

# Erickson Financial Services

## Application Instructions for Humana

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Erickson Financial Services for review along with the completed application. If you do not have access to a fax machine, send the completed application to Erickson Financial Services along with the required first month's payment.

## HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

## IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Humana** if you are not paying by credit card for the first month.

Mail completed applications and check to:

**Erickson Financial Services**

**Attn: New Enrollment**

**5527 Altitude Dr.**

**Colorado Springs, CO 80918**

Erickson Financial Services will review your application for completeness and accuracy before we submit it to Humana for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 800-373-1164 or e-mail us at [lynne@efsbenefits.com](mailto:lynne@efsbenefits.com); [sharing@efsbenefits.com](mailto:sharing@efsbenefits.com).

Norvax form #IN-1

# Erickson Financial Services

## FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**\*\*Please FAX this cover letter with the completed application to:**

**Erickson Financial Services**

**FAX# 719-328-0107**

Dear Erickson Financial Services,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name \_\_\_\_\_

E-mail \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

Please contact me at this phone number \_\_\_\_\_  
after you have reviewed my application for completeness and accuracy.

I will contact Erickson Financial Services at 800-373-1164 to verify receipt of my application.

**\*\*I understand that Erickson Financial Services will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend**

I understand that the original, signed application and premium payment must still be mailed to Erickson Financial Services. :

**Erickson Financial Services**

**Attn: New Enrollment**

**5527 Altitude Dr.**

**Colorado Springs, CO 80918**

I will send the original, signed application and premium payment, as soon as I have been contacted by Erickson Financial Services with confirmation that my application has been received by fax and reviewed for completeness.

# HumanaOne Dental & Vision Application



Requested Effective Date: \_\_\_/\_\_\_/\_\_\_\_\_

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

**COLORADO**

Reason for change \_\_\_\_\_ Change/Modification to Existing Policy or Plan # \_\_\_\_\_

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

<input type="checkbox"/> <b>Dental Coverage</b>	<input type="checkbox"/> <b>Vision Coverage</b>
Product Name _____	Product Name _____

**2. Primary Applicant Information**

First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> 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 applying for coverage. Attach an additional family information sheet if necessary. Each additional page must be signed and dated.

<b>Spouse</b> First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / / _____
Social Security # _____		E-mail _____		
<b>Dependent</b> First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / / _____
Social Security # _____		E-mail _____		
<b>Dependent</b> First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / / _____
Social Security # _____		E-mail _____		
<b>Dependent</b> First name _____	MI _____	Last name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / / _____
Social Security # _____		E-mail _____		

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

<b>1. Agent / Agency of Record: (for commissions and correspondence)</b>	<b>2. Writing Agent / Producer:</b>
Name (print) <u>Scott R. Erickson</u>	Name (print) <u>Scott R. Erickson</u>
Humana Agent # <u>1258381</u>	Humana Agent # <u>1258381</u>

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant 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 primary applicant 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. 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 policy 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 policy 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 on the policy. 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 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 supplements, will form part of and be the basis for any policy issued. **It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. 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 application as "Humana."

**Dental products insured by HumanaDental Insurance Company  
 Vision products insured or administered by Humana Insurance Company**