Humana Employee Enrollment Form - 1-50 Employees FLORIDA

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

Life and Vision plans insured or administered by Humana Insurance Company. PPO, EPO and Indemnity plans offered by Humana Health Insurance Company of Florida, Inc. HMO plans offered by Humana Medical Plan, Inc. Prepaid, Basic, Intermediate and High Dental plans underwritten by The Dental Concern, Inc. Prepaid and AdvantagePlus dental plans offered and administered by CompBenefits Company. All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.

Please print clearly and fill in each applicable circle. Proposed effective date: _ _ / _ _ / _ _ _ _

Company name	Company city	State

Enrollment Information FL-72000-EI 2/2008

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		

Medical Group #: Benefit #: Class/Div: FL-72000-MD 2/2008

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

Plan name

1. Prior medical coverage during the past 18 months (individual or other group coverage)? ❍ N ❍ Y

Prior medical insurance carrier name	Policy #	**Prior coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _ Term date _ _ / _ _ / _ _ _ _

2. Other medical coverage in effect at the same time as this Humana coverage (individual or other group coverage)? ❍ N ❍ Y

Other Medical Insurance carrier name	Policy #	**Other coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _ Term date _ _ / _ _ / _ _ _ _

3. Medicare coverage:

Employee coverage: ❍ N ❍ Y	Medicare ID	Effective date _ _ / _ _ / _ _ _ _	Term date _ _ / _ _ / _ _ _ _
Spouse coverage: ❍ N ❍ Y	Medicare ID	Effective date _ _ / _ _ / _ _ _ _	Term date _ _ / _ _ / _ _ _ _

Health Savings Account Group #: Benefit #: Class/Div: FL-72000-HA 2/2008

If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details.

Please refer to Humana's HSA contribution worksheet to calculate your maximum allowed contribution. You can find additional information on HSAs on Humana.com. Select the Quick Link for Spending Account information on the Member page.

Do you elect the Health Savings Account? ❍ N ❍ Y (If no, complete waiver.)	Beneficiary for this account will be the employee's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Last name:	First name:

Dental	Group #:	Benefit #:	Class/Div:	FL-72000-HD 2/2008

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 # ( )

Basic Life	Group #:	Benefit #:	Class/Div:	FL-72000-BL 2/2008

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.

Voluntary Life	Group #:	Benefit #:	Class/Div:	FL-72000-VL 2/2008

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) $

Vision	Group #:	Benefit #:	Class/Div:	FL-72000-VS 2/2008

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

Evidence of Health Status FL-72000-HS 2/2008

This information should not be submitted more than 60 days prior to the effective date.

Complete this section for employees and dependents enrolling for medical coverage who are members of groups with 1-50 applicants and applicants requesting Life insurance over the guarantee issue amount, and all late enrollees applying for Life coverage.

1. Are you or any dependent currently under any treatment or prescribed medications from a licensed medical provider?	❍ N ❍ Y

2. Within the past 5 years, have you or any eligible dependent to be covered been diagnosed with, counseled, consulted or treated by a licensed medical provider for any of the following:

a	Coronary artery disease, chest pain, or any disease of the arteries or blood vessels; phlebitis; high blood pressure?	❍ N ❍ Y	**f**	Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?	❍ N ❍ Y
b	Nervous, mental or emotional condition; convulsions; epilepsy; unconsciousness?	❍ N ❍ Y	**g**	Stomach, gall bladder, intestinal or colon condition?	❍ N ❍ Y
c	Asthma or other disease of lungs or respiratory organs?	❍ N ❍ Y	**h**	Rheumatoid arthritis or back condition?	❍ N ❍ Y
d	Kidney stones; disease of kidney, bladder, male or female organs; or infertility?	❍ N ❍ Y	**i**	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
e	Cancer, and/or cancerous tumor? (state type & part of body in details section below)	❍ N ❍ Y	**j**	Alcoholism or drug habit, or been a member of Alcoholics Anonymous?	❍ N ❍ Y

3. Have you or any dependent tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	❍ N ❍ Y
4. During the past 5 years, have you or any dependent been hospitalized or received treatment from a licensed medical provider for any reason not already mentioned above?	❍ N ❍ Y
5. Are you or any eligible dependent enrolling for coverage been diagnosed by a physician as being pregnant?	❍ N ❍ Y

If you answered "yes" to any of the questions above, please provide details below and specify the question #. Attach additional signed and dated sheets if necessary.

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Scheduled treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Last name:	First name:

Waiver (refusal of coverage) FL-72000-WV 2/2008

I hereby waive coverage for (check all that apply):	**I decline to apply for group coverage because of**:
Medical for: ❍ Myself ❍ My spouse ❍ My dependent child(ren) 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) Health Savings Account for: ❍ Myself	❍ Spousal coverage ❍ Medicare supplement ❍ Individual coverage ❍ Coverage under another carrier's plan provided by my employer ❍ Other:

Agreement FL-72000-AA 2/2008

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.
- 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 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.

Authorization

My dependents and 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.

Signature - please sign below if enrolling or waiving group coverage. FL-72000-SA 2/2008

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.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date: _____

(Only if selecting Life coverage over the guarantee issue amount.)