please choose either credit/debit card or one-time bank withdrawal of the first payment.

A. ONE-TIME AUTOMATIC BANK WITHDRAWAL

Bank name	Account holder's name
Routing #	Account #

B. ONE-TIME CREDIT/DEBIT CARD PAYMENT

Choose one: ❑ Visa ❑ Mastercard

Card #	Expiration Date /
Cardholder's name	

2. SUBSEQUENT Payment Options

Please select payment option for your billing cycle and payment preference for your payment.
If the monthly payment option is chosen, an Administration fee of $1.00 will apply.

A. RECURRING AUTOMATIC BANK WITHDRAWAL - Choose one: ❑ Monthly Payment ❑ Annual Payment

Choose one: ❑ Savings ❑ Checking

Bank name	Account holder's name
Routing #	Account #

B. CREDIT/DEBIT CARD - Choose one: ❑ Monthly Payment ❑ Annual Payment

Choose one: ❑ Visa ❑ Mastercard

Card #	Expiration Date /
Cardholder's name	

C. PAPER BILL - Choose one: ❑ Monthly Payment ❑ Annual Payment

Agreement and Signature

I understand and agree this product is not insurance. I also understand that the Dental Savings Plus Plan only provides discounts for services received from certain providers. I further understand that the Dental Savings Plus Plan does not make payment or reimbursement for services, and that I am obligated to pay for such services but will receive a discount upon proper identification prior to services being rendered. I agree to automatic withdrawal from my specified bank account or credit card for payment and administrative fees if selected on the Payment Authorization section. I also understand that the Dental Savings Plus Plan may not be combined with any other dental and/or vision coverage, insurance, or discount products. I acknowledge that I have read the Important Information statement. This authorization shall be effective unless otherwise revoked by me.

By my signature, I acknowledge that I am an authorized user of the account information provided.

➲ Primary Enrollee or Legal Guardian Signature

_____ Date_____

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

Agent / Agency of Record: (for commissions and correspondence)	**Writing Agent / Producer:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary enrollee submitting this enrollment form in order to fully and accurately represent the terms and conditions of the product and services.

➲ 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.