Humana Employee Enrollment Application - Specialty Benefits — Connecticut

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana". To elect primary dentist, please complete GN-51340-PP.

Life plans insured or administered by Humana Insurance Company. Dental plans insured or administered by HumanaDental Insurance Company. Vision plans insured or administered by Humana Insurance Company. Short Term Disability, Long Term Disability and Life plans insured by Kanawha Insurance Company.

Please print clearly and fill in each applicable circle.

Proposed effective date: _____

Company name	Company city	State

Qualifying Event Instructions Date of Qualifying Event: _____

☐ New business enrollment ☐ Open Enrollment event ☐ Dependent birth or adoption ☐ Loss of coverage
☐ New hire/Newly eligible ☐ Rehire/Reinstatement ☐ Marital status change ☐ Other_____

Enrollment Information

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs.)	Gender	Full-time student?	Date of birth	Disabled? If yes, indicate reason and SSN within the field below.
Employee				☐ F ☐ M	N/A		☐ N ☐ Y Reason: SSN: N/A - complete in Employee Information section.
Spouse				☐ F ☐ M	N/A		☐ N ☐ Y Reason: SSN:
Child				☐ F ☐ M	☐ N ☐ Y		☐ N ☐ Y Reason: SSN:
Child				☐ F ☐ M	☐ N ☐ Y		☐ N ☐ Y Reason: SSN:
Child				☐ F ☐ M	☐ N ☐ Y		☐ N ☐ Y Reason: SSN:
Other (specify):				☐ F ☐ M	☐ N ☐ Y		☐ N ☐ Y Reason: SSN:

EMPLOYEE INFORMATION: **HOURS WORKED PER WEEK:** _____ **DATE OF FULL-TIME HIRE:** _____

SSN #	Street address		APT / Suite / Box
City	State	ZIP code	Phone #
Language: ☐ English ☐ Spanish	E-mail address		Occupation

Dental

Group #: | Benefit | Class/Div:

Coverage type: ☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family ☐ NO COVERAGE (complete waiver)

Prior dental coverage during the past 12 months (individual or other group coverage)? ☐ N ☐ Y

Prior dental insurance carrier name	**Prior coverage type:** ☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family	Effective date	Policy #
Prior orthodontia coverage in the past 12 months? ☐ N ☐ Y		Term date	Prior carrier phone

Vision

Group #: | Benefit #: | Class/Div:

Coverage type: ☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family ☐ NO COVERAGE (complete waiver)

Plan name

Last name:	First name:

Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer. I proclaim that I was not pressured or forced by my employer, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature is evidence of this action.

I hereby waive coverage for (check all that apply):	I decline to apply for group coverage because of:
Dental for: ☐ Myself ☐ My spouse ☐ My dependent child(ren) Vision for: ☐ Myself ☐ My spouse ☐ My dependent child(ren)	☐ Spousal coverage ☐ Medicare supplement ☐ Individual coverage

Agreement

True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/certificate of insurance.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within 31 days after the qualifying event.
- If I or my dependents becomes eligible for premium subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within 60 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or certificate provisions which may require additional limitations and waiting periods.
- I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 60 days after my coverage under these programs ends.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer for the purposes of depositing any contributions.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claims or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete this application.
- 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.
- Any person who willingly and knowingly submits an application containing a false, incomplete or deceptive statement may be guilty of insurance fraud. If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Authorization

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with an application, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

Authorization for Release of Medical Records for Life or Disability

If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/ certificate of insurance issued.

Last name:	First name:

Signature - please sign below if enrolling or waiving group coverage.

If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.

Employee or legal representative signature: ___ Date: _____