Dental & Vision Application

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

Humana®

Texas

Dental products insured or offered by Humana Insurance Company or DentiCare, Inc.
Vision products insured or offered by Humana Insurance Company

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

Requested Effective Date: 1/1/2017

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.**

■ **Dental Coverage**		❑ **Vision Coverage**
Product Name Dental Value Plan (HI215)	Facility # (DHMO only)	Product Name

Proposed Primary Insured Information

First name Cevera	MI	Last name Stecker	
Social Security # 000003296	Primary phone # 2103658373	Secondary phone #	
E-mail ctsteck12@gmail.com	Gender ❑ M ■ F	Date of birth 12/4/1984	
Home address (not P.O. Box) 14303 Briarcircle St	City SAN ANTONIO	State TX	ZIP code 78247
Dentist name (DHMO only)			

Primary Language: ❑ English ❑ Spanish ❑ Other _____
When available, communications will be provided in the preferred language.

Please explain any disability affecting your ability to communicate or read. Please include an additional page if you need more space for your explanation. Each additional page must be signed and dated.

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.

Spouse First name: Travis	MI	Last name: Stecker	
Social Security #: 000007593	Gender ■ M ❑ F	Date of birth: 3/22/1980	
Dentist name (DHMO only)	Facility # (DHMO only)		
Dependent First name: Brooklyn	MI	Last name: Stecker	
Social Security #: 000007029	Gender ❑ M ■ F	Date of birth: 6/22/2004	
Dentist name (DHMO only)	Facility # (DHMO only)		
Dependent First name: Wesley	MI	Last name: Stecker	
Social Security #: 000005636	Gender ■ M ❑ F	Date of birth: 6/2/2002	
Dentist name (DHMO only)	Facility # (DHMO only)		
Dependent First name	MI	Last name	
Social Security #	Gender ❑ M ❑ F	Date of birth	
Dentist name (DHMO only)	Facility # (DHMO only)		

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. I have received and reviewed any state or federal 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 misrepresentation of material fact or omission 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 necessary insurance 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.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of 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)

Electronically Signed by Travis Stecker Date *11/28/16*

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) CO HUMANA INSURANCE	Name (print) CO HUMANA INSURANCE
Humana Agent # 1064625	Humana Agent # 1064625

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 *CO HUMANA INSURANCE* Date *11/28/2016*

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.

Additional Information

ADDITIONAL DETAILS PRIOR INSURANCE

ADDITIONAL DETAILS HEALTH SURVEY

Signature: _____ Date: _____