Humana.

Member ID:

DECLARATION OF PRIOR PRESCRIPTION DRUG COVERAGE

Date:_____

Enrollee First Name: _____ Enrollee Last Name: _____

Address:_____

Phone: _____

Name of Medicare Prescription Drug Plan: _____

Check all boxes that apply to you. Include coverage date(s). Add another page if necessary. Remember to sign at the bottom of the form.

☐	I had creditable* prescription drug coverage from an Employer/Union, including the Federal Employees Health Benefits Program (FEHBP).	From: MM/YY To: MM/YY
☐	I had creditable* prescription drug coverage from Medicaid, State Pharmaceutical Assistance Program (SPAP), or another plan sponsored by my state.	From: MM/YY To: MM/YY
☐	I had prescription drug coverage through my VA benefits (veterans, survivor, or dependent benefits).	From: MM/YY To: MM/YY
☐	I had prescription drug coverage through my TRICARE or other military coverage.	From: MM/YY To: MM/YY

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☐	I had a Medigap (Medicare Supplemental) policy with creditable* prescription drug coverage.	From: MM/YY/YY To: MM/YY/YY
☐	I had prescription drug coverage through the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian organization (I/T/U).	From: MM/YY/YY To: MM/YY/YY
☐	I had prescription drug coverage through PACE (Program of All-Inclusive Care for the Elderly).	From: MM/YY/YY To: MM/YY/YY
☐	I had creditable* prescription drug coverage from a different source not listed above. Name of other source: _____	From: MM/YY/YY To: MM/YY/YY
☐	I had Humana coverage.	From: MM/YY/YY To: MM/YY/YY
☐	I have/had extra help from Medicare to pay for my prescription drug coverage.	From: MM/YY/YY To: MM/YY/YY
☐	I lived in an area affected by Hurricane Katrina in August 2005 and joined a Medicare prescription drug plan before Dec. 31, 2006.	From: MM/YY/YY To: MM/YY/YY
☐	I had prescription drug coverage through Puerto Rico Reforma.	From: MM/YY/YY To: MM/YY/YY
☐	I never had creditable* drug coverage.	

Member ID:

***"Creditable" means that the coverage you had before joining Humana met Medicare's minimum standards.**

Please complete this section
To the best of my knowledge, the information on this form is true and correct. I understand that if I didn't have creditable coverage and/or don't give proof of creditable prescription drug coverage if asked, my premium may be higher.

I understand that my signature - or the signature of the person authorized to act on my behalf under the laws of the state where the individual resides – on this document means I've read and understand the contents of this declaration. If signed by an authorized individual, as described above, this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by Humana by Medicare.

Signature: _____ Date: ⌊M⌋⌊M⌋⌊D⌋⌊D⌋⌊Y⌋⌊Y⌋⌊Y⌋⌊Y⌋

If you're the authorized representative, you must provide the following information:

First Name: _____ Last Name: _____

Address: _____ Apt or Ste:_____

City: _____ State: ⌊⌋⌊⌋ Zip Code: ⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋

Phone: (⌊⌋⌊⌋⌊⌋) ⌊⌋⌊⌋⌊⌋ - ⌊⌋⌊⌋⌊⌋⌊⌋ Relationship to enrollee:_____

Contact Information
If you have questions, please call our Customer Care team at **1-800-457-4708**. If you use a TTY, call **711**. You can call Monday through Friday, from 8 a.m. to 8 p.m.

Our automated phone system may answer your call after 8 p.m. and on Saturdays, Sundays, and some public holidays. Please leave your name and telephone number and we'll call you back by the end of the next business day. For 24 hour service you can visit us at www.humana.com. Please be sure to keep a copy of this letter for your records.

Humana is a Medicare Advantage HMO, PPO and PFFS organization and a stand-alone prescription drug plan with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal Civil Rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion.

Humana Inc. and its subsidiaries provide: (1) free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate; and, (2) free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call **1-877-320-1235**, or if you use a **TTY**, call **711**.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion, you can file a grievance with Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.

If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html.**

Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 **(TTY: 711)** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-320-1235 **(TTY: 711)**。... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-320-1235 **(TTY: 711)**.... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-877-320-1235 **(TTY: 711)** 번으로 전화해 주십시오 .... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-320-1235 **(TTY: 711)**.... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-320-1235 (телетайп: 711).... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 **(TTY: 711)**.... ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-320-1235 **(ATS: 711)**.... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 **(TTY: 711)**.... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 **(TTY: 711)**.... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 **(TTY: 711)**.... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 **(TTY: 711)**.... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-877-320-1235 **(TTY: 711)** まで、お電話にてご連絡ください。...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-320-1235 **(TTY: 711)** تماس بگیرید.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-877-320-1235 **(TTY: 711)**....

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 **(رقم هاتف الصم والبكم: 711)**.

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