Humana Group EE Enrollment Form- Instructions Medical and Ancillaries 2-50

Please complete the following sections:

Page 1:
Complete the Employer/ Group Name:
Qualifying Event: Select applicable event

Enrollment Information- Complete the whole section listing every individual being enrolled.

Employee/ Individual Section - Complete the whole section

Prior/ Existing Coverage

Medical-Complete if there was prior medical coverage.

Page 2:
Prior/ Existing Coverage

Dental- Complete if applying for dental and there was prior dental coverage.

Coverage Options

Medical - Select the coverage tier ie. Employee only, Employee and Spouse, etc.

- **Plan Name:** Enter plan description if more than one plan is offered

Dental - Select the coverage tier only i.e. Employee only, Employee and Spouse, etc.

- **Plan Name:** Enter plan description if more than one plan is offered

Voluntary Life/ AD&D - Complete is electing Voluntary Life for Employee, Spouse, or Child(ren).
Vision- If Electing: Select the coverage tier only i.e. Employee only, Employee and Spouse, etc.

Page 3:
SKIP this whole page.

Page 4:
ONLY complete **Beneficiary Information** at the very bottom of the page**. Skip everything else.**

Page 5:
Evidence of Health Status- ONLY complete if requesting more than $100,000 for Employee Voluntary Life or 65 years of age and older, or Dependent Spouse 60 and older.

Page 6:
SKIP this whole page.

Page 7:
Waiver (refusal of coverage)

Medical - Complete if waiving coverage for you or any eligible dependent and the reason why.
Dental - Complete if waiving coverage for you or any eligible dependent and the reason why.
Vision - Complete if waiving coverage for you or any eligible dependent and the reason why.

Page 8: Signature- Sign and date

Group Employee and Individual Application and Enrollment Form - 1-100 Employees Georgia

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group Employee and Individual Application and Enrollment Form as "Humana". To elect primary care physician or dentist, please complete reorder GA-51340-PP.

HMO and POS plans offered by ☐ Humana Employers Health Plan of Georgia, Inc., and/or insured or administered by ☐ Humana Insurance Company. PPO and Classic Medical plans and Vision plans insured or administered by ☐ Humana Insurance Company. Dental plans insured or administered by ☐ HumanaDental Insurance Company, or ☐ Humana Insurance Company, or ☐ CompBenefits Insurance Company. PrePaid Dental Plans and Advantage Plans offered by ☐ CompBenefits of Georgia, Inc. Vision plans insured or administered by ☐ HumanaDental Insurance Company or ☐ Humana Insurance Company, and ☐ CompBenefits Insurance Company. Life plans insured and/or administered by ☐ Humana Insurance Company or ☐ Kanawha Insurance Company. Short Term Disability, Long Term Disability and Workplace Voluntary Benefit plans insured or administered by ☐ Kanawha Insurance Company.

Please print clearly and fill in each applicable circle.

Proposed effective date: _ _ / _ _ / _ _ _ _

Employer / Group name	Employer / Group 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	Gender	Date of birth	Disabled? If yes, indicate reason below.		Social Security Number
Employee / Individual		❍ F ❍ M	_ _ / _ _ / _ _ _ _	❍ Y ❍ N		N/A (complete in Employee/ Individual Information section.)
Spouse / Domestic Partner		❍ F ❍ M	_ _ / _ _ / _ _ _ _	❍ Y ❍ N		
Child / Dependent		❍ F ❍ M	_ _ / _ _ / _ _ _ _	❍ Y ❍ N		
Child / Dependent		❍ F ❍ M	_ _ / _ _ / _ _ _ _	❍ Y ❍ N		
Child / Dependent		❍ F ❍ M	_ _ / _ _ / _ _ _ _	❍ Y ❍ N		
Other (specify):		❍ F ❍ M	_ _ / _ _ / _ _ _ _	❍ Y ❍ N		

Employee / Individual Information

Hours worked per week: **Date of full time hire:** _ _ / _ _ / _ _ _ _

Social Security Number	Street address		APT / Suite / Box
City	State	ZIP code	Phone # ( )
Language: ❍ English ❍ Spanish ❍ Other	E-mail address		Occupation
Employment status (check one) ❍ Active ❍ Retiree ❍ COBRA			Annual salary $

Prior / Existing Coverage: IMPORTANT - DO NOT cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

Medical

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 / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual 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 / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _
			Term date _ _ / _ _ / _ _ _ _

3. Medicare

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

Last name:	First name:

Dental

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

2. Prior orthodontia coverage in the past 12 months? ❍ N ❍ Y

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

Coverage Options

Medical

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

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family ❍ No Coverage (complete waiver)

Plan name:

Health Savings Account

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

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 / individual's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Dental

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

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family ❍ No Coverage (complete waiver)

Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)

Plan name:

Basic Life / Accidental Death and Dismemberment

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

Basic dependent life ❍ N ❍ Y (If no, complete waiver.)

Class (employer will provide you with this information, if needed)

Voluntary Life / AD&D

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

Voluntary employee / individual life coverage ❍ N ❍ Y

Amount (min $15,000)
$

Voluntary spouse life coverage? ❍ N ❍ Y

Amount (min $5,000)
$

Voluntary child(ren) life coverage? ❍ N ❍ Y

Vision

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

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family ❍ No Coverage (complete waiver)

Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)
Rate Amount $_____ Rate Frequency (Monthly)

Plan name:

Short Term Disability

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

Short Term Disability ❍ N ❍ Y (If no, complete waiver.) Buy-up percent/amount _____

Long Term Disability

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

Long Term Disability ❍ N ❍ Y (If no, complete waiver.) Buy-up percent/amount _____

Last name: | First name:

Workplace Voluntary Benefits: Optional riders availability based on employer / group election.

Accident Group #: | Benefit #: | Class: | Div:

❍ Accident ❍ N ❍ Y — Benefit Level: ❍ 1 ❍ 2 ❍ 3 ❍ 4

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

❍ Optional Hospital Intensive Care Unit Benefits Rider
❍ $150 ❍ $300 ❍ $450 ❍ $600

❍ Optional Fracture and Dislocation Benefits Rider
❍ $750 ❍ $1,500

❍ Optional Accident Total Disability Benefits Rider: **Elimination Period:** ❍ 1 Day ❍ 7 Days ❍ 14 Days ❍ 30 Days
Elimination Benefit: ❍ $400 ❍ $500 ❍ $600 ❍ $700 ❍ $800 ❍ $900 ❍ $1000

Accident - 2012 Group #: | Benefit #: | Class: | Div:

❍ Accident ❍ N ❍ Y — Benefit Level: ❍ 1 ❍ 2 ❍ 3 ❍ 4

Coverage type: ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family

Disability Income Plus Group #: | Benefit #: | Class: | Div:

❍ Disability Income Covering Accident and Sickness ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14 ❍ 30/30 ❍ 60/60 ❍ 90/90 ❍ 180/180 ❍ 365/365

❍ Disability Income Covering Accident and Sickness with Waiver of Elimination Period ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14

Monthly Benefit $

Optional Disability Income Benefits: ❍ ICU / CCU Benefit ❍ $200 ❍ $400 ❍ $600 ❍ $800
❍ Physical Therapy Benefit ❍ COBRA Rider | COBRA Monthly Benefit $

Disability Income Advantage Group #: | Benefit #: | Class: | Div:

❍ Disability Income Advantage ❍ N ❍ Y
Base Benefit Period: ❍ 3 Month ❍ 6 Month ❍ 1 Year ❍ 2 Year ❍ 3 Year
Base Elimination Period: ❍ 0/7 ❍ 7/7 ❍ 0/14 ❍ 14/14 ❍ 30/30 ❍ 60/60 ❍ 90/90 ❍ 180/180 ❍ 365/365

Monthly Benefit $

Optional Riders: ❍ Hospital Confinement ❍ COBRA Rider | COBRA Monthly Benefit $

Whole Life / AD&D Group #: | Benefit #: | Class: | Div:

❍ Whole Life / AD&D ❍ N ❍ Y | ❍ Whole Life 99 | ❍ Whole Life 65 | Employee / Individual Benefit $

❍ AD&D Rider ❍ Automatic Premium Loan Option

❍ Automatic Benefit Increase Rider
❍ $1 / Week
❍ $2 / Week

❍ Employee / Individual Term Rider to 65
Employee / Individual Benefit $

❍ Family Term Rider
Spouse Benefit $
Child(ren) Benefit $

Whole Life Spouse / AD&D Group #: | Benefit #: | Class: | Div:

❍ Stand Alone Spouse / AD&D ❍ N ❍ Y | ❍ Whole Life 99 | ❍ Whole Life 65 | Spouse Benefit $

❍ AD&D Rider | ❍ Family Term Rider (Child Coverage Only)
Child(ren) Benefit Amount $ | ❍ Automatic Premium Loan Option

Last name:	First name:

Whole Life Child(ren) / AD&D Group #:		Benefit #:		Class:		Div:	
❍ Whole Life Child(ren) / AD&D ❍ N ❍ Y							
Child(ren) listed here must also be included as dependents under the Enrollment Information section of this application.							
❍ N ❍ Y **Coverage on Child 1**	Child 1 Name					Child 1 Benefit $	
❍ N ❍ Y **Coverage on Child 2**	Child 2 Name					Child 2 Benefit $	
❍ N ❍ Y **Coverage on Child 3**	Child 3 Name					Child 3 Benefit $	

Level Term Life	Group #:		Benefit #:		Class:		Div:	
❍ Level Term Life / AD&D ❍ N ❍ Y		**Coverage type:** ❍ Employee / Individual only ❍ Spouse ❍ Child(ren)			**Base Plan:** ❍10-Year Term ❍20-Year Term **Optional Benefit:** ❍ Automatic Benefit Increase		
Employee / Individual Benefit $		Spouse Benefit $			Child(ren) Benefit $		

If your employer or group has elected the critical illness rider, have you or any dependent had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? ❍ N ❍ Y
If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent.
❍ You (Employee / Individual) ❍ Spouse ❍ Dependent Name_____

Critical Illness	Group #:		Benefit #:		Class:		Div:	
❍ Critical Illness ❍ N ❍ Y ❍ Critical Illness and Cancer ❍ N ❍ Y		**Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family						
Optional Benefits: ❍ Automatic Benefit Increase ❍ Health Screening ❍ Return on Premium					Employee / Individual Benefit $			

Have you or any dependent had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60? ❍ N ❍ Y If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent.
❍ You (Employee / Individual) ❍ Spouse ❍ Dependent Name_____

Group Lump Sum Cancer	Group #:		Benefit #:		Class:		Div:	
❍ Group Lump Sum Cancer ❍ N ❍ Y		**Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family						

Have you or any dependent had a parent, brother, or sister with a history of cancer diagnosis prior to age 60? ❍ N ❍ Y
If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent.
❍ You (Employee / Individual) ❍ Spouse ❍ Dependent Name_____

Rider: ❍ Automatic Benefit Increase ❍ Health Screenings	Base Benefit $

Cancer Expense	Group #:		Benefit #:		Class:		Div:	
❍ Cancer Expense ❍ N ❍ Y		**Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family						
❍ Lump Sum Benefit (Equal to 50% of Base Benefit Amount)		**Rider:** ❍ Hospital Indemnity Rider			Base Benefit $			

Supplemental Health	Group #:		Benefit #:		Class:		Div:	
❍ Supplemental Health ❍ N ❍ Y		**Coverage type:** ❍ Employee / Individual only ❍ Employee / Individual and spouse ❍ Employee / Individual and child(ren) ❍ Family						

Plan type: ❍ 1 ❍ 2 ❍ 3 ❍ 4

Beneficiary Information for Life, Disability and Workplace Voluntary Benefits

Primary beneficiary name (Last, First MI)	Relationship to Employee / Individual
Secondary beneficiary name (Last, First MI)	Relationship to Employee / Individual

Last name:	First name:

Evidence of Health Status - Do not submit more than 90 days prior to the effective date.

Complete this section if you are selecting workplace voluntary (excludes Accident) benefits.

ALL MEDICAL QUESTIONS SHOULD BE ANSWERED IN RELATION TO TREATMENT OR DIAGNOSIS MADE BY A MEDICAL PROFESSIONAL OR PHYSICIAN AND ARE LIMITED TO THE LAST 10 YEARS UNLESS OTHERWISE INDICATED.

1a.	In the past 12 months has any applicant used any tobacco product? If yes, applies to: ❍ Employee ❍ Spouse/Domestic Partner ❍ Other ❍ Child/Dependent names_____	❍ N ❍ Y
1b.	Is any applicant currently a smoker? If yes, applies to: ❍ Employee ❍ Spouse/Domestic Partner ❍ Other ❍ Child/Dependent names_____	❍ N ❍ Y
2.	In the past 12 months, have you missed 5 or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu, back problems, strained/sprained/fractured/broken limb or as a result of pregnancy?	❍ N ❍ Y
3.	Has anyone on this application been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), Acquired Immune Deficiency Syndrome (AIDS), or tested positive for AIDS or Human Immunodeficiency Virus (HIV)?	❍ N ❍ Y
4.	Within the past 5 years, has anyone on this application been diagnosed with diseases or disorders related to, counseled, consulted, or treated by a doctor, including surgery, for any of the following:	

a.	Coronary artery disease, chest pain, heart surgery, or any disease of the arteries, or blood disorders; anemia; hemophilia; phlebitis; high blood pressure (reading higher than 140/90)?	❍ N ❍ Y
b.	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	❍ N ❍ Y
c.	Stroke; Transient Ischemic Attack (TIA)?	❍ N ❍ Y
d.	Emphysema; asthma, or other disease of lungs, or respiratory organs?	❍ N ❍ Y
e.	End stage renal disease; disease of kidney?	❍ N ❍ Y
f.	Cancer, and/or cancerous tumor; including skin cancer?	❍ N ❍ Y
g.	Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	❍ N ❍ Y
h.	Rheumatoid arthritis; or back disorders; or joint disorders?	❍ N ❍ Y
i.	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
j.	Chronic Fatigue Syndrome/Fibromyalgia?	❍ N ❍ Y
k.	Diseases of the eye, ear, nose, or throat? Disease or disorder which has led or may lead to a permanent or progressive loss of vision, hearing or speech?	❍ N ❍ Y
l.	Alcoholism or drug habit?	❍ N ❍ Y

5.	Has anyone on this application been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past 5 years?	❍ N ❍ Y

Last name:	First name:

Medical Health History - Do not submit more than 90 days prior to the effective date.

For groups 51+, complete this section if you are selecting medical benefits.

ALL MEDICAL QUESTIONS SHOULD BE ANSWERED IN RELATION TO TREATMENT OR DIAGNOSIS MADE BY A MEDICAL PROFESSIONAL OR PHYSICIAN AND ARE LIMITED TO THE LAST 10 YEARS UNLESS OTHERWISE INDICATED.

1.	Is anyone on this application covered currently pregnant? If yes, please indicate anticipated delivery date below. Anticipated delivery date:	❍ N ❍ Y
2.	In the past 12 months, have you missed 5 or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu, back problems, strained/sprained/fractured/broken limb or as a result of pregnancy?	❍ N ❍ Y
3.	Has anyone on this application been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), Acquired Immune Deficiency Syndrome (AIDS), or tested positive for AIDS or Human Immunodeficiency Virus (HIV)?	❍ N ❍ Y
4.	Is anyone on this application currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	❍ N ❍ Y
5.	During the last 24 months, has anyone on this application been diagnosed with, or treated for, any illness or injury or had surgery or hospitalization recommended?	❍ N ❍ Y
6.	Within the past 12 months, has anyone on this application incurred covered medical expenses in excess of $10,000?	❍ N ❍ Y

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs)
Employee		/	
Spouse / Domestic Partner		/	
Child / Dependent		/	
Child /Dependent		/	
Child /Dependent		/	
Other (specify):		/	

If you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets (reorder GA-51340-MH), if necessary.

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

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 / group. I proclaim that I was not pressured or forced by my employer / group, 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):

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)
Short Term Disability for:	❍ Myself		
Long Term Disability for:	❍ Myself		
Health Savings Account for:	❍ Myself		

Waive Coverage for Workplace Voluntary Benefits:

Whole Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Level Term Life for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Critical Illness for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Group Lump Sum Cancer for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Cancer Expense for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Supplemental Health for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Accident for:	❍ Myself	❍ My spouse	❍ My dependent child(ren)
Disability Income Plus for:	❍ Myself		
Disability Income Advantage for:	❍ Myself		

I decline to apply for group coverage because of:

- ❍ Spousal coverage
- ❍ Medicare supplement
- ❍ Individual coverage
- ❍ Coverage under another carrier's plan provided by my employer / group
- ❍ Other: _____

Agreement

True and complete acknowledgement

I understand, agree, and represent:

- I have read the Group Employee and Individual Application and Enrollment Form 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 / group 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 the Group Employee and Individual Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate.
- 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 become eligible for premium or rate 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. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- In the event that I should decide to apply for coverage hereafter, that subsequent Group Employee and Individual Application and Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- Based on the coverage I have elected, I may be required to furnish 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. I understand eligibility for enrollment does not apply to an HDHP.
- 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 submissions of the Group Employee and Individual Application and Enrollment Form 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 / group for the purposes of depositing any contributions.
- 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 the Group Employee and Individual Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Group Employee and Individual Application and Enrollment Form to cover the benefit actually issued.
- An act of fraud or an intentional misrepresentation of a material fact may void or terminate an individual's or group's coverage as specified under the terms of the Policy or Certificate. Providing incomplete, inaccurate, or untimely information may reduce, or increase past premium, or terminate an individual's coverage or the group's coverage.
- Medical coverage will not be declined due to health status.
- I have received a copy of the plan provider directory and disclosure that includes provider limitation rules, and any financial arrangements with providers.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Group Employee and Individual Application and Enrollment Form by Humana.
- Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and, upon conviction, may be subject to fines or confinement in prison, or both.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Last name:	First name:

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 the Group Employee and Individual Application and Enrollment Form, 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.

The Group Employee and Individual Application and Enrollment Form, together with any supplemental forms, will make up part of any contract and be the basis for any policy or certificate.

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 / Individual or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date:_____

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

Agent / Producer Information

If applying for workplace voluntary benefits, this section to be completed by Agent or Producer.

1. Agent / Agency of Record:	**2. Agent / Agency of Record:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:

1. Writing Agent / Producer:	**2. Writing Agent / Producer:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Commission split:	Commission split:

Will the coverage selected replace or change any existing life or disability insurance policy(s) and/or annuity(s)? ❍ N ❍ Y

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Group Employee and Individual Application and Enrollment Form in order to fully and accurately represent the terms and conditions of the plans 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 plan literature.

Signed at _____ _____

County State

Writing Agent's Signature _____ 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.