To apply for HumanaOne Dental or Vision Coverage;

Complete the attached application and return with your payment information to:

TennHealth Insurance Services
210 Hidden Hills Circle
Lexington, TN 38351

Or by Fax: 866-306-8009 (recommended)

For assistance, please call 731-968-8403.

HumanaOne Dental & Vision Enrollment Form

TENNESSEE

Requested Effective Date: __ __/__ __/__ __ __ __

This form is for: ❑ New Business (First time enrollee) ❑ Reinstatement (Reenrollment)
❑ Change/Modification to Existing Policy or Plan

Reason for change________________________________ Change/Modification to Existing Policy or Plan # ________________

1. Coverage Options **Please complete this section when selecting a dental or vision product.**

❑ **Dental Coverage**	❑ **Vision Coverage**
Product Name	Product Name

2. Primary Insured Information

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

3. Family Information

Please complete only if your spouse and/or dependent children are enrolling for coverage. Attach an additional family information sheet if necessary. Each additional page must be signed and dated.

Spouse First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Social Security #	E-mail			
Dependent First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Social Security #	E-mail			
Dependent First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Social Security #	E-mail			
Dependent First name	MI	Last name	Gender ❑ M ❑ F	Date of birth / /
Social Security #	E-mail			

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

1. Agent / Agency of Record: (for commissions and correspondence)	**2. 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 insured submitting this enrollment form 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 primary insured in the benefit summary document or other product literature.

Writing agent's signature ____ Date __ __/__ __/__ __ __ __

5. 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 to the best of my knowledge. I have received and reviewed any state or federal required disclosures. Neither I nor any agent or producer 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 product applied for is not an employer-sponsored group insurance 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 insurance plan or receive favorable tax treatment under federal or state law that will be used to pay insurance premiums. If this enrollment form for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate. Acceptance of premium and fees does not guarantee coverage. I agree to automatic withdrawal from my specified bank account or credit card for premium payment and administrative fees if selected on the HumanaOne Payment & Billing Authorization form. Any misrepresentation on this enrollment form may be used by Humana during the first two certificate 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 enrolling for coverage, I attest by my signature below, that I have gathered the necessary insurance information from my dependent in order to fully and truthfully complete this enrollment form. This document, together with any supplements, will form part of and be the basis for any certificate issued. Membership in the Association is required, at an additional cost, in order to be eligible for insurance coverage. The Association is a membership organization that provides educational information and discounts on goods and services to its members. The Association benefits information will be sent under separate cover. I understand while covered by this product that I must at all times be a member of the Association.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Primary Insured or Legal Guardian Signature ______________________________ Date __ __/__ __/__ __ __ __

Relationship of Legal Guardian ______________________________

Spouse Signature (if covered dependent) ______________________________ 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.

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

Dental products insured by HumanaDental Insurance Company
Vision products insured by Humana Insurance Company

HumanaOne Payment & Billing Authorization and Association Enrollment

This form is for: ❑ New Business (First time enrollee) ❑ Reinstatement (Reenrollment)
❑ Change/Modification to Existing Policy or Plan

Reason for change ______________________ Change/Modification to Existing Policy or Plan # ____________

PREMIUMS	1 member	2 members	3+ members
❑ Dental Plan	$13.99	$27.98	$48.97
❑ Vision Plan	$14.99	$27.99	$48.99

CHOOSE YOUR PLAN(S) by placing a check in the box

Additional Charges

- **Association Dues: 75¢ Monthly**
- **Administrative Fee: $1 Fee applies to each payment, (no fee applies to annual payments)**
- **Enrollment Fee: $35 One-Time Fee per plan, (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 the Payment Options section 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 insured 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 insured.

Primary Insured First name	MI	Last name

Payment Options

Please select payment option for your billing cycle and payment preference for your premium payment. Payment of premiums for each product enrolled in will be drafted separately against your account.

❑ A. Credit Card

Choose one: ❑ Annual Payment ❑ Monthly Payment

❑ Visa ❑ Mastercard ❑ Discover ❑ American Express

Card # Expiration date /

Cardholder's name

❑ I authorize Humana to draw premium payment (checked above) and charges from my credit card account until this authorization is revoked by me.

❑ B. Check or Money Order

Choose one: ❑ Annual Payment ❑ Monthly Payment

Please make check or money order payable to HumanaOne. Mail completed enrollment form, payment form and check or money order for the full amount of premium, association and enrollment fees to:

Humana Insurance Company
P.O. Box 769929
Roswell, GA 30076-8232

❑ C. Automatic Bank Withdrawal (Monthly Payment)

Choose one: ❑ Savings Account ❑ Checking Account

Account holder's name

Bank name

Routing #

Account #

❑ I authorize Humana to draw premium payment (checked above) and charges from my designated checking account until this authorization is revoked by me.

Please note: Please include a blank voided check when you submit your payment form to:

Humana Insurance Company
P.O. Box 769929
Roswell, GA 30076-8232

I understand this is a minimum one-year contract and is non-refundable and non-cancellable.

Payor Signature ______________________ Date __ __/__ __/__ __ __ __

Association Enrollment

The Association, Peoples' Benefit Alliance, is a membership organization that provides educational information and discounts on goods and services to its members. Membership in the Association is required, at additional cost, in order to be eligible for insurance coverage. The Association benefits information will be sent under separate cover. By signing below, you are requesting enrollment in the Association.

Primary Association Member or Legal Guardian Signature ______________________ Date __ __/__ __/__ __ __ __