Humana Employee Enrollment Form - Dental, Life, Vision — TEXAS

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

PPO and Classic Medical plans, Life and Vision plans insured or administered by Humana Insurance Company. HMO plans offered by Humana Health Plan of Texas, Inc., a Health Maintenance Organization. POS plans offered by Humana Health Plan of Texas, Inc., a Health Maintenance Organization and insured or administered by Humana Insurance Company. Prepaid and AdvantagePlus dental benefits offered and administered by DentiCare, Inc. (d/b/a CompBenefits). All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

Please print clearly and fill in each applicable circle.

Proposed Effective Date: _ _ / _ _ / _ _ _ _

Company name	Company city	State

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.
Employee		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Spouse		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:
Other (specify):		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason:

EMPLOYEE INFORMATION: **HOURS WORKED PER WEEK:** ❍ **RETIREE** **DATE OF FULL-TIME HIRE:** _ _ / _ _ / _ _ _ _

SSN #	Street address		APT / Suite / Box
City	State	Zip code	Phone # ( )
Language: ❍ English ❍ Spanish	Email address		
Do you have a disability that affects your ability to communicate or read? ❍ N ❍ Y			
TX-72000-EI 5/2008			

Dental

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

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

Plan name

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 # ( )
TX-72000-HD 5/2008			

Basic Life

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

Primary beneficiary name (Last, First MI)	Secondary beneficiary name (Last, First MI)	
Class (employer will provide you with this information if needed)	Annual salary (if applicable) $	**Basic dependent life?** ❍ No ❍ Yes If no, complete waiver section.
TX-72000-BL 5/2008		

Voluntary Life

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

Voluntary employee life coverage? ❍ N ❍ Y	Amount (min $15,000) $	Primary beneficiary name (Last, First MI)	Secondary beneficiary name (Last, First MI)
Voluntary spouse life coverage? ❍ N ❍ Y	Amount (min. $5,000) $	**Voluntary child(ren) life coverage?** ❍ N ❍ Y	Annual employee salary (if applicable) $
TX-72000-VL 5/2008			

Last name:	First name:

Vision	Group #:	Benefit #:	Class/Div:	
Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ NO COVERAGE (complete waiver)				Plan name

TX-72000-VS 5/2008

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) Basic Life for: ❍ Myself ❍ My spouse ❍ My dependent child(ren) Vision for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)	❍ Spousal coverage ❍ Medicare supplement ❍ Individual coverage ❍ Coverage under another carrier's plan provided by my employer ❍ Other:

TX-72000-WV 5/2008

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 with in 31 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 plan 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. This information will be used only for rating and administrative purposes and not for purposes of eligibility for coverage.
- 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.
- 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 intentional 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 intentional misrepresentation materially affected the acceptance of the risk.
- In the event that I should decide to apply for HMO or POS coverage hereafter, I will only be eligible at the group's open enrollment period, unless I meet one of the exceptions of the late enrollee provisions. In the event that I should decide to apply for PPO, Classic or Indemnity coverage hereafter, Humana reserves the right to impose a 12-month pre-existing limitation.
- Any intentional material false statement, misrepresentation or omission contained herein relied on by Humana may be used to reduce or deny a claim or void the contract within the contestable period if such intentional misrepresentation or omission materially affected the acceptance of the risk.
- For small employer groups, I understand that any misstatements of health status will not be used to cancel, non-renew or void my medical coverage under this policy or plan but may result in an increase in medical premiums following a written notice as required in the Policy or Group Contract.

Authorization

I authorize any third party to have information regarding myself and my dependents. 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.

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. 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.
- A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below and I have the right to revoke this authorization at any time by writing to Humana's Privacy Office.

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.

TX-72000-AA 5/2008

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: _____

Name and relationship of legal representative: _____

TX-72000-SA 5/2008